Here we Theodore Georgis, Jr., MD May 18, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.

- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Matthew Steiner, MD May 18, 2018
Expedient Medicolegal Services

Having had the opportunity to read many of the draft responses generated by attorneys, physicians and various stakeholders I have a good idea about the types of legal arguments that will be put forth to dispute these proposed changes. Not being an attorney, I will not be making any legal arguments.

As a physician, I choose to provide a physician's perspective on these proposed changes. I will be briefly outlining a case with some details changed or omitted to protect privacy.

I recently evaluated an applicant who presented in a double wide wheelchair to an evaluation that had been scheduled for almost 60 days in which I was not presented with any medical records prior to the appointment. My office made every attempt to obtain records before the evaluation. The only document I was able to obtain was an attorney letter which did not contain any appreciable case specific information but did contain the usual generic list of 16 to 20 questions requiring my attention.

It turned out that the applicant had what was one of the most complex medical histories I had ever

encountered and an employment which lasted approximately three decades (ending over 10 years prior). Unraveling the answers to the many questions posed to me in the attorney letter took many hours to say the least. There were multiple dates of injury claimed which were poorly characterized due to lack of recollection and inability to present a chronological history of any considerable detail. Causation of these various medical problems were not elucidated by the applicant.

The applicant was a poor historian (although otherwise quite pleasant) and, in my view, exhibited clear cognitive deficits which prevented them from aiding me in answering the numerous questions posed to me. Medical and psychiatric pathology was evident; the applicant had a rare and long-standing autoimmune neuromuscular disease, morbid obesity, approximately 100 pounds of lymphedema (contained in lumps ranging in size from a golf ball to the size of a basketball) distributed between the knees and lower abdomen, clear psychiatric pathology, chronic use of high-dose opioid analgesics for in excess of a decade (with all associated comorbidities), bowel and bladder incontinence, was essentially non-ambulatory, and had an additional list of medical problems including cardiovascular, pulmonary, blood dyscrasia, and endocrine disease. Sexual function for this applicant was physically impossible for the last several years due to the lymphedema obstructing sex organs.

All QME's are familiar with being placed in this set of circumstances; it is commonplace.

Given these circumstances, under the current proposed rules there is no chance that this case would be eligible for a fair compensation; it would likely be limited to less than four hours of billable time (i.e., ML103). Without causation or medical records as a complexity factor perhaps the proposed regulations would limit it to an ML102? The time it would take any QME to perform an evaluation that met the standard outlined by the DWC in compliance with their regulations exceeds the billable time of the proposed regulations. More troublesome, the proposed regulations do not serve as a good marker to judge the complexity or difficulty of evaluations.

QMEs should not be penalized for not receiving medical records prior to evaluation; under the current system, this precludes a QME from using medical records as a complexity factor. In retrospect, this evaluation should have been rescheduled on the basis of not receiving medical records since this is allowable for psychiatric evaluations.

Should the proposed rules be instituted, attorneys and the DWC should expect that many psychiatric exams would be rescheduled due to lack of medical records received.

Under the proposed rules, the only way for this evaluation to be billed as an ML-104 would be to have an agreement allowing extraordinary circumstances under ML-104(3). It is currently unclear (based upon my discussion with many stakeholders who offer differing opinions) whether the DWC considers it adequate to receive a signature from a defense attorney or an adjuster to satisfy this agreement. Who does the signature need to be obtained from to be valid in the DWCs eyes? Why don't QMEs have a clear understanding of this? Why do stakeholders disagree so fiercely on this topic? Why does it seem that the consequences of this ambiguity fall only to QMEs?

The proposed rules also state a QME cannot refuse to perform an exam on the basis of not receiving such a signed agreement when requested. Under the current rules, the return rate for such letters varies but could be estimated to be around 50%. Under the proposed rules, with the knowledge that a QME cannot refuse to see an applicant should the letter not be signed, I would

worry that the attention to these letters would decrease even further.

Is it fair to limit billing to less than four hours for such a case as described above? Is four hours enough time for a QME to fulfill their obligations to the DWC and in compliance with their regulations and to the attorneys in the case? Are these fair circumstances to place a QME physician in?

Some cases are simple; others are not. Some cases that don't have records (i.e., a complexity factor) are much more complex than other cases that do have records. Some simple cases meet more complexity factors than complex cases. Some extremely complex cases, that take a great deal of time to complete based on reasonable medical evidence, have no chance of meeting ML-104 without a signed extraordinary circumstances letter under the proposed guidelines.

The proposed regulations are intellectually dishonest. A reasonable and objective person would agree that it places the QME Doctor in bad circumstances in many respects. The proposed regulations compel QMEs (i.e., they cannot refuse) to perform work in compliance with their certification and their obligations to the DWC in circumstances where they will not be compensated.

A good QME did not learn to answer the questions in attorney letters in medical school. The terminology, concepts, and lexicon are almost completely foreign to medical education. QME physicians choose to expand their knowledge base by obtaining a certification from the DWC to bring their medical knowledge into a completely new area of practice which requires careful study as well as required continuing education.

Enactment of these proposed regulations will result in a dramatic drop in the number of offices listed by QME's in the State of California and a dramatic drop of the overall quality of the medical reporting provided. Providing reasonable medical evidence that is based upon all sources of available data takes time. Assisting attorneys in developing the record when data is missing takes time.

I assume that the purpose of these proposed regulations is to solve a problem. I suggest that the problem be defined as narrowly as possible and that a commonsense solution be implemented to address that particular problem. These proposed regulations are not narrowly defined, and I believe that it will result in a dramatic decrease in the availability of QME physicians. As I understand it, the core mission of the DWC is to ensure that there are well-trained physicians available all over the state of California to assist in evaluating injured workers by supplying medical opinions that take into consideration all of the reasonable medical evidence. These proposed changes, if enacted, will seriously jeopardize that core mission.

Jerry Hall, Medical-Legal Expert May 18, 2018
Principal of Brightspeed Consulting

Since graduating from business school, I have had the privilege of working in the medical-legal industry for over a decade, serving as a chief operating officer for more than one network of physicians (or "medical management companies" as I've heard some in California refer to them). That experience has provided me exposure to medical-legal assessments in all fifty states for workers' compensation, auto, disability, and other insurance types while facilitating these

services as requested by federal and state government agencies, insurers, self-insured employers, third-party administrators, attorneys, or claimants themselves.

Whether they are called QMEs, AMEs, IMEs (most states), RMEs (in TX), or DDs (also in TX), the work done is important and valuable. Done well, medical-legal assessments benefit all parties involved. Claimants benefit from additional expertise to ensure they achieve optimal outcomes and return to work as appropriate. Payors benefit from receiving valuable insights which help them care for their claimants and make critical claims management decisions. Doctors benefit from additional income and the opportunity to consider interesting cases while strutting their expertise that they studied and toiled for years to obtain.

The overwhelming majority of those involved in this industry have everybody's best interests at heart. Thanks to them, people heal more quickly, workplaces are safer, and advances in medicine and claims management evolve. However, disappointingly, I have enough experience to be aware of the dark side as well: claimants exaggerating or making false claims altogether, payors saving a buck for themselves by forbidding a claimant the medical care and esteem they deserve, and doctors gaming the system for financial gain with compromised opinions and excessive, even phony, billing.

Several comments made about the proposed changes to the reimbursement of medical-legal expense regulations suggest an intent of the proposed changes is to fight fraudulent billing and abuse of the current medical-legal fee schedule by certain QMEs. Knowing how they did so, I can name QMEs who have committed billing fraud. Jaws would drop at the amounts of their resulting financial gains. These doctors should be removed from the QME system, relieved of their medical license, and welcomed by a California or federal penitentiary. There are likely more QMEs committing billing fraud than I'm currently aware. Candidly, § 9794 and § 9795 make it way to easy for QMEs who bill fraudulently to get away with what they do. In fact, it's so easy, it wouldn't shock me if QME billing fraud were rampant. Changing the medical-legal expense regulations will not bring justice against QMEs who have committed fraud for years. Nor will the proposed changes stamp out the billing fraud that could continue to occur.

Finding certain QME billing fraud is like spotting constellations. Unless someone shows you beforehand what to look for, constellations are difficult to see. But once you've seen Orion's belt or the trapezoidal scoop of The Big Dipper, those constellations are undeniably there, and their distinct patterns and resulting shapes make them easy to spot forevermore. Certain QME billing fraud is the same. If you know what to look for, the patterns and results of that fraud become prima facie evidence of its existence.

The DWC's relatively recent audits of QMEs failed to ferret out the fraud. If that was the purpose of those audits, their methodology was flawed, and it's clear that nobody correctly showed the DWC beforehand what to look for. Now, the proposed changes mirror the methodology used by the DWC to decline renewal to some QMEs. If the purpose of the changes is to ferret out the fraud, the result will be as ineffectual as the audits. Meanwhile, many QMEs who do excellent work will be inclined to discontinue conducting these essential medical-legal evaluations.

Interest alignment is critical when it comes to compensation or reimbursement schedules. Other states like Washington, Minnesota, and Texas also have fee schedules in place for workers' compensation medical-legal assessment work. None of those fee schedules seems perfect. However, all of them seem to succeed in mitigating billing fraud for those services far better than § 9794 and § 9795 currently do, or the proposed changes would do. Study of those fee schedules will reveal strengths that should be mirrored as California consider very necessary

changes to § 9794 and § 9795 to improve interest alignment among all parties. As a general concept, what seems to work reasonably well is to pay a flat fee for a medical assessment (with a different fee for psychiatric evaluations), while allowing for additional remuneration when there are voluminous records (paid on a per page basis) or multiple body parts involved. The billing becomes very objective and can be known before the examination ever takes place. I'm happy to offer my experience and expertise to help devise an improved fee schedule for California that better aligns interests of all parties so that doctors are appropriately rewarded for their effort without potential compromise to their opinions, and payors are charged appropriately for the value they receive.

As mentioned at the beginning of my comments, medical-legal assessment work is important and valuable to claimants, payors, providers, and society at large. It's critical for California to cultivate a system and environment that encourages and rewards all parties to providing quality results with utmost integrity. Done well, the results will lessen the financial and emotional costs of workplace injuries, while improving the care and outcomes for all involved when those injuries unfortunately happen.

Miguel Alvarez, Ph.D., QME May 18, 2018

The newly proposed fee schedule was clearly written by someone who has never written a QME report and/or who has no knowledge or appreciation for the amount of time, attention, education and consideration that must go into one. This proposal is akin to proposing that someone drive a car with only two wheels on it. There is no doubt what-so-ever, that if this proposal goes into effect, the quality of report writing is going to suffer dramatically, a lot of redundant and unnecessary work will be created in order to clean up the messes that will be left behind, while many QME's will have to stop doing this kind of work altogether. Nobody can afford to work several hours for free. What a shame it will be for the injured workers in our state who will no longer benefit from careful medical analyses of their cases. What a shame it will be for the Triers-of-fact, who will no longer have careful medical analyses to rely upon in making their determinations. What a shame it will be for those medical providers who previously dedicated years of their lives to learn how to produce quality work and who will no longer be in a position to render careful and qualified opinions because they will not get reimbursed for their time and expertise. The QME's are already underfunded and limited by the current regulations. Please do not contribute to this proposed travesty, and vote against doing more harm with this proposal.

Scott Thompson, Certified Workers' Compensation Claims Administrator, Former WC Adjuster
CEO – Arrowhead Evaluation Services, Inc. May 18, 2018

For those of us following the drama in our state regarding the MLFS, there have been QMEs being non-renewed, regulators being sued for allegedly making up rules ("underground" regulations), parties suing each other, QMEs dropping out of the system, etc., and there have certainly been some unscrupulous doctors who have abused the MLFS by padding time, adding miscellaneous costs not allowed in the MLFS, and generally being dishonest. Up until 2016, medical legal fees were generally not controversial, and the fee schedule had generally done its job since 1993. In the summer of 2016 the DWC Medical Unit began to "prosecute" QMEs by way of non-

reappointment, which usually went something like this (from a QME office administrator's perspective): QME re-appointment date arrives, but Medical Unit has not sent re-appointment paperwork to the doctor; Doctor calls medical unit, asks about re-appointment; Medical Unit faxes paperwork announcing that charges of overbilling have been leveled against the QME by the DWC, despite the QME never being notified; Doctor then either drops completely out from system (leaving parties to go through the QME process all over again) or spends thousands of dollars in attorney fees to fight with the DWC for 3-18 months or more (also leaving the parties to go through the QME process all over again.) Meanwhile, WC claims are left open, injured workers cannot settle their cases, and system costs are increased.

A lot of the blame for this can be assigned to the confusing nature of the MLFS itself. Many doctors who had good reputations (and several who perhaps did not) were snared in this QME-reappointment-denial controversy because of the ambiguities of the fee schedule. One person's "complex" report is another person's "basic" report, and so on. A common complaint amongst doctors is the scenario in which a file-box sized volume of records arrives, (unsorted) and the doctor spends 6 or more hours reviewing the medical records, sub rosa investigation records/videos, depositions, etc, and then examines the claimant, who has had one previous claim, spends an hour with the claimant taking a history, then spends 2 hours dictating and editing a report. It sounds like it would qualify as "extraordinarily complex", but if the claim has not been denied by the carrier, and the claimant is not MMI, the physician most likely cannot use causation and apportionment as complexity factors. How does the doctor go about being reimbursed for 9 hours of professional time? If the doctor is an orthopedic surgeon, he/she is faced with the choice of billing at ML104 (hourly at $250/hour) and possibly losing his/her QME, or billing at ML102 ($625 for 9 hours of MD work) or ML103 ($938 for 9 hours of MD work.) In this case, since the medical legal evaluation does not qualify for anything other than ML102, billing anything above the "Basic" ML102 level could get the doctor into hot water with the DWC. Is it worth losing your QME designation to bill over $625 for 9 hours of your time as a physician? Many physicians have taken this position: Why even bother being a QME? In fact, the number of QMEs in the system has been dwindling according the recent DWC data. My first hand experience has been that once you explain to a doctor who is still treating patients what the QME system pays, and the fact that the fee schedule is rather convoluted, and that billing at levels above ML102 exposes you to possible disqualification by the DWC, that doctor typically does not want to become a QME.

On the other hand, the Medical Legal Fee Schedule (as written) can be abused to victimize insurance carriers and employers as well. Insurance carriers are often faced with this scenario: Doctor submits a bill in which he/she allegedly spends 2 hours face to face, 4 hours on a small amount of records, one hour on research (does an orthopedic surgeon really need to do research on a simple low back injury?) and 4 hours on report prep, and addresses causation and apportionment. The doctor sends a bill for $2,750. Did the doctor really spend 11 hours on what seems like a simple case? Well, you don't need to consult the Apple store Genius to answer that question. In fact, an attorney friend of mine recently related this outrageous situation: Claimant shows up for an orthopedic panel QME evaluation (hand complaints), large box of records arrived beforehand; doctor cancels appointment on-site because, as a hand specialist, does not want to examine non-hand complaints to neck, etc.; insurance carrier later gets bill for over $20,000 (twenty thousand dollars) for review of records, which was done by a chiropractor and jointly signed by the QME and the chiropractor. If you were the claims manager or self-insured employer on this case, wouldn't you be on the phone to the DWC Medical Unit and writing a letter to the authorities about this? Again, no Apple store Genius needed for that answer.

In 1996, I had the opportunity serve on the MLFS Task Force that met several times in South San Francisco at the invitation of the Industrial Medical Council, the product of which was the MLFS

that, for the most part, exists today. As a former claims adjuster, (and in 1996, a medical group administrator) I was not in favor of the current MLFS because I believed that it was susceptible to abuse by both providers and payers because of the subjective nature of "complexity" combined with time spent. "Complexity" is always going to be a subjective term and time spent can be abused. It's important to note that prior to the current Fee Schedule, doctors were paid a fixed amount per evaluation, (about a $1,000 in 1992 dollars, which translates into $1,777 in 2018, after taking inflation into consideration) which fell out of favor to the current "time/complexity" model that exists today, which, decades later, has now fallen out of favor, according to former DIR Director Christine Baker, who expressed an intention to move away from a time-based fee schedule.

So, as a Workers Compensation claims community, how do we create a Medical Legal Fee Schedule that payers and providers can live with? According to LC 5307.6, the MLFS is supposed to reflect reimbursement for "reasonably comparable work".

What is reasonably comparable work? A comparable fee schedule is reflected in the disability evaluations in the CalPERS retirement system which asks physicians if its members are qualified for disability retirement, and the physician is typically paid $1,000 or more for what is usually a more simple evaluation which typically goes like this: Here is a job description, here are the records, please examine the member and tell us what the member cannot medically do; is the member exaggerating; and is the disability permanent or temporary? There is no apportionment, causation is rarely an issue, no Almaraz/Guzman, no Benson, no depositions of treating doctors to consider, and there is rarely a grilling of the doctor by deposition. If there are inches of records, CalPERs will allow extra compensation to the doctor for extended time spent.

Another comparable system is the civil litigation system - - auto accidents, slip-and-falls, etc. For this medical legal work, the doctor names his or her own price and the attorney or the insurance carrier agree on the rate before the work is done. Typically, this work is reimbursed as either a fixed flat fee or an hourly fee, but the fees range per specialty and usually start at about $350/hour for chiropractors and psychologists and up to $850/hour or more for experienced spine surgeons and neurosurgeons. A system such as this would not be practical for the QME arena, but it provides an **example of comparable work**, at least for doctors that are chosen for their expertise and proven track record of valuable, credible reports. (Let's be honest, there are many QMEs in California that do not provide valuable, credible reports, but that is a byproduct of the panel system, as opposed to the choose-your-best-doc system.) As another economic yardstick, attorneys in employment law (not necessarily related to workers comp) typically charge $300-$350 per hour or more. Why should physicians be paid less per hour than the attorney taking their deposition?

Finding an equitable medical legal fee schedule is a difficult task. Texas tried it many years ago; their fees averaged about $800 per evaluation, and their number of participating MD's dropped to about 160 state-wide, leaving chiropractors to do the bulk of the work. (By comparison, California has over 2,500 QMEs, although the number is falling steadily.) Recently, Texas changed their fee structure in an attempt to lure MD's back into the system. So, getting it wrong can be costly in many ways - - doctors drop out, reports lose quality, and more frictional costs are created.

A medical legal fee schedule should do the following:

- Establish fees that both payers and doctors can live with
- Establish fees that are simple to understand and are predictable to all parties, and not subject to abuse by either party
- Attract good doctors to the QME system and provide incentives to stay in the system
- Minimize frictional costs/arguments/liens

- Incentivize both parties to be timely with services and payment
- Establish fees that adjust with inflation, negating the need for future fine-tuning

The problem with the changes proposed by the DWC is that it leaves in place the onerous steps of "causation" and "apportionment" and it more or less asserts that a physician will not spend more than three hours in report preparation when, in the real world, internal medicine specialists and psychiatrists and psychologists regularly spend over three hours compiling information and preparing lengthy, detailed reports that must meet the definition of substantial medical evidence. In this first substantial update of the fee schedule since 2006, the DWC has also failed to account for 12 years of inflation, which would justify at least an increase of 27% based upon the Bureau of Labor Statistics inflation data. Most importantly, the proposed changes leave in place a MLFS that has proven itself to be outdated, controversial, confusing, frustrating, and has created more friction and litigation than ever intended.

In summary, it's time for a new, simple, and durable medical/legal fee schedule:

I therefore propose the following:

The 2018 SIMPLE Medical Legal Fee Schedule

ML-100 Failed Appointment - Applies to no-shows or cancellations with less than 72 hours notice.

$450 for all specialties except: Internal Med - $450; Psych $700.

ML-101 Re-evaluation within 9 months – 75% of ML-102, 103 or 104 as noted below.

ML-102 Initial Evaluation - $1,100 - For all specialties except Internal Medicine, Pain Medicine, Neurology and Psychology/Psychiatry evaluations

ML-103 Initial Evaluation - $1,750 – For Internal Medicine, Neurology & Pain Medicine evaluations

ML-104 Initial Evaluation - $3,500 – For Psychology & Psychiatry evaluations only

*NOTE: ML-101, 102, 103, and 104 fees are inclusive of up to 100 pages (one-sided) of records submitted to the physician by the referral source. Additional records reviewed by the physician exceeding 100 pages shall be reimbursed at $2 per page. (Record review charges are not subject to modifiers.) [Example: Orthopedic Surgeon sees applicant, 300 pages of records received. Total fee = $1,100 + (200 pages x $2/page=$400) = $1500.] Since most med/legal evaluations involve less than 100 pages of records, this additional fee will be infrequent.

ML-105 – Testimony/Depos/Video Review: $400/hour

ML-106 Supplemental Reports – The physician may not charge for corrections to typographical errors or omissions from previous reports. *Example:* Physician failed to address apportionment, or typo fix = No charge. For all other inquiries from the parties, the physician may charge $150 for responding to up to 2 questions, and up to $250 for up to 4 questions, and $350 for up to 6 questions, and additionally, for supplemental records received after the DOI, the physician may charge $2 per single-sided page reviewed, and $4 for double-sided pages.

Modifiers: 93 modifier for interpreter present - same as current fee schedule (+10%)
94 modifier (+25%) applies to AMEs, Joint QMEs, and Agreed PQMEs. (Since complexity is same as an AME and doctor is rewarded for credible, useful, reporting habits.)
99 modifier (+4%) for reports mailed within 10 calendar days of date of service, or date of receipt of new supplemental records or inquiries.

What the 2018 SIMPLE Medical Legal Fee Schedule does:

- Mirrors flat-fee disability evaluations starting at $1,000 currently paid by CalPERS to providers.
- Eliminates all hourly physician billing, except for depositions, court testimony or review of video evidence.
- Saves payers money by reducing average cost of ML evaluations, and eliminating frictional costs.
- Eliminates fraud and abuse of time-based fee schedule by unscrupulous providers.
- Creates simplicity for a system that badly needs it.
- Vastly reduces confusion, regulatory agency burden, disputes and liens amongst system participants.
- Incentivizes efficiency and rapid med/legal reporting.
- Provides incentives for good QMEs to stay in the system and for new QMEs to join the system.
- Provides incentives for physicians to produce AME quality reports.
- Establishes predictability to supplemental reporting.
- Incentivizes carriers/referral sources to eliminate useless records sent to doctors, i.e. duplicates, blank pages, proofs of service, etc.

Jacob Rosenberg May 18, 2018

While we can all recognize that there is a greater proportion of ML104 evaluations and a greater number of supplemental reports over the last 5 years no one has looked at the effect of the SB899 apportionment changes as a significant causal factor . By changing the requirements for apportionment the defense is almost required to obtain all prior non industrial records which creates a situation where record review alone is frequently 5 hours. That of course leads to additional ML104 reports. In addition the changes with Kite, Almarez, Hikida frequently lead to a request by one party or another to reconsider some aspect of the rating or apportionment. As the awards have increased in size the (financial) stakes for the parties have increased leading to more supplementals as every issue is considered and reconsidered.

The simple fact that there are more reports (ML104s, and ML106s)does not mean that evaluators are being sloppy nor does it mean that they are over billing. Therefore there may not be a need for "fix" the system based simply on the changes in report charges.

Having said all of the above I have some comments on the specific proposed changes.
I would start by stating the obvious: That is the goal should be to reward physicians for performing the work that results in an evaluation that provides appropriate information. Unfortunately in considering the proposed regulations I am not sure that there is any purpose except arbitrarily limiting the ability of the physician to bill an ML104 regardless of the work required.

Starting with AOE
I recognize that the current interpretation is that AOE is necessary only when an injury is disputed. The existence of a disputed injury is self evident if applicant has filed for a cumulative and specific and only the specific is accepted then there is a genuine issue of AOE/COE that must be addressed Your proposed rule of both parties asking for this to be addressed is not appropriate since there is an issue of causation of injury that must be addressed.

For the medlegal examiner to be required to perform work but to limit his payment based on the competence (or fairness) of attorneys is clearly ridiculous. A defense attorney can do his client a tremendous service simply by not asking the evaluator to address AOE. That will limit the number of ML104 reports billed to his client.

In response evaluators could not address the issue to" punish the attorneys" but that actually punishes the injured worker and leads to more supplemental reports clearly not an intended outcome.

Therefore you should drop the requirement for both the parties to request an AOE evaluation.

If all the dates of injury are accepted then there is no dispute regarding causation of injury. if not then there is an issue. Requiring the attorneys to formally ask is irrelevant to the work required.

That brings us to a second issue which is extent and nature of injury ie. which body parts are injured. Frequently this requires looking at records in great detail, considering the mechanism of injury, the DFR, physical therapy notes, and the pathology present in the disputed body part. This is an essential part of the report and certainly a factor that involves extra time in consideration and preparation. As it currently stands with your proposed rule changes there is no way for the physician to be compensated for this type of work. (especially true since you have arbitrarily limited report preparation time).

In my opinion the need to address whether a body part arises out of employment should count as a factor (6) in reaching an ML104 threshold. Either an issue regarding extent of injury or an issue involving causation of injury should be sufficient to trigger factor 6 assuming that the evaluator actually resolves the issue. (an orthopedist cannot resolve an issue on nature and extent of injury for a psychiatric or some internal medicine issues).

Next is the issue of requiring research to be used to claim factor 5
That also appears to simply be an attempt to arbitrarily limit ML104 exams especially in the context of the other proposed changes.

The evaluations that I am doing this year frequently (over 30% of the time) have over 1500 pages of medical records. Many times these records arrive the within 48 hours of the exam. Yet per your rules, I have no mechanism to charge for the time it takes to perform record review if both attorneys don't specifically ask me to address AOE. Because I cannot claim factor 6 (not asked) or factor 5 (no research) I either must spend an extra hour with the patient (which is unnecessary medically) or play games with the research requirement. Spending two hours with the patient will

slow down the system (less evaluations being done) and pushing evaluators to "game" the research requirement cannot be an intended outcome but is surely going to occur.

I would propose that you abolish the requirement for research to be used for claiming factor 5. If you need an arbitrary requirement then state that there must be a minimum of 800 pages of records to review and /or research related to an issue which is appropriately documented.

I understand that it is appropriate to limit billing for research that has essentially already been performed. The issue can be resolved by allowing/requiring for billing smaller blocks of time (15 minutes to 30 minutes) for research which involves finding and using references that have been previously cited. Research consists of1) finding/obtaining relevant references, 2) reviewing the articles 3) applying them to the case after analysis 4)citing them in the report. When doing research on a subject for the second time, the time spent on the first two activities is greatly reduced but the time spent on the second two activities is still necessary and in fact essential. The evaluator is not claiming credit for work already done if he reduces the total time spent.

I recently had a carpal tunnel case. I have certainly cited some articles previously but this case involved extensive mousing which required that I review two of the articles again for that specific issue. Doctors have a general sense of what is in articles but applying findings to specific cases requires reviewing the articles again plus the time spent in locating the articles and citing them. Our memories are not infallible nor can most of us remember the specifics of individual articles as required for thorough discussion of issues. To simply state that research cannot be claimed twice in a year for the same subject again seems simply an excuse to arbitrarily limit ML 104 reports.

Finally there is the issue of a 3 hour limit on preparation time. In 10 years and 3,000 reports I have probably gone over 3 hours 5 times or less. Nonetheless, I recognize that internal medicine and psychiatric evaluations frequently take additional time in report preparation. I have never met an internist or psychiatrist that told me (on or off the record) that they could finish a report in under 5 hours. The arbitrary 3 hour limit will damage the quality of these reports and probably eventually lead to thoughtful evaluators dropping out of the system. Sometimes you get what you pay for. As for ML 106 reports a 3 hour time limit on preparation may be appropriate but the major portion of an ML106 depends on the quantity of records submitted for review.

This is a complex subject.
I am confident that if we agree on the common goal of encouraging high quality reports with accurate billing an appropriate solution can be found. These temporary rules will not encourage higher quality reporting and will slow down the evaluation system.For the evaluators they appear to have only one goal which is to prevent an ML104 report from being billed regardless of the amount of time or number of issues involved in the preparation of the report. Like all professionals we expect to be paid for the work that we perform.

Certainly there are some evaluators over billing egregiously for multiple factors including time spent with patients, in record review and in report preparation. These proposed rule changes punish everyone for the transgressions of a few who will probably go on billing in exactly the same fashion.

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§ 9794. Reimbursement of Medical-Legal Expenses.

(a)(3) The new section is ambiguous. What is meant by "no other charges"? Other than what precisely? If you are referring to subsections (a)(1) and (a)(2), it should say so specifically. In addition, what about missed appointments?

In addition, although there is no specific fee set forth for a missed appointment, it is payable "By Report" and isn't included under the rest of the allowed charges spelled out in this section, so by the new language in this section, it could be argued that they are never payable or that a physician may not be billed for them.

Lastly, it's not really what gets billed that's the problem. It's what must be paid. The language should be changed from "shall be billed" to "are payable".

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

(b) The new language in this subsection should be its own separate subsection, not buried in how the payment is calculated.

(c) **ML 100** Although no changes were proposed for this subsection, I recommend defining when a Missed Appointment would, in fact, be payable. Since this code was developed, new rules under 8 CCR 34 were added regarding when the parties or the physician can cancel an appointment. This spells out that one must cancel an appointment at least 6 (six) days out unless there is good cause. I propose that if an appointment is cancelled in less than 6 days or when there is a no show, a minimum payment of $250 be paid to the physician. Additional charges may be appropriate if the physician has already done more than an hour of preparation in advance of the appointment date. Additional time would be paid the same way as ML 106, with a verification under penalty of perjury related to time spent in record review or other appropriate preparatory activities.

Proposed language: *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. In a situation where an appointment is cancelled in less than 6 (six) days, when the injured worker fails to appear for the appointment with no notice, or when when no interpreter appears when the need for one was indicated on QME Form 110, the physician will be entitled to reimbursement. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, or other appropriate activities. Time spent shall be tabulated in increments of 15

minutes or portions thereof, rounded to the nearest quarter hour. 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. The physician shall be paid a minimum of one hour for a missed appointment meeting the criteria above.

ML 101 Limiting report preparation to 3 hours is unrealistic. If you wish to put in a limitation, you need to include a method to exceed the limit if the circumstances warrant it. I recommend adding a provision for "good cause" for exceeding the 3 hour limitation or to allow for exceeding the limit upon agreement of the parties. The agreement, doesn't not need to be obtained prior to the evaluation as that would prove to be impossible. I don't have any specific recommendations for the definition of "good cause", but suggestions are evaluations with excessive records requiring review and summation, excessive medical research or any other circumstance that can increase the length of the report.

Proposed language: No more than 3 hours may billed for report preparation under this code, unless there is agreement of the parties or upon a showing of good cause. The good cause will be identified in the verification.

ML 102 I am unclear on what the additional language adds to the specification of complexity factors.

(2) "All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code". This should be under complexity factors (4) and (5), not here.

(3) "using 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 this complexity factor." This new provision is not well thought out. First, it's going to be impossible for bill reviewers to know whether or not research has been used previously when they are reviewing the the bill, so it's impractical. Second, there are situations where a physician may need to refer to a different section of the same source for a different patient.

"All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code". Same as the comment under (2).

(4) Add this language here: All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code.

(5) Add this language here: All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code.

(6) "provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to

the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation" How exactly are the parties and the physician supposed to agree on whether or not causation is a disputed medical fact? Are you proposing that there must be an exchange of letters between the physician and the parties asking if causation is a disputed medical fact every time there's an evaluation rather than just have either party request it be addressed in a one way letter from the party to the physician. A more practical way of addressing this is to specify what language needs to be in the communication from a party to the physician.

Proposed language: ...upon written request of the party or parties requesting the report. If a party or the parties request that the physician address the issue of medical causation the following language will be used to notify the physician: "Please address the issue of medical causation as it is a disputed medical fact in the above referenced case."

ML 104 (1) I am unclear on what the additional language adds to the specification of complexity factors.

Limiting report preparation to 3 hours is unrealistic under this code as well. Please see recommendations under ML 101.

(2) See comments related to 3 hour report preparation limitation above.

(3) Don't see what the phrase "start of the" adds to the definition.

"When billing under this subdivision of the code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities." This paragraph was always intended to apply to the entire ML 104 section and not just this subdivision of the code. I recommend removal of the phrase "subdivision of the code" and moving the entire paragraph to a separate subdivision of its own following subdivision (3). It should apply to all three scenarios.

ML 106 Please see discussion of the 3 hour limitation on report writing under ML 101. I also question the 2 hour limitation on Medical Research. There logical reason to limit the time spent on necessary research. As there are new requirements proposed to justify the research being performed, it appears that an additional limitation as to how any hours can be used for research is unnecessary.

Additional comments unrelated to proposed changes: There have been no proposed changes to 9793 and the definitions contained within it. DWC needs to clarify several things that appear under 9793.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

1. When, if ever, can a Primary Treating Physician perform a medical-legal evaluation and be paid for it? The current version of 9793 seems to contradict Statutes 4060, 4061, 4062 , 4062.1 and 4062.2 regarding use of PTP's for medical-legal evaluations.
2. I recommend the addition of a definition for Record Review which gives an objective method of determining how long a physician spent reviewing the records. Using number of pages reviewed as the basis is the most objective method, in my opinion. My suggestion is 100 pages reviewed equals an hour and 50 pages equals 30 minutes. An additional requirement to indicate how many pages of records were reviewed by the physician can be added under Complexity Factor (2) under ML 103.
3. I recommend that DWC consider an additional payment to physicians when the parties do not the records in a compliant manner. For example, when the records are not in date order and there is no resume of the records provided. In addition, if the records are sent using digital media instead of on paper, the physician incurs additional expense related to record review as they may need to print them out in the office. Frequently records sent on digital media do not separate the records into individual files, but simply provide a single PDF of everything lumped together. This makes it more difficult for the physician to efficiently review the records.

Kenneth H. Geiger, MD, QME May 18, 2018
Board Certified in Neurology by the ABP&N

First, a serious joke. A physician calls a plumber to his home to repair a leaky faucet. The plumber is there for about 18 mins, takes a faucet apart and replaces a washer. He looks at the physician and says "that will be $125." The physician says "I'm a doctor and I don't even charge $125 for a house call." The plumber then says "Neither did I when I was a doctor." It's a joke, but a serious situation for doctors doing M-L evaluation and reports."

Given the complexities and reimbursement levels for Med-Legal/QME evaluations there has been at least a 20% drop in the number of QME listed doctors during the past 1-2 years. The cost of maintaining a medical office has increased significantly BUT the last Medical-Legal fee increase during was 12 years ago, from $200-$250. per hour. Not only have physician costs increased, but we have a new expense. In the past we were sent copies of the medical records to review. Now we're send an emailed pdf file or a CD_ROM disc. My office staff then has to print the medical records such that they can be put in chronological order to be reviewed in my report. I can't review the medical records as provided in a pdf or on a CD. It would be like scuffling the pages of a novel and reading the book as shuffled.

Using the plumber as a analogy. There is a charge based on time spent plus supplies. He doesn't charge more for his labor if he had to replace the float and less if the toilet float did not have to be replaced, but rather the time spent to complete the task. Doing a Medical-Legal evaluation is complex enough without have to add more hoops to jump through.

In private practice as a neurologist a patient is typically evaluated for one symptom. Doing a Med-Legal evaluation, we're typically seeing a patient with multiple injuries and multiple symptoms, often both industrial and non-industrial.

The proposed changes in the Medical-Legal fee schedule do not resolve problems with the current fee schedule, but add more complexities and more ambiguities.

Quite often I review thousands of pages of medical records to complete a M-L, QME or AME report. In these cases, a properly thought out report cannot be complete with a three hour limitation in report preparation!!! There does not appear to be any rational reason for a three hour limitation. The report time preparation may also vary considerable between the various medical specialties; i.e. psychiatry vs dermatology.

This examiner does agree that a physician shouldn't bill for the same medical research if the comments are simply a "cut and paste" from a prior report generated during the prior 12 months; however, if the physician must utilize the same articles from the medical literature to emphasize a slightly different point, the physician should be allowed to bill for the time spent re-dictating the paragraphs.

Regarding the limitation on causation as a complexity factor unless "the physician and the parties agree prior to the start of the evaluation," this would add more ambiguities to the evaluation process. I don't see most patients and their medical records prior to the start of the evaluation. How can i determine in advance whether an agree is necessary with the parties to complete my report.

In summary, if the evaluation process is to have accurate evaluations performed by well-trained Board Certified Medical and Surgical specialists, there must be adequate compensation for the quality of the physician and reports. In that regard there must be an increase in the M-L fee schedule from its current $62.60 per quarter hour and an annual increase utilizing some type of inflation factor. Adding additional hoops to be jumped through to qualify a report for the various M-L categories will add unnecessary complexities to an already complex fee schedule. The bill for the M-L report should simply be based on the time spent to generate the report.

Thanks for listening

Niveen Gorgy, DC QME May 18, 2018

Thank you for taking the time to review my comments on the recommendations to changes for ML expense. I hope that my comments are seriously taken into consideration by the individuals who are proposing the changes.

Regarding 9794 (a) (3) – the wording is confusing as written, as written it appears that one cannot bill OMFS codes at the same time as a Medical-Legal code.

Regarding 9795 ML100 – This code needs to stop being a communication code and follow suit with the rest of the ML codes to have the carriers pay for time allocated in anticipation of the scheduled appointment which has been scheduled well in advance for the injured worker not to attend.

Regarding 9795 ML101 – placing a cap on the report prep is unjustified and inappropriate. Costs have increased since 2004 when the code was last modified. To place a cap will hamper physicians ability to

issue an evidence based medical report. In complicated cases and re-evaluations, the information to review and process is justifiably higher than what is being proposed.

I ask for the cap to be removed.

Regarding 9795 ML103 Complexity Factor (3) Medical Research. It is my opinion that the cap on when research can be used is not realistic with the real world we work in. Research is not for the benefit of the physician but the provide an evidence based medical report. In the Physician's Guide we are instructed to write a medical report for the reading of nonmedical personal, in order to support the opinion of the examiner research is essential in certain cases. In my experience I may evaluate injured workers' who are claiming the same body part as others within a 12 month period and as proposed to be able to only use the research once will be a detriment to the other injured workers'. It was prevent me from providing the high quality report that is expected of me. Also, the individuals proposing the changes do not appear to be individuals who are at all knowledgeable in medicine, if they were they would know that medical research is not something that is updated on a daily basis. Medical textbooks that are used in training of medical students world-wide are updated every 1-2 years sometimes nothing has changed except for the page numbers. Physicians are constantly reviewing the medical journal for updates as well as attending medical conferences in their perspective fields in order to keep up to date with any changes and if needed research can be modified at that time. Countless hours are spent in researching particular topics and to expect the costs associated with said research to one carrier would be astronomical. Recently I performed research on the effects of worker's in hot/cold environments and one of the articles still being used was from the 60s since nothing has changed, hours spent hours upon hours of reviewing different sources, coming up with a layman explanation of the research found and how it did or didn't apply to the injured worker in order to provide a scientifically evidence based medical report. How can you expect not to harm injured workers' overall case by limiting the number of times I can reference relevant research that has not changed in years in their reports is beyond comprehension.

Regarding ML103 (5) adding language that changes what was originally attended to allow for any combination, meaning that not all 3 needed to be used, is deemed an attack on what a physician can be properly compensated for their time spent. In some cases when we may spend more than the recommended times to get a picture of what is going on directly from the source. Medical records provided are missing pieces relevant that have not been provided to date and the only source is the injured worker. In some instances a poor historian may increase the face to face time to be able to get to the facts at hand. Others are provided bankers boxes upon bankers boxes that need to be reviewed and to prevent physicians from spending the appropriate time necessary to come to a conclusion is again beyond belief. The new language should not be included and remain as originally written.

Ml103 (6) – Through testing and training we are provided the definition and how to address causation appropriately in a medical report in order to be considered substantial medical evidence. The language as originally written and proposed changes are not in conjunction with the requirements for addressing causation and therefore should be re-written based on the requirements posted on the Physician Guides and regulations.

ML103 (7) – As noted above and based on LC 4663 and 4664, and by definition of Apportionment this as well should be re-written to be in conjunction with what is expected to be addressed. In order to comment on apportionment the IW does not need to be MMI as it will not have a bearing on the

discussion. MMI will only impact the impairment rating of an injured worker and not apportionment. Again proposed changes seem to have been proposed by someone who has no medical knowledge or understanding of the criteria needed to address it. The AMA Guides should only be used to reference impairment rating and not what is considered related to work or not.

ML105 – Wording to indicate that a retainer or payment needs to be made prior to the start of the deposition as well as time associated with review of the deposition transcript should be included. Payment not received prior to start of deposition is subject to cancellation.

ML106 – As previously noted please note the proposed changes for report prep in unjustifiable and would be a hindrance in provided a substantial scientific evidenced based report that a physician is expected to provide. I have had supplemental reports where the amount of records provided was much more than the initial evaluation thereby creating the need for more time to come to my opinions.

The code as originally written should eliminate the wording that a physician cannot bill for testing ordered during the initial evaluation. I have had cases where the requested testing has not been completed after months and months of waiting and to expect someone to recall what the case is about is not possible. If one is allowed to review the material for depositions and bill for then the same should be allowed for supplemental reports.

Michael G. Adelberg, MD May 18, 2018
CEO/Medical Director
Adelberg Associates Medical Group

I am Michael G. Adelberg, M.D., Medical Director, Adelberg Associates Medical Group ("AAMG") (since 1985). This group is the oldest and most established medical-legal group in northern California, and among the oldest and most established, if not *the* oldest, in the entire state. The business manager, whose input is incorporated in these remarks, has been qualified as an expert in medical-legal billing in a Workers' Compensation administrative law court. Inclusive of supplements, this group has issued in excess of 50,000 reports.

The proposed DWC medical-legal report billing regulations change will not work, as written, because:

(B) They preclude, in many foreseeable instances, the Applicant's proving his injuries (for purposes of establishing temporary or permanent disability) and/or his industrial treatment needs, and/or the Defense's proving apportionment. These two general classes requirements, those of the Applicant and of the Defendant, are the essential functions of DWC medical-legal regulations in general.

The general reasons they are preclusive is: although conforming to the general concept that complexity, not time, is the principle determinative factor in setting up the various ML codes, they address only one of the two kinds of complexity: the legal complexity. They ignore the other complexity factor essential to any medical-legal report, namely, medical complexity. There is no warrant for restricting the meaning of complexity in a medical-legal report, since the report must be both medical and legal. For reasons described below, medical-legal reports in medically-complex situations cannot be produced under these proposed regulations.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

(A) Existing and applicable DWC Reg §10606 says medical reports should include, where applicable,

"(5) the patient's medical history, including injuries and conditions, and residuals thereof, if any

"(8) opinions to the nature, extent, and duration of disability and work limitations, if any

"(12) apportionment of disability, if any

"(14) the reasons for the opinion"

(A) Existing DWC Reg §35 (c) (1) "The evaluator shall address all contested medical issues arising from all injuries report on one or more claim forms prior to the date of the employee's appointment with the medical evaluator that are within the evaluator's scope of practice of practice and areas of clinical competence. The reporting evaluator shall attempt to address each question raised by each party in the issue cover letter sent to the evaluator as provided in subdivision 35(a)(3)."

(B) To be billable at all, the report must be sufficient to prove a disputed medical-legal point (DWC regulations).

(C) Applicable case law bears on item (14), above ("reasons for the opinion") and, as a requirement to explain the reasoning (in order to qualify as substantial evidence), applies to all medical-legal opinions:

(*Hegglin v. Workmen's Comp. Appeals Bd.* (1971) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93, 97] ("Medical reports and opinions are not substantial evidence … if they are based … on incorrect legal theories"); quoted as binding in *Almaraz-Guzman* II 24:4-7

"Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess [citation] ..." *Milpitas Unified School District v. WCAB and Joyce Guzman*, page 19

"Also, a medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess. *Hegglin v. Workmen's Comp. Appeals Bd.* (1977) 4 Cal.3d 162, 169 [36 Cal.Comp.Cases 93], *Place v. Workmen's Comp Appeals*

Bd. (1970) 3 Cal.3d 372, 378-379 [35 Cal.Comp.Cases 525]; *Zeman v. Workmen's Comp. Appeals Bd., supra* 68 Cal 2d. at p. 798). Further, a medical report is not substantial evidence unless its sets forth the reasoning behind the physician's opinion, not merely his or her conclusions. (*Granado v. Workers' Comp. Appeals Bd*. (1970) 69 Cal 2d 399, 407 (a mere legal conclusion does not furnish a basis for a finding);

(D) Recent citable case-law decisions have emphasized the limited applicability of mechanical *AMA-Guides* scores as measures of disability. Although, for several years, cover letters from Applicant sources *invariably* ask for Almaraz-Guzman scoring where the mechanical impairment scores are inadequate, the cumulative effect of this series of WCAB decisions makes in preponderantly likely

that reports requiring Almaraz-Guzman assessment, with rationale for the opinion, will continue to increase.

To this point, my remarks indicate that there exist, in law/regulation, standards that reports must meet. In a general way, if reimbursement for reports does not yield a profit in real-market conditions, for reports of sufficient standard *in order for Applicants/Defendants to meet their respective burdens of proof*, then there will be no reports. The number of reports will not drop to zero immediately – it might take a year. But the length of time Applicants will wait to get a scheduled appointment will rise sharply and immediately, reaching the 16-18 month time period which almost destroyed the workers' compensation system around ~1990.

WHY THE PROPOSED REGULATIONS WILL NOT COVER REPORT PRODUCTION EXPENSES, WITH SUFFICIENT PROFIT TO KEEP ADEQUATE PHYSICIANS PARTICIPANT IN THE SYSTEM:

(A) By no means all physicians are capable of making the legally required diagnoses, and relatively few are capable of understanding regulations sufficiently to pass the IME-licensing examination. Those capable typically occupy the middle range of physician salaries: well above the low-end, e.g., physicians working administratively for government agencies, in charitable and nonprofit settings (e.g., Indian reservations) and well below the high end (neuroradiologists, electrophysiologist cardiologists, certain pathologists, certain surgical fields, etc.)

From my own direct experience of having hired hundreds of physicians (as independent contractors) to write evidence-admissible report, my opinion is that physicians below the middle salary range prove consistently unable to write admissible reports.

(B) The vast majority of these reports emanate from medical groups like Adelberg Associates Medical Group, identical in structure although many are much larger. The economic constraints are, ignoring some rent differences based on California region, are essentially the same for all:

(i) Adelberg Associates having spent more than 30 years streamlining and cutting production costs, produces reports as efficiently as any group out there, and considerably more efficiently than most. Hence the costs described here represent the minimum possible costs to produce the reports.

(ii) The actual ratio between full time employees and independent contractors (regardless of what percentage of time they dedicate to writing reports for my office) is: ~0.8 full time employees per independent contractor. So, for example, AAMG has 13 independent contractors (varying from time to time, but that number is fairly typical) but requires 10.4 full time employees to perform the functions of scheduling, billing, front office receptionists, obtaining (by rental) 20 different locations where examinations are done, compiling and printing reports, checking reports for completeness, tax and accounting procedures, and all the other usual costs of doing information-intensive business under highly regulated conditions.

(iii) Representative fees charged and obtained for medical-legal testimony, by physicians comparable to those performing workers' compensation reports, is (on average, but conservatively) about $800 per hour.

iv) My best estimate, based on a thorough and informed reading of the proposed regulations, and on 32 years of experience, taking into account the actual mixture of incoming cases at the various complexity levels of the existing §9795 regulations through a great many regulation and legislative changes over the years -- is that prices paid per report, under the proposed regulations, will drop by an average of 35%. There are, however, relatively few physicians capable of doing really complex reports, and for those, the reduction will be closer to 50%

To illustrate what a really complex report looks like, and to illustrate what some medical-legal evaluations must actually undertake, I am appending 4 of my own reports, absent patient—identifying, and trimming 90% or so of the actual pages.[1]

The second report: roughly 30 medical conditions, of which 23 survive an initial screening intending to determine for which conditions there is at least a prima facie indication of a related industrial injury. This report ran to about 120 pages.

The third report ran to about 75 pages, and addressed at least a dozen injured body parts.

The fourth report ran to about 65 pages, and required roughly 15 AMA-Guides Tables

The baseline used for comparison, the pre-regulations environment, takes into account no income for anything improper or illegal per existing regulations.

Currently, taking into account actual averages from AAMG records, about 1500 reports per year, physicians make about $415 per report. A minimal estimate of the actual time requirements makes that about $130 hour. Under the proposed regulations, that will drop to about $85/hour.

(iv) Even though most physicians have work available to them considerably below 40 hours per week, $85 is well below what they do make, and can expect to continue to make, doing ordinary clinical work -- again, taking into account the volume of payable work actually available to them.

However, the reason the vast majority of medical-legal reports come from offices like mine with independent contractor arrangements with doctors, is that the doctors require exactly the services offices like mine provide. Turning now to these offices:

(iii) All employees must be hired at prevailing market rates for their skills.. However, the actual cost (to the medical group employer, like mine) is about 122% percent of their salary or hourly wage, because of various workplace benefit laws. This number is still misleadingly low. Realistically, there are costs of administration and supervision. For example, a medical group like mine pays substantial legal fees: for example, the recent *Dynamex* case will cost small-employers (like my group) some thousands of dollars in legal fees. A recent Calif. State Court decision determined that certain DWC regulations were rogue regulations, unenforceable: the related legal fees to correct for errors not made by the medical groups ran to many thousands of dollars. Although these costs fluctuate from year to year, they are, like employee costs, actual and unavoidable costs of doing business.

[1] The first of these concluded that there were three industrially injured body parts, but those had to be sorted out from another ten or so substantial medical conditions, most of them not diagnosed before the evaluation. This report ran to 114 page.

Business expenses added to the above examples include, among other things: rent costs, utilities, purchase of equipment and supplies, and the costs of medical education which must somehow be amortized out of payments received.

C) For reasons I will now explain in greater detail, my group's income, and the income of all similar groups (we all have the same general categories of cost, similar costs for employees, similar costs per square foot of office rental space, etc.), will be negative, i.e., well below unavoidable and minimum costs, should the proposed regulations come into effect.

Obviously, under that circumstance, groups like mine will close as quickly as they can, and, bottom line, neither Applicants nor Defendants will be able to meet their actual burdens of proof. This means that the Constitutionally-required business of the workers' compensation will not be carried out.

Appended to this letter are 4 actual reports, identifying information deleted (but available to DWC on request).

OPTIONS FOR BILLING OF COMPLEX REPORTS (E.G., LIKE THOSE APPENDED, AND MOST OF THOSE ROUGHLY A QUARTER TO ONE HALF OF THOSE SCOPES), AND WHY THEY WILL NOT WORK UNDER PROPOSED REGULATIONS.

The rationale supplied below pertains to report like those appended, on down to reports requiring about a third as much analysis, in order to meet the *formal requirements*, substantial evidence requirements per law (LC§4663, 4664, DWC regulations cited, case law cited) detailed earlier in the present note:

ML	Maximum permissible price	Why this option is not realistically possible
102	$625	Inapplicable: reports referred to in this table are all complex, both legally and medically
103	$937.50	This fee just about covers the real production costs, exclusive of payment to physician. Unrealistic, since physicians cannot work for nothing, and offices like AAMG (which they require) likewise cannot exist as non-profits.
104, type 1 (4 complexity factors)	$62.5 per quarter hour, or $250/hour $187.50 cap on report preparation	Report preparation (4 complexity factors) typically requires 3-15 hours of preparation, but sometimes 3 or more times that amount (please see submitted samples, appended) The number of items for which the physician must supply an explanation (and which can only be billed under report preparation) Amounts billed for other aspects (history, physical examination including *AMA-Guides* procedures, records, research) are not themselves profitable, in terms of the actually applicable hourly rate of $250/hour), or so little

		profitable that it cannot make up for the physician underpayment for report preparation ($187.50 cap).
104, type 2: involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors ..., including three or more hours of record review by the physician	$250/hour $187.50 cap on report preparation	Report preparation (3 complexity factors, multiple injuries to one or more evaluated body parts) typically requires 5-15 hours of preparation, but sometimes 3 or more times that amount (please see submitted samples, appended) The number of items for which the physician must supply an explanation (and which can only be billed under report preparation) Amounts billed for other aspects (history, physical examination including *AMA-Guides* procedures, records, research) are not themselves profitable, in terms of the actually applicable hourly rate of $250/hour), or so little profitable that it cannot make up for the physician underpayment for report preparation ($187.50 cap).
104, type 3 "extraordinary circumstances"	$250/hour	Requirements for obtaining prior authorization of the parties for treating the assignment as "extraordinary circumstances" are not realistically possible to comply with, because: (a) Except under the circumstances that both parties supply cover letters (realistically occurs about 50% of the time, as of the time of the evaluation appointment) and that both of these indicate "extraordinary circumstances" (in their respective opinions), there is no way to know, prior to obtaining history from the applicant and reviewing extensive records, that anything DWC is likely to accept as "extraordinary circumstances" is present. The circumstance requires the physician to perform the analysis necessary to ascertain if extraordinary circumstances are present, with no assurance of being paid for that work. The physician who performs that analysis is not entitled to any pay at all, for that service, under the proposed regulations. Although it is customary (and apparently legal) to assign unpaid work requirements to physicians as part of the duties to be performed for doing paid work, the is an upper bound of how much of this the system will sustain: namely, when it requires the physician to work for wages so low, in terms of hourly amount paid or for other reasons, that the assignment is not worthwhile.

		But under the proposed regulations, physicians are *obliged* to perform the unpaid work under the circumstance that the physician does not know, as of the time of the patient appointment, whether the parties think extraordinary circumstances are or are not present. This creates a strong disincentive, added to many others, discouraging physicians from working in this system. Similar effects have been seen in other systems, e.g., when physicians are obliged to work at a loss (MediCal payment, many MediCare situations): increasing numbers of regulations, State and Federal, have had to be written to *force* physicians to accept the risk that their overall production costs will exceed their actual overall payment. Moreover, short of the Applicant's being in a coma, hence taking more time to evaluate, it is highly unlikely that ANY actually-encountered circumstance would qualify as "extraordinary circumstances" according to the DWC/EU, for reasons given in the next paragraph. Examples of things which DWC would likely NOT consider extraordinary circumstances include (a) 1000 pages of medical records (not unusual) or (b) evaluations of multiple body parts with various dates of injury, because both of those would be classified as ML 104 type 1, or ML 104 type 2, both of which have $187.50 caps on billing for report preparation.

My thanks for your attention to these issues.

[COMMENTER PROVIDED COPIES OF REPORTS THAT HAVE NOT BEEN INCLUDED IN THIS SUMMARY]

Peggy Sugarman, PhD, Workers' Compensation Director May 18, 2018
Department of Human Resources
City and County of San Francisco

In addition to the comments submitted by the California Workers' Compensation Institute, which we support, I would like to add an issue that should be addressed in connection with the complexity factors. PQMEs commonly fail to address all of the questions posed so that a reasonable and prompt resolution of the claim can ensue. When this happens, we follow up and re-ask the same questions and then get billed for a supplemental report. This not only increases the costs for the M/L Evaluation but delays the resolution of the claim.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I suggest adding language to ML106:

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 for (A) ~~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) where the results of laboratory or diagnostic tests ~~which~~ were ordered by the physician as part of the initial evaluation, or (C) when responding to questions that were originally posed to the physician prior to the initial evaluation where the physician failed to address them in the initial evaluation.

Michael Anthony, Psy.D., QME May 18, 2018

As a QME in psychology I'd like to voice my concern for the proposed changes to the QME billing schedule. In particular, the proposal to limit report writing to three hours is untenable. In my experience, a report usually takes eight to ten hours to complete due to the complexity of issues involved. Limiting report writing to three hours does not seem possible to allow enough time for a thoughtful and thorough report of the injured worker.

E. Medina, MBA May 18, 2018
Health Care Administrator

The proposed cap of only paying up to three hours is ridiculous. This will be just like when dictated reports were taken away. There won't be all the documentation required for providers to render an honest and fair medical opinion which could be a detriment to the case. One that could help a patient and hurt the insurance company when it wouldn't have happened if all the records were examined – the same can happen the other way around. It's like insurance companies say to the consumer you get what you pay for in every product they sell i.e home owners insurance ,car, general liability… Wonder what will be said or be done when doctors say the same, doctors need to be united in this front.

With the cap of time that means that medical records will probably not be as thoroughly reviewed. Why would anyone perform a professional service knowing you will not be paid for it? The eventual outcome is the medical providers will not be able to meet its overhead. No one has that luxury of time to give away to insurance companies whose prime concern is to perform better than the last quarter.

They are proposing the capped time on the all the codes exams that are not a set fee schedule. ML101 is a review within 9 months where reimbursement is based solely on time. ML106 is a comment or response to a letter or review when it has been more than months since the original QME. ML104 is when you exceed the criteria of a ML103. No medical professional is going to want to perform extensive exams knowing that after a certain time they will not be getting compensated.

Some of the QME cases are very complicated with multiply body parts and CT's. These would be the cases that are going to be hurt the most because there will not be any detail reports that are required on complicated cases. Again this will hurt both patients and insurance carriers will lose.

If the QME providers are supposed to be impartial and render their opinions based on the information given to them this new fee schedule is going to kill that part because there will be very little reviewing of the records. Some say it will be the best guess one can give within the limited time.

What I see happening is that every QME will now be a ML102 for $625 which does not pay for any record review. It's just the exam of the patient and a dictated report. Maybe that is what the insurance company's want but what they are not thinking about is that many providers that are going to go to is the patient side of story and believe most of what the patient is saying because there will be nothing to contradict the patient. So if there was an issue of apportionment it would be not be addressed in great detail as well as there would be very little history to review except what the patient tells the provider. Again, no provider will want to review medical records unless they get paid for doing so.

Ron Y. Goldstein, MD May 18, 2018

These changes, like many in the past are draconian. We as providers in the AME/pQME world work for many years to be able to present our expert opinion when we evaluate these injured workers with their complex issues. There is already a shortage of panel QME's and there is no doubt that the number of physicians will go way down if a reasonable incentive is removed out from under our feet

The real goal is for us to review as many medical records that we can get our hands on, to really get to the bottom of the issues of apportionment and causation. Without the opportunity to get or read those medical records, the reports will be sub-par and may begin reflecting inappropriate results…which the applicant attorneys will pounce on…this will lead to more litigation, less patient care, fewer doctors willing to provide care in workers comp and more of a collapse of the system. I see it all around me…

I have been in workers comp for over 20 years in California and I can categorically state that everyone involved is losing, but the biggest losers are the patients

The system was designed to help the patients

Physicians should never be allowed to see patients for 5 minutes
Physicians should never be allowed to write voluminous reports and never touch or exam the actual patient

These are the issues that should be addressed. As a PTP and operating surgeon, I ask every single patient that sees a pQME is he/she spent reasonable time and if that physician (not the PA) actually did a "Real" exam…frequently, the answer is no

I and many of my colleagues have a lot to offer the system to improve it, but cutting out our reasonable benefits is not just nor is it fair. Remember, the physicians in general and specifically in workers comp have not had a real raise in forever…but we keep working harder and harder to make this system work

Why do you wish to punish us??

Perhaps try to make the system work without the senior physicians and see what you will get…who is willing to take that chance? Is there anyone who really cares about a quality report??

Please really consider leaving the system as it is and working WITH the physicians to make it a better system were all parties will benefit

I would be happy to be on a panel to address these and other issues in the pQME and AME world

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Jane Wang, MD May 18, 2018

It is very disheartening to see the changes in reimbursement. I am hesitant about continuing performing QME examinations going forwards.

Emily Ziegler, Psy.D. May 18, 2018

I am writing to express my concern about the proposed changes to the fee schedule. I am a psychologist so am only involved when a case has a claimed psychiatric injury. These reports are lengthy and complex. Capping the number of hours billed for report prep at 3 displays a profound misunderstanding of the amount of time it takes to prepare a thorough and well reasoned report. Furthermore, causation is almost always disputed in a psyche injury and requiring written requests from both parties will serve to increase billing as it will require more communication and request for documentation. In summary, I strongly OPPOSE both of these changes.

Dr. Nkiruka Akabike May 18, 2018

I think that the proposed changes will not be good for the industry for the following reasons-

- The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases.
- They are clearly not in the best interest of an employer, injured-worker, or any other stakeholder.
- The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work.

- The causation complexity factor is written in such a way that insurers are given a veto power to pay QMEs for their time. No reasonable physician would agree to work under such conditions.

- DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

- These regulations should be authored with the input from QME Physicians.

Joel Bird, QME May 18, 2018

As a concerned QME I must point out a few issues.

I understand that this change may be in part to get rid of the large companies that facilitate the QME process for their doctors and in part may be doing some of the work that the doctor themselves is actually supposed to be performing. This will drastically effect those of us who do not work for these companies and actually do all of the work we are supposed to do.

I understand that the WCIRB is looking at the increase in med legal costs, but has that been compared in the decrease in spending on the treatment of injured workers. Med legal exams have gone up because treatment authorization has gone down. Clinics are closing, doctors are going out of business, MRI centers are no longer taking liens, and if surgery is authorized the post surgical rehabilitation or DME are not.

If this passes what we will be left with is injured workers who cant seem to get treatment, who need QME exams and there will be a drastic shortage of QME's left to do these exams.

If I am sent 1000 pages of record review how can I be asked to review, organize, interpret and summarize these records in 2 hours?

Just a few points to express my view.

Mark W. Vogel, MD, FACS May 18, 2018
Faculty, Urology Residency, Ceders-Sinai Medical Center
Clinical Professor of Urology and Family Medicine
Keck School of Medicine USC

I am concerned about the proposed changes to the DWC med-legal expense reimbursement regulations. The current rules are comprehensive and require rigorous adherence to the regulations. Experienced AME's and QME's take great care to produce good reports that provide substantial medical evidence that assist all parties in a fair and thorough evaluation of each injury, without being overly burdensome with overwhelming complexity. Some of the proposed changes do not seem necessary and are restrictive. For example, the proposed change where the medical research

cited by the doctor cannot be used again for a year and must describe in detail the findings in the research and the justification for using it do not seem appropriate. Often there are sentinel research studies in a given field or subject that serve as a benchmark for medical findings and are used as "a gold standard". It is artificial and inappropriate to reject such research and cite less compelling papers only to avoid repetition. I ask that the DWC seek additional input and carefully consider whether changes are really necessary and helpful to the injured worker.

Ronald Perelman May 18, 2018

I am unclear as to why this revision is necessary ,unless the DWC wants the insurance company just to pay us less. The system with the complexity factors is much to difficult and it seems that the idea is not to get to ML 104 . Those of us who this type of work know how long it takes to prepare a good substantial evidence report can tell the DWC that it takes what it takes. The old system of $62.50 every 15 minutes was simple and worked. I might point out that most of the doctors who do ML exams are older and the number is decreasing. If this revision is accepted, many will just stop doing these or at least tailor the reports to lower fees. Record reviews will not be detailed, analysis of the case will superficial and the report many not be substantial medical evidence. Very few young doctors are available. They are all working for Kaiser, UCLA, etc where they get jobs and want to do private medicine. I suggest you make no changes and talk to doctors for their input before a real problem is created.

Stacy L. Jones, Senior Research Associate May 18, 2018
California Workers' Compensation Institute

On behalf of its members, California Workers' Compensation Institute offers these comments on the proposed amendments to the Medical-Legal Fee Schedule regulations. The Institute members include insurers writing 83% of California's workers' compensation premium, and self-insured employers with $65B of annual payroll (30% of the state's total annual self-insured payroll).

Insurer members of the Institute include AIG, Alaska National Insurance Company, Allianz Global Corporate and Specialty, AmTrust North America, Berkshire Hathaway, CHUBB, CNA, CompWest Insurance Company, Crum & Forster, EMPLOYERS, Everest National Insurance Company, The Hartford, ICW Group, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Insurance, Republic Indemnity Company of America, Sentry Insurance, State Compensation Insurance Fund, State Farm Insurance Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members include Adventist Health, Albertsons/Safeway, BETA Healthcare Group, California Joint Powers Insurance Authority, California State University Risk Management Authority, Chevron Corporation, City and County of San Francisco, City of Los Angeles, City of Torrance, Contra Costa County Risk Management, Contra Costa County Schools Insurance Group, Costco Wholesale, County of Alameda, County of Los Angeles, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway

Farms, Kaiser Permanente, Marriott International, Inc., North Bay Schools Insurance Authority, Pacific Gas & Electric Company, Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Shasta-Trinity Schools Insurance Group, Southern California Edison, Special District Risk Management Authority, Sutter Health, University of California, and The Walt Disney Company.

The Institute congratulates the Division on drafting regulatory changes to address interpretation issues related to complexity factors used to determine billing and payment levels for medical-legal services. The Institute provides the following recommendations for additional clarity.

Recommendation:

§ 9794. Reimbursement of Medical-Legal Expenses.

(a)(3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report; and neither the employee nor the employer shall be liable for any charges billed in violation of this section.

Discussion:
The additional language would help avoid unintended disputes.

Recommendation:

(g) If the claims administrator receives a written objection to the denial of the medical-legal expense under subdivision ~~(d)~~(f) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a ~~petition to review of the denial of medical-legal expense~~ "Petition for Determination of Non-IBR Medical-Legal Dispute" and a declaration of readiness to proceed pursuant to section ~~10228~~ 10205.10 et. seq.

Discussion:
Referencing subsection (f) corrects an error that appears to have been introduced when the regulations were filed with OAL. Below is the text from the 2nd comment period.

~~(d)~~(f) If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid pursuant to the fee schedule set forth in section 9795, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which shall also contain the following statements:

(1) The physician may object to the denial of the medical-legal expense issued under this subdivision by notifying the claims administrator in writing of their objection within ninety (90) days of the service of the explanation of review; and

(2) If the physician does not file a written objection with the claims administrator challenging the denial of the medical-legal expense issued under this subdivision, neither the employer nor the employee shall be liable for the amount of the expense was denied.

~~(e)~~(g) If the claims administrator receives a written objection to the denial of the medical-legal expense under subdivision (~~d~~ f) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a petition to review of the denial of medical–legal expense and a declaration of readiness to proceed pursuant to California Code of Regulations, title 8, section 10228 et. seq. ~~of title 8 of the California Code of Regulation.~~

Naming the document identified under §10451.1(2)(A) is appropriate. This may also be an appropriate time to correct the previously renumbered section (10228 to 10205.10).

Recommendation:

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

(b) The fee for each evaluation is calculated by multiplying the relative value by $12.50, 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. ~~If prior agreement of the parties is required under any provision of this regulation,~~. ~~the~~The physician may not condition performance of the evaluation, or issuance of the related report, on receipt of any prior agreement of the parties under this regulation.

(c)

ML103	75	*Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below.
		In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report, ~~and were~~ why they were required for the evaluation, and the circumstances uniquely

		specific to the actual evaluation being performed ~~which~~ that made these complexity factors applicable ~~to the evaluation~~.
		(1) Two or more hours of face-to-face time by the physician with the injured worker;
		(2) Two or more hours of record review by the physician. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2), as well as the name and credentials for the individual who provided the record review and summary. ~~All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;~~
		(3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. ~~All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;~~

Discussion:

§9795(b): Because no agreement is ever required, the focus of the language should remain on the physician's duty to provide an evaluation and report pursuant to the regulations.

Corrections to syntax and text are suggested in §9795(c), ML103 – 75.

In §9795(c), ML103 – 75 (2), additional language mirroring the disclosure requirements under Labor Code §4628(b) is appropriate.

The Division's intent in the closing sentences in both (2) and (3) of §9795(c), ML103 – 75, is not apparent. The language should be revised or deleted.

Thank you for the opportunity to comment, and please contact us if additional information would be helpful.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

Teresita Morales, PhD May 18, 2018

I am a psychologist QME and have enjoyed evaluating patients in this capacity the last several years. I am strongly opposed to the proposed changes to the fee schedule. As a psychologist, I have to write lengthy reports to adequately address the relevant issues regarding apportionment, causation and diagnosis, and this requires providing a reasonable basis for my conclusions. Going forward with the proposed restrictions will compromise my ability to provide substantial evidence.

Kinan Hadaya, D.C. May 18, 2018

In review of the proposed changes to the Medical Legal Fee Schedule, It is my opinion that it may have a negative impact on our current system.

It is my understanding that the RAND corporation was commissioned by CHSWC in order to retrieve data on the efficacy and appropriateness of our QME system. That information has yet to be determined and obtained. Before the proposed changes can take place, it would be unreasonable to review the RAND reports recommendations and conclusions and then make appropriate changes if necessary.

At this time, I am against the changes until further data is received. Prematurely acting on regulation would be careless.

Jeffrey M. Steinhardt, DC, QME May 18, 2018

There has been a rush to judgement by the DWC to pass this regulation without transparency or evidence-based data. This is against everything the DWC has been promoting and introducing regulations for over the past 10+ years. UC Berekely studies, data from the CHWSC and WCIRB show that medical-legal costs are not rising and are not plaguing the Workers' Comp system. Additionally, the CHWSC commissioned the RAND corporation to perform a study addressing this issue, and it has not been released yet. This will be a thorough, investigative, and unbiased report from a highly, if not the highest, respected data gathering organization in the US and world. The DWC should not rush to judgement without having all the data at hand, and this report will be available soon. DO NOT PASS THIS REGULATION!!!

Fred Blackwell, MD, QME May 18, 2018

With respect to the suggested change regarding LC 9795, the proposed change puts the physician at a severe disadvantage by not requiring a response from the parties requesting the evaluation. There is no accountability for simply ignoring the request from the physician. What is the purpose of such a one-

sided proposal? It is clearly punitive to the physician as currently proposed A yes or no answer should at the very least be required, and a penalty imposed if the request is ignored.

With respect to the proposed change for ML101 and limit for report prep time. It is patently unfair for the physician to receive a box of records to review that may be a 1000 pages or more and expect that the records review, report prep and analysis with conclusion and editing may not exceed the 3 hours allowed. Greater flexibility is needed here.

Brian Boni, MD, MPH May 18, 2018

This is a supplement to my posting on this forum the other day.

Noting that the proposed QME billing schedule is **extremely complicated,** I suggest the following:

All QME reports would be billed at an hourly rate (such as $ 100, 200 or 300) to be determined by the stakeholders. There would be a cap on the billable hours permitted, such as 8, 10 or 12.

Additional hours might be permitted, if the evaluator can document and justify appropriately.

A simple program such as this would save everyone time, money and aggravation.

Bob Markison May 18, 2018

Further thoughts re: proposed QME changes

I'm a currently and continuously board certified hand surgeon of nearly 40 years experience, teaching hand surgery on 2 faculties (UCSF and SF Orthopedic Residency Program) for 35+ years; and running a busy international solo practice for 25+ years. I've been a QME, AME, and IME for nearly 30 years. I've reported work injuries to the California workers Comp system for 42 years. I continue to practice and teach surgery full time. Care of non-industrial patients is generally easy, uncomplicated, and emotionally rewarding. Care of work-injured patients is complex, contentious, paperwork-laden, and emotionally draining.

Some thoughts:

1) California already ranks #48 out of 51 (50 states + District of Columbia) in physician compensation adjusted for cost of living. Fewer than 5% of the many surgeons whom I have trained have fared well enough financially to pay off their loans and settle in the SF Bay Area.

2) Master surgeons who would make great QMEs/AMEs refuse to enter the system for lack of residency/hand fellowship medlegal training/experience, incentives, time, staffing, and interest.

3) More than 80% of the surgeons whom I have trained refuse to treat injured workers.

4) I am frequently receiving calls from dispirited expert QMEs up for renewal asking: "Why bother?". I don't have a good answer for them.

5) There is continued flight of master surgeons from California into states that are more physician-respectful and physician-friendly.

6) I don't know of any American Hand Surgery Fellowship programs that focus on workers compensation medlegal evaluation as part of the curriculum.

7) As I continuously re-certify in hand surgery via the American Board of Surgery (which grants the CAQSH; i.e. Certificate of Added Qualification in Surgery of the Hand), I note that there are no questions about medlegal evaluation methods on the boards exams.

8) I take injured workers lives and limbs and work spans very seriously when I do medlegal evaluations; and wonder whether non-MD legislators have any personal sense of the often-sleep-disturbing gravity of such deliberations.

9) 35-40% of current US med school graduates plan to bypass clinical care/point of service work in favor of biotech jobs, most of which pay better and do not entail listening to and examining sick and injured people.

10) I have invited many attorneys and a number of legislators to shadow me while I examine sick and injured workers - and no one has ever taken me up on the offer.

11) Studies confirm a 20% decrease in the population of QMEs in the past 5 years.

12) California's century of previously fine and expert management and evaluation injured workers is steadily drifting towards mediocrity; and the proposed changes will surely accelerate the decline and fall of a once exemplary system. I was trained by master surgeons who were honored to care for and evaluate injured workers. Sadly, their views began to change with the advent of nonindustrial HMO/networks in the 1980s, soon followed by the advent of workers comp networks and sweeping legislative changes in the 1990s and beyond.

13) Legislators must carefully consider the fates of future work-injured Californians before tinkering with an already compromised system.

Richard A. Levy, MD, FACC May 18, 2018

I have carefully reviewed the proposed reimbursement changes for medical-legal reports, I want to express my strong opposition to the proposed changes. These changes will seriously undermine the QME process by denying fair and reasonable compensation for physician time & effort, as to degrade the much-needed thoroughness and quality of all

but the simplest evaluations.

The proposed changes will undoubtedly discourage the current evaluators from remaining in the system as well as the physicians that are considering applying for certification. Physicians just like myself, who practice a specialty where the complexities of cases tend to be the greatest due to the multiplicity of injuries or organ systems involved, and the extent of differential diagnoses tend to be the most numerous. Therefore, I am giving serious consideration to retire from all further QME work.

The proposed limitations would dramatically undermine the physician's capacity or willingness to provide a report which incorporates the elements universally requested and required by all parties: a comprehensive history based on the patient interview plus thorough record review, particularly when the records are voluminous (thousands of pages), which often the case. This would pertain to all cases in which ML-4 cannot be applied due to the new restrictions, and to supplemental reports where a 3-hour limit on record review is arbitrarily applied despite the volume of records which might be presented. Limiting the record review to such an extent will seriously degrade the quality of many reports and to be detrimental to the fair resolution of such cases, harming either or both the injured worker and the employer.

Unfortunately, this reflects the worst of mindless bureaucratic interference with a process supposedly designated to provide substantive medical evidence. It is not at all infrequent that a reference is the most relevant to a common problem, and occasionally may be the only pertinent reference, especially if it contains recently developed information. While its use in more than one report a year should not require extensive repeat research every time is referenced, nonetheless the time spent in re-accessing the material, and reviewing it to find the elements which relate more closely to the case at hand, and dictating the relevant passages into the report, is time which is often critical to providing a substantive report which explains the rationale for the conclusions reached.

To imply that this time cannot be used for billing is absurd and illogical. It will certainly discourage the use of appropriate supportive scientific information, with the detriment of all parties involved and to the Trier of Fact who is attempting to determine the accuracy and relevance of the arguments brought to bear the conclusions reached.

Michael D. Ciepiela, MD May 18, 2018

In review of the new regulations for reimbursement to QME physicians I find significant fault. Without question there are significant abuses and cost inefficient practices that have caused the Workers Compensation budget to be out of control.

Highly skilled QME physicians are generally not part of this. In fact if patients were referred to an expert QME sooner, misdiagnoses, ineffective treatment, and prolonging off work time could be reduced, saving millions of dollars.

Reducing reimbursement with drive out the highly skilled QME physicians and allow the ineffective ones to continue.

I urge you to reconsider your priorities and examine what can be done to create a more efficient and cost conscious system versus automatically reducing QME costs.

Lee T. Snook, Jr., MD May 18, 2018

Thank you for the opportunity to respond to proposed changes in the Medical-Legal Fee Schedule.
As a QME since October 1, 1995 I have had the privilege to evaluate many cases as a Pain Medicine specialist. I strive to provide the best possible report that serves the interest of injured worker to move their claim forward. In order to provide the most complete and thorough report, I need to review the complete medical file. Sadly, often times, I do not receive necessary information at the time of the evaluation, even though many evaluations are scheduled months in advance. All too often I receive medical reports, depositions, sub Rosa videos and other information piece meal. This requires a supplemental report that must consider ALL of the information for consistency and clarity. In addition, if I order at test or evaluation necessary to complete the report, it usually takes more than 30 days to get that information, assuming it is even "authorized" or completed in a timely fashion when I request it.
In order to provide an opinion based upon substantial medical evidence, ALL of the available medical records needs to be reviewed. Outstanding issues need to be resolved, particularly contested body parts, the nature of the claim, cumulative or date specific, with consideration of many other variables
In part due to the current use of Electronic Medical Records, a file may be thousands of pages long. I review each page personally. It is NOT uncommon to find important information pertinent to apportionment and causation buried in the chart, masquerading as duplicative medical records, or otherwise not clearly noted in the compendium of medical records provided. As volumes of records may come in over time, it is paramount that the reviewer put them all together.

A complete report must be cohesive, cogent, pertinent, and accurate. Substantial medical evidence is the basis of our opinions.

I believe it is penny wise and very pound foolish to truncate or modify the current fee schedule.
The QME process, currently, is the most cost efficient method of moving a claim towards a reasonable conclusion. The unintended consequence of such actions will be to reduce availability of QME's and drive down the quality and completeness of reports. I believe it is in the best interests of all parties, the injured worker, applicant and defense representatives, and of course the employer and insurer, to support high quality, efficient, and fair QME evaluators.

I recommend against the current proposed changes pending more input, data, the RAND report and a more thorough analysis of perceived or real problems with the current system.
Thank for the opportunity to opine.

Daniel Schainholz, MD, MPH, QME May 18, 2018

Ophthalmology

The proposed changes to the medical-legal fee schedule are seriously flawed.

Third party reviewers are contracted by and paid for by the Defense, but are not, in my personal experience, privy to the reports for which the claims are submitted. It is a violation of the trust between the medical and legal communities when a report, that was not read (or even if it had been, not necessarily understood from both a medical and legal perspective by the reviewers) is denied or discounted. When a report writer is obliged to gamble his or her time and resources on a report of extraordinary complexity, and the compensation for that report is denied, delayed or discounted, this only adds additional workload on the part of the report writers with existing backlogs in an attempt to settle these disputes, creating multiple additional rounds of correspondence (and cost) within the Workers' Compensation system.

The report writers are a critical element to the resolution of complex, often multisystem cases. The intrinsic bias towards discounting the fees for report writing is a violation of the workers' rights, since this intrinsically represents an inducement in favor of the Defendants, who are inherently incentivized to pay when they prevail. Every denial or discount for a valid claim could be challenged as unequal protection under California Labor Code Section 139.3, a prohibition against such inducements.

The proposed changes to what is and is not considered an "extraordinary" circumstance is perplexing owing to the very definition of the word. Constraining the report to specific isolated limitations is anti-intellectual, since it limits input such as the identification of an occult diagnosis, complex mathematical manipulations determinative for the enumeration of a whole person impairment rating, or any other specific reason that makes the report extraordinary in comparison to most other medical-legal reports.

These proposed changes are harmful and might have unintended consequences, including the loss of impartiality in the medical-legal system. Please do not make these proposed changes that give unequal powers to the Defendants, and likely will put independent report writers out-of-business.

James M. Fait, MD May 18, 2018
Fellow, America Academy of Orthopaedic Surgeons

I am writing in response to the recently proposed revisions to the Medical-Legal Fee Schedule. Recently, there has been increasing concern among those of us who continue to perform medical-legal evaluations within the Worker's Compensation system. As a QME, we are tasked to perform a comprehensive evaluation of an injured worker, address all alleged injuries, and review any associated medical reporting to determine if the evidence supports the alleged claim of injury. This frequently involves meticulous review of medical records, including primary care and HMO records as well as therapy notes and even review of pain diagrams and patient-completed questionnaires. It is only through careful consideration of these records that the QME can arrive at conclusions that are substantial medical evidence.

Placing arbitrary limits on the time spent reviewing records and preparing reports further disincentivizes careful review of the available information. There is currently no oversight or limit to the amount of records that may be provided for review, and the QME is at risk of sanction if the totality of records are not taken into consideration during preparation of the report.

There is little incentive for a physician to enter into such a system. When a panel is produced by the DWC and a QME is selected, the QME has no way of determining the complexity of the evaluation when the appointment is scheduled. The QME is required to notify the board when the appointment is set, but the QME still has no information about the complexity of the case. It is at this time that the QME is committed to evaluate the applicant, and must subsequently consider all associated medical reporting, regardless of its complexity or extent. The new regulations suggest that the QME must agree to this evaluation while accepting that there will be a cap on the amount of time he or she is able to bill for their services, even though the QME has no knowledge of how long the evaluation, review of records, and report preparation may actually take.

In being selected as the QME, the physician assumes the risk that the parties may serve unlimited amounts of reports that must be reviewed and considered, while being unable to bill commensurate for the time spent. The QME faces investigation, discipline, and suspension if either party objects to the report and contends that the QME failed to consider the evidence provided, and therefore billed for a report that did not constitute substantial medical evidence. Why would a reasonable physician agree to work under such conditions?

While the proposed changes allow for preauthorization of complex cases, the amount of time spent by the QME and support staff to contact application and defense, obtain prior authorization, and coordinate the collection of written permission is extensive. Once again, the burden is placed on the physician to coordinate and justify such authorization, and the physician is assuming the time and expense for such coordination, without any guarantee that such authorization will be forthcoming, and yet will still be mandated to perform the evaluation.

Finally, there is limited incentive for the insurer to ever provide authorization for elevated levels of billing. The QME has already been selected and is required to provide an appointment and perform the evaluation under statutory mandate. If the insurer fails to agree that the case is of increased complexity, the QME must still perform the evaluation and is captive to the new billing constraints. Why would the insurer ever agree to elevated complexity billing agreements? They already have the QME appointment set, and the QME cannot refuse to perform the evaluation if the insurer does not agree to the increased billing structure. What incentive does the insurer have to ever agree to pay more?

Should the proposed changes stand, fewer physicians will participate, resulting in further delays for QME evaluations and likely a deterioration in the quality of reporting. This only further leads to delays in providing care and resolving cases, in a system that is already flawed and frustrating.

B. Holmes May 18, 2018

The QME fee schedule should Not be artificially throttled by arbitrary limitations with respect to time for any the components which are typically encountered. The goal of the QME process is to get a fair

and complete report establishing the legitimate limitations of a patient utilizing well researched, well reasoned and well supported conclusions... Thereby satisfying the requirements of substantial medical evidence.

Dr. Lori A. Harral, QME May 18, 2018

My name is Dr. Lori A Harral. I am a Clinical Psychologist and have been a QME with the State of California for approximately 7 years. Being a QME is a position that I am very invested in and is the culmination of 20 years of testing and evaluations experience. While I enjoy my private practice I have been blessed to have the opportunity to work with the DWC to assist with the interpretation of complex psychological issues for this population. I enjoy working within this venue and I enjoy report writing. In the seven years of providing these services, I have never used dictation, but I have been able to streamline my ability to provide reports. I am also well aware that it would NOT be possible to offer an ethically acceptable Medical Legal report for the court with three hours of preparation.

If one is addressing psychiatric injuries, it would seem every QME evaluation must follow the complex guidelines in order to be considered substantial medical evidence. In seven years, I have never prepared a report that took less than 6 hours. Most of my reports are between 28-35 pages without the med review. I cannot fathom being able to provide appropriate documentation, with well thought out analysis, in less time, nor do I think one would want me to.

If QME's are restricted to three hours of report preparation, I believe this would be putting the entire ethics of the report in jeopardy. Sadly, I am certain I would not be able to continue to provide services in this area.

Katheryn Rapael, MD May 18, 2018

I have reviewed the proposed changes and have some concerns. My specialty is internal medicine. Most of my cases are complex and involve different body systems. I work hard to provide a thorough discussion of the issues in my reports to help resolve disputes.

The proposed changes would effect the issue of causation, which although a particular claim may not be disputed, I need to discuss regardless of whether I agree or disagree- because it is part of my medical opinion. I have had cases that were accepted claims, and disagreed as to causation.

Some cases have many medical records (I have had cases with over 10,000 pages of records to review), and yet if causation cannot be used as a factor, or apportionment, my report may not be able to be billed as an ML104. In other words, this will limit my ability to provide complete substantial medical evidence. It takes time to prepare a report that answers all the questions poised by the DA & AA. I do not want to have to focus on limiting the time that it takes to prepare a report as this would effect the quality of reports.

I have the impression that there is concern that some QMEs are taking advantage of the system and that this is a way to curtail that. But I think the effect of these changes will serve to decrease the quality of the reports and cause many QMEs to not renew their licenses. This will mean that applicants, the DA and AA will have more difficulty resolving medical disputes. I hope that you think this through carefully before deciding on these changes.

Cynthia M. Masters, CEO/CFO May 18, 2018
Med-Legal Services, Inc.

I am writing to address my concerns with the proposed changes in the reimbursement of medlegal fees.

Having worked in this field with many different doctors and companies, I feel that capping these fee's will seriously affect the doctors capability to provide a truly substantial and helpful report. Many times doctors are presented with challenging cases, which seem to be getting more and more challenging as the years go on, that require a lot of time. Medical records presented in no particular order, some missing, out of date order etc. For these doctors to truly research a patients case they need to thoroughly review all information available, thoroughly interview the patient and perform accurate tests and examinations. To cap the time limits on these would in fact cause a doctor to have to "rush" through a case, resulting in either an incomplete evaluation or the need for numerous evaluations and supplemental reports. That is an injustice to all parties, from the doctor, the patient, insurance adjusters and attorneys. Not only will it result in delays but will in the long run end up costing more than a complete and thorough first evaluation would have cost.

As far as limiting research, as a lot of these doctors have a particular specialty, a lot of the injuries are repeated from patient to patient, calling for the same information. For instance if a doctor sees a patient for carpal tunnel and sites a particular article or medical journal to suggest what has happened and/or what should be done, what happens to the next patient with the exact same problem? Again, these limitations will impede the doctors ability to provide the best information to that particular patients situation.

If these changes are implemented, no one will be getting the level of service they should and there will just be more strain on an already strained system.

Eric Matsuda, DC May 18, 2018

I think the proposed changes to the reimbursement of Med-Legal reports is quite unfair. Much time, thought, and preparation go into the development of my reports, and those of many other doctor's within the AME/QME system. By changing the reimbursement schedule, the quality of many reports is likely to suffer, as well as many good doctor's leaving the system, which in turn will likely bog the system down even further. It is my hope that all the feedback given will be seriously taken into consideration before making any changes. I know the system is not perfect right now, but I don't think there is such a thing as a perfect system, and the current system has seemed to work well for all parties involved for the most part.

Mohinder Nijjar, MD, QME May 18, 2018

I am an Orthopedic surgeon and a certified QME since 1993.

As I understand to avoid pitfalls and confusion, billing be simplified , current proposal actually makes complexity worse and requires a lawyer to comply with it.

Putting limits to timing,issues of causation- one party wants other does not, Apportionment issue is complex medical conditions are occupational or otherwise as one or other party does not based on pathology.

This version of billing and provision will cause excessive burden and lot of pro bono work.
I hope you would consider changing to more "Accurate and Acuabble " set of rules.

Bob Markison May 18, 2018

Further thoughts re: proposed QME changes

I'm a currently and continuously board certified hand surgeon of nearly 40 years experience, teaching hand surgery on 2 faculties (UCSF and SF Orthopedic Residency Program) for 35+ years; and running a busy international solo practice for 25+ years. I've been a QME, AME, and IME for nearly 30 years. I've reported work injuries to the California workers Comp system for 42 years. I continue to practice and teach surgery full time.

Some thoughts:

1) California already ranks #48 out of 51 (50 states + District of Columbia) in physician compensation adjusted for cost of living. Fewer than 5% of the many surgeons whom I have trained have fared well enough financially to pay off their loans and settle in the SF Bay Area.

2) Master surgeons who would make great QMEs/AMEs refuse to enter the system for lack of residency/hand fellowship medlegal training/experience, incentives, time, and interest.

3) More than 80% of the surgeons whom I have trained refuse to treat injured workers.

Richard Alloy, Ph.D. May 18, 2018

I have been a QME in psychology (and neuropsychologist) since the beginning of the QME program.
I am STRONGLY AGAINST these proposed changes.

Psychological and neuropsychological reports are hugely complex and complicated, requiring a great deal of time and consideration.

Record review, often with a great number of records, is also VERY time consuming.
There should be NO limit on the hours needed and used for these very critical and important reports.

To restrict or limit hours needed for professional quality reports ultimately only serves to hurt, insult, and do further damage to injured workers.

Doctors should be obligated to justify the time used, not blind arbitrary regulation.

Marjorie Cohn, Ph.D., QME, Clinical Psychologist May 18, 2018

I've been evaluating and treating injured workers since 2006. In response to the DWC proposed changes to QME reporting, I looked back over the last ten QME reports I worked on and see that the report writing time averages eight hours. It typically takes three to four hours to complete the first half of the report which includes the psychosocial history, report of injuries, medical treatment to date, psychological testing, and the diagnostic section. The front section also includes comments on the review of records and the psychological testing. The time of course varies based on the complexity of the case. The Discussion section typically takes another three to four hours and often weaves in information from the psychosocial history, medical records, and psychological testing. To write a well thought-through report, based on the substantial evidence presented, considerable time is required and it is difficult to see how this kind of reporting can be accomplished in three hours.

I hope these facts will be considered when the DWC adopts any new policies.

Thomas S. Allems, MD, MPH May 18, 2018

It does not seem that anyone who has ever been involved in complex QMEs has had anything to do with these proposed restrictions on a physician's work product.

A couple of specific issues:

Limiting a research citation to once every year is wholly inappropriate. For example, for a particular disease that has been claimed as an industrial injury, the same set of core reference articles are required to be reviewed and cited in every case, to establish the risk factors and epidemiology of the condition in the general population - this has to be consistent across reports over time, with modification as new data accumulate. This establishes the physician's expertise and fund of knowledge and forms the basis on which his or her opinion about the relevant occupational / toxicological issues are determined.

Then a core set of research articles need to be reviewed and cited that are applicable to the specific facts, the specific occupation involved in the claim, general occupations at risk, environmental / chemical risk factors and nuances of the particular case being evaluated. The same articles often need to be reviewed and cited in multiple reports in a years' time - not only to establish background epidemiological and toxicological issues in similar cases, but to sort out complexities that are unique to one case but were not relevant to the previous case of the same disease (or they need to be re-reviewed because there is a different disease or a different occupation / exposure at issue). And of course seminal articles on certain diseases, toxins, occupations, etc. need to be reviewed and referenced in multiple reports in a year.

It is simply not ethical to attempt to restrict a physician from using all the necessary tools at their disposal in rendering a science-based opinion - we are supposed to be practicing "evidence based medicine", yet for the DWC to try to limit the evidence we can resort to in forming our opinions is arbitrary and unprecedented in my experience (I have never actually heard of a regulatory body trying to restrict what information a doctor can use in the practice of their specialty and the implications of this are rather chilling).

Secondly, the arbitrary restriction on supplemental reports is also untenable. As often happens, the evaluation is done before complete medical records have been received, and sometimes at the time of the evaluation, the medical diagnosis or actual "exposure" is not entirely clear or confirmed in any of the available medical records. For these reasons supplemental reports can sometimes entail voluminous medical record review and substantial research, the direction of which has only been clarified by the information contained in the records that were not provided at the time of the original evaluation.

Dr. Elsie Cheng, Forensic Neuropsychologist May 18, 2018

I am a new QME and am against the proposed changes. Having additional logistical work to do only takes away from the actual patient contact/evaluation, therefore possibly compromising the quality of the QMEs work. Whenever possible, I think the emphasis should be on enhancing patient contact and assessment as oppose to creating more paperwork, thereby taking away from the patient. Thank you.

Emmett Cox II, MD May 18, 2018

I am writing this letter in regard to the proposed changes in the Med-Legal Fee Schedule. I respectfully disagree with the proposed changes to the Med-Legal Fee Schedule for the following reasons:

The QME Medical-Legal reports are used to discover facts that are of paramount importance to everyone involved in the evaluation, most importantly the injured worker. The majority of the cases I have done do not meet the three-hour preparation time the DWC is proposing. The time required to prepare a medical-legal report that constitutes substantial medical evidence and to answer all the questions from the attorneys and claims adjusters, in most cases requires more than three hours of preparation time. The majority of the QMEs I perform involves a review of several thousand pages of records, multiple body parts, as well as numerous questions from the attorneys and claims adjusters.

Three hours is an insufficient amount of time to prepare a comprehensive medical legal report to address all unresolved issues. Imposing a three hour cap on report preparation time will only increase the need for Supplemental Reports and/or Depositions in order to bring closure to unresolved cases, which is costly, time consuming and ultimately may impact the entire system negatively, especially to the injured worker and employers.

Regarding Causation as a complexity factor, I respectfully urge the DWC to reconsider and allow Causation as a independent complexity factor without having to obtain pre-authorization.

I have been a QME/AME provider for over 25 year's duration and consider it a privilege to be a part of the Workers Compensation process as an orthopedic surgeon. I take pride in producing the most comprehensive and substantial medical report to assist in resolving complex Medical-Legal issues. I respectfully urge the DWC to pull back the proposed regulations and have an actual stakeholder panel process to come up with an improved solution that would more accurately account for dealing with complex claims. The proposed changes to the Med-Legal Fee Schedule are unreasonable and may potentially cause an adverse impact to the entire system.

Steve Nitch, Ph.D, QME May 18, 2018

My biggest concern about the proposed revisions to the California Workers' Compensation Medical-Legal Fee Schedule is limiting the preparation time of a ML-104 report to 3 hours. This will have a tremendous impact upon the quality of Psychology PQME reports, as it is a wildly unrealistic metric given the complexity of these evaluations. If practitioners are not sufficiently reimbursed, or not approved for enough time to do a thorough evaluation, the work product will inevitably suffer. This will be to the ultimate harm of the consumer.

In the long run, this will also have a monumental negative impact upon QME availability for psychological evaluations. There will be a mass exodus of qualified providers, because this will no longer be a feasible enterprise.

Tet Toe, MD, FACP May 18, 2018

In my opinion, the proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. I myself sometimes thinks whether it is worth my time and effort to be working as an Internal Medicine QME any more even with the current rules in place as some of the cases are so complicated. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to

limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for the system as a whole and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical time frame is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Doreen Fukushimia, MD, QME May 18, 2018

My name is Doreen Fukushima and I'm a psychiatrist who works in the capacity of a Qualified Medical Examiner. I've had an opportunity to review the proposed reimbursement adjustments and want to express my objection to the proposed changes. These qualified medical evaluations are quite extensive and complicated and compensation for these reports should not be limited. Reports have varying requirements regarding the research that gets documented and some of the articles that are used for 1 case are applicable to other cases. If stipulations are put in place to limit the amount of compensation for certain aspects of our reports, then it penalizes evaluators that put in the time to make their reports comprehensive so that depositions and further supplemental reports that are costly are not needed as often. I foresee that the quality of these reports will decrease if these new limitations regarding compensation are activated. If that occurs I may reconsider renewing my status as a QME because the compensation for doing quality work will be decreased.

Dr. Rapoport May 18, 2018

It will not be possible to write a report with three hour limitations.

The quality of reports will dramatically decline and many doctors may not want to continue with this arrangement.

It will be more difficult for injured worker to find a QME if this occurs.

Carol W. Fetterman, Ph.D. May 18, 2018

I am emailing to express my objections to the Daisybill.

Review of these proposals will add complexity in obtaining information from the parties in order to determine complexities in the reporting process. All parties must agree that causation is an issue and can be used as a complexity factor. This information is not available to the QME prior to the evaluation in order to get authorization from the parties on the issue of causation.

To Whom it May Concern:

Below are my objections to these proposals:

The parties have to agree that causation is a complexity factor and this determination is needed before the appointment. The doctor may get information during the evaluation that it is or is not work related. There is no way to know this prior to the appointment in order to get approval. It is already extremely difficult to get a customized cover letter and medical records prior to an appointment.

Further, it makes no sense to cap the time arbitrarily that the QME will be compensated for a report. There is a great variety in the complexity of cases, resulting in vast differences in the amount of time needed to obtain information. This is particularly true in the case of psychiatric evaluations which involve different kinds of analyses, usually requiring much longer interview times.

Capping the time spent on supplemental reports, regardless of the amount of records or the complexity of issues being requested will likely result in QME's 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.

Michael Butler, MD, Neurologist May 18, 2018

Penny wise, pound foolish.

I recommend maintaining the existing regulatory regime for QME physicians and rejecting the proposed amendments.

The proposed regulation changes appear aimed at cutting costs; they will likely have the opposite effect. That’s because they encourage the production of reports that do not answer the questions workers and employers need answered to resolve their cases. Which means more subbing-in of other evaluators, more deferring decisions, more supplemental reports, more depositions. And much more delay.

Re: Causation not in dispute unless both parties consent

While medical causation is only one aspect of determining industrial causation of a claimed injury, it is nevertheless an important part. This proposed rule change seems to mean that either party will have an effective veto over whether causation is in dispute, from a medical point of view. I have to wonder whether this will engender a flood of new claims from workers who may previously have been reluctant to file when there was a chance they would have had to prove medical causation to someone who knows

medicine. I hope we will have enough evaluators to handle the load, considering that these proposed changes are already prompting a number of current evaluators to call it quits.

Re: Time limit for report preparation

In the last decade, thousands of QME/AME reports have been submitted in which the evaluator claimed to have spent more than three hours in preparation time. There are only two possible explanations for this fact: either (1) every one of those reports was submitted fraudulently, under penalty of perjury, or (2) it does in fact sometimes take more than three hours to prepare a report. Since there has been no news of massive fraud from the DWC, I suspect the latter is the case.

So, since those complex cases that require more than three hours to prepare a report on DO exist, what will become of them under the proposed new rule? The three-hour limit will likely result in more cookie-cutter reports in complex cases, particularly in those involving complex issues of apportionment (too bad for employers) or the issue of derivative injuries (too bad for injured workers). There will likely be more deferring to evaluators in other specialties, more supplemental reports or depositions to clarify issues that were not adequately explained in the original report, and more reports that fail to constitute substantial medical evidence.

Re: Medical research

The work we QME's and AME's do takes time. It's that simple. The same is true for the work legal professionals do. Attorneys and judges sometimes consult the same statute or ruling twice in the same year, whether to be sure of content they have not memorized, to look at different portions of the same ruling, or to consider how the law may apply to one case versus another. I suspect that doing these things takes time.

The same is true for doctors. We do not have every piece of research we have done in the last year committed to memory. We have to look it up, read it. We sometimes use different portions of a given research source in different cases. And we must determine how a given piece of research applies in a particular case, which may be quite different from the last case. Sure, the process may indeed be quicker the second time we consult a given article or text, but it is not instantaneous.

The proposed rule will mean QME's must choose among three difficult options in cases that require medical research: (1) Choose alternate research that is not the best suited for a given case, because we've already used the best research in the last year. In other words, produce a "second-best" report. (2) Don't do the research, since we won't be paid for doing it anyhow. Merely rely on our experience and what we think we recall about previous similar cases and how previous research may have applied to them. In other words, guess. (3) Do the research that is needed for the case and do it properly, however long that may take, and then say in our report that it took us zero minutes to complete this task. In other words, lie.

I strongly suspect the result of having to make the choice between a second-rate report, a guess, and a lie will be more reports that consider medical issues in the most superficial way possible, and that fail to constitute substantial medical evidence. More supp reports. More depositions. More need for alternate evaluators.

Bottom line: more delay for injured workers and more cost for employers and insurers.

Penny wise, pound foolish.

Dr. Cynthia Neal May 18, 2018

I am a new QME, in the last two years. I would not have taken the most challenging exam, had I known of this development.

I will not continue to provide services that would compromise the integrity of the evaluation. It would not be possible to provide a quality report, addressing the complex legal requirements with the proposed constraints.

Dr. Nemo, QME May 18, 2018

Creating a failed system

The new Work Comp changes proposed will decrease physician payment significantly. At the same time, inflation and overhead are rising. There has not been an increase in payment to physicians in over 10 years. More and more physicians will drop out of the system and the quality of the evaluations will drop dramatically.

The significant decrease in payment to physicians you propose will cause a downward spiral in the system as fewer and fewer doctors, spend less and less time with the patient and the reports.

You cannot ask the physicians to do complex evaluations and reports that require hours of their highly trained time and then pay significantly less and expect the docs to still follow all the QME requirements.

No matter what the system will stagger on but you will be left with awful reports that slow down the system and cause more fraud and abuse as the honest docs leave the system and the scammer move in.

The sharp cuts in payment you propose will save the State little or no money and result in an increase in fraud and unhelpful reports as providers scramble to flee the failing system you are creating.

Please reconsider and generate new rules with input from the physicians.

Don Williams May 18, 2018

Causation changes: What happens when only one party send a letter that causation is denied?

What happens when one party accepts causation and the other party denies causation. Is that considered an accepted dispute?

What happens when a specific injury causation is accepted but there is evidence of a separate CT injury which is denied? Is that a disputed claim for one half of the exam and accepted for the other half of the QME?

Craig C. Joseph, MD May 18, 2018

I would like to talk to **[REDACTED]** in June, next month, when many of us will be at a convention in Long Beach. First, in this email I am going to provide some historical perspectives. I remember in the 1980's that there was a significant expansion of unnecessary back surgeries. In 1997 a very highly respected spine surgeon told me that if disc surgery was delayed beyond approximately 90 days, then there was a high risk of back failure surgery because the nerves would already have been permanently damaged. There were many back surgeries performed way beyond the 90 days,with some being performed years after a date of injury .How did the insurance companies respond ? The insurance companies engineered the contraction of the number of surgeries—if I remember correctly, the 1993 regulations required a second opinion on proposed spinal surgeries. Then ,in the 1990's, the volume of fibromyalgia filings ballooned out of sight—as a predominantly defense doctor from 1986—2004,I evaluated more than 200 cases for fibromyalgia—most of them were frivolous claims, but the medical treatment bills and awards were often, in total,over 500,000 dollars. Then, the insurance companies encountered the billings for topical medicines. The insurance companies were also ordered by the WCAB to pay 20,000 dollars to 25,000 dollars for facility fees for epidurals, when the doctor billed approximately 300—400 dollars. This is part of the motivation for the insurance companies being the foundation for the scorched – earth approach / killing and murdering the mechanism of QME's AME's.It is my understanding that the funding for the DWC/medical unit is derived from assessments on the insurance companies—assuming that to be true regarding the funding, then the following question must be asked—did the insurance companies command and dictate the content of the newly proposed regulations .In addition, in previous years there was the Industrial Medical Council—it was a mechanism for doctor input to the DWC and the IMC constructed excellent protocols/ guidelines – who was responsible for the abolition of the IMC –it doesn't take an Einstein to answer that question ! Also,it is my understanding that prior to doctors having to pay a lien activation FEE, that assessments on the insurance companies provided the funding for the WCAB. Is it fair to ask the following question – the insurance companies are getting revenge by commanding and dictating these newly proposed regulations. Indeed, do you really think the DWC gives a hoot about the comments from the doctors ? To quote Shakespeare, in the play, Hamlet, the following is stated: "SOMETHING IS ROTTEN IN THE STATE OF DENMARK ."

Miguel Oportot, PhD May 18, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through, it will surely adversely impact the pool of QMEs and the quality of reporting.

Please reconsider adopting this language and listen to the input from the QME community. Please consider finding a more equitable way to solve the concerns you are trying to remedy.

Thank you for your time and consideration.

James O'Brien, MD May 18, 2018

A lot of good ideas in the comments so far but these don't get to the essence of the problem...QMEs were always a bad idea. The idea of forcing two parties to use a doctor neither really want for what is essentially binding arbitration is bonkers, and sounds like something out a Soviet apparatchik would come up with. And there is no logic to defining work level or complexity by whether or not apportionment or causation are approved and addressed. The complexity is in the narrative.

It's the central planning fallacy, what Von Mises and Hayek called the fatal conceit.

How do you control costs? Competition and accountability, not arbitrary criteria that can be gamed by the most Macchiavellian among us.

Here's how to solve the problem of billing research and billing too much for medical records…once the defense attorneys and insurance companies know Dr. X does that way too much, they stop using Dr. X.

Prices, costs, and report quality issues will take care of themselves if attorneys avoid can choose doctors they know and respect while avoiding doctors who overbill

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Charles Feng, DC, ATC, CSCS May 18, 2018

As a new QME, I am deeply concerned by the proposed changes to the QME Medical Legal Fee schedule. The QME report needs sufficient time to compose and I often receive 20-30 questions/comments from attorneys and claims administrators that require addressing. The limitations on the Fee schedule will severely decrease the quality of reports and thus place the livelihood of the injured workers at risk.

Pamela Hall, Ph.D., Psychologist, QME May 18, 2018

I respectfully offer the following brief analysis of how time is spent when writing a forensic psych report.

In the forensic psych examination, the biopsychosocial clinical interview is the basis of evidence on which opinions are based. The two hour minimum requirement for face to face time allows sufficient time to collect this evidence in more simple cases. More complex cases (i.e., cases with a history of

psychiatric treatment and/or multiple medical conditions) require up to three hours of interview, rarely more. Evidence is gathered by the Psych QME expert regarding the circumstances of the alleged psych injury, current psych symptoms and functioning, and pre-existing psych symptoms and functioning. All aspects of the injured worker's life are examined as contributing factors to the mental condition, whether industrial or non-industrial. The time required to present this evidence in an effective manner consumes the entire three hours report writing time allowed under the DWC proposal.

Per my colleagues on this board and consistent with my own practice, a typical forensic psych report takes a total of 8-12 hours report writing time. As noted, three hours of report writing is spent on compiling evidence from the clinical interview. The remaining 5-9 hours of report writing time is spent on formulating diagnoses, determining treatment recommendations and MMI status, analyzing the relative impact of nonindustrial and industrial stressors on the mental condition, integrating evidence from a review of records and medical research, and presenting opinions regarding AOE/COE and apportionment. The actual amount of time spent in report writing is determined by the amount of evidence that has to be analyzed.

If the proposed DWC time limitation on report writing takes effect, the resulting forensic psych report would contain an abbreviated presentation of clinical evidence that will, without question, under represent the intricacies of an injured worker's mental condition over time. Necessary evidence from the clinical interview will be lost in favor of meeting the report writing limitations. Expert opinions regarding AOE/COE and apportionment can be provided but would not be substantially explained.

I cannot imagine that a DWC judge would appreciate the inadequacy of this report. The concerns of injured workers would not be sufficiently addressed. Parties on both sides would not have the information they require to proceed with providing appropriate treatment or with settling disputes. No one is well-served by the forensic psych report that could be written in three hours.

Benjamin A. Carey MD, CAPT MC USN (retired) May 18, 2018

As I have reviewed the proposed changes, I note that Jason Marcus ESQ, President of the California Applicant Attorneys Association has adequately addresses the pending problems that will happen. Rather yuan my making the same arguments 5hat he has well described, I will tell you my response if these proposals are implemented.

I have been doing medical legal evaluations since 1986 and a large per cent of the evaluations have been as the AME in Psychiatry. I have commuted 5o California from my home in Virginia Beach, VA since 1988. I also have a medical legal practice in Virginia. Fortunately, my military pension, my VA Compensation, my Social Security and my investment income as well as my Virginia practice income is significant such that I do not need to continue to commute to California to make a living. I have performed over 6000 evaluations and you will lose my expertise, often as an AME if these proposals are implemented.

Rodney J Reid, MD PhD May 18, 2018

The proposed changes to the Med-Legal Fee Schedule will cause 95% of the QMEs to quit. It may be even more salient to note that 100% of the competent QMEs will quit. The proposed changes to the fee schedule do not appear to be a good faith effort to improve the Worker's Compensation system. These changes will only benefit insurance companies, in that, for years cases will go unsettled with delayed payments for treatment and damages. Instead of destroying the Worker's Compensation system with the proposed changes to the Med-Legal Fee Schedule, it seems reasonable to wait for the findings of the RAND study and then carefully address any systemic problems that are found.

David Chang May 18, 2018

Simply, the imposed limits and restrictions proposed with the new fee schedule will incentive poorer quality work and will ultimately prove to be a huge disservice to California's injured workers, who rely on QMEs to uphold a fair assessment of their cases, which often can be quite complex and span many years.

Please do not pass the new fee schedule as it stands.

Wei-Ching Lee, MD May 18, 2018

I am opposing all your proposed changes to the QME Medical Legal Fee schedule.

This cap at 3 hours for report preparation time would make it impossible for a QME to provide the adequate service necessary to fully evaluate the patient and review the required medical records. If the payment is capped then QMEs will have to shorten their sessions and may only be able to provide incomplete QME evaluation reports. Thus this would be a waste of resources if only incomplete QME reports can be done. Then you would have to indemnify all the QME physicians from any accountability for incomplete QME reports.

Physicians are already dropping out from performing QME's and if these proposed changes are pushed through then I think there will be very few physicians willing to participate in QMEs including me and this would be unfair to the injured workers as they would not readily have access to QMEs who provide due process for them.

The causation requirements are not realistic and would make it very difficult to perform a QME in that claims adjuster and attorneys do not always provide us with cover letters for the QMEs.

I am opposing all your proposed changes and will consider cancelling my QME if these changes were to occur as will many other physicians and there will be a very small pool of QME physicians left if any.

Thomas E. Leonard MD May 18, 2018

I have been a QME for over 20 years. The proposed new regulations will hand cuff experienced reporters and clearly cause claims to be even more prolonged. Please reconsider --- the unforeseen consequences may be many.

Bradley Bower, MD, QME May 18, 2018

If the intent of the DWC is to completely disrupt the med-legal process and to promote further pervasive mediocrity if not chaos within the CA WC system, then the DWC should proceed with submitting these reckless proposed revisions for legislative review and ultimate approval.

As a QME in Internal Medicine, I am accustomed to receiving boxes of medical records, most often poorly organized and containing multiple redundancies. After sorting, I am required to review these documents and utilize the information to create a med-legal report that meets the standard of substantial medical evidence. I am more often than not required to address causation issues pertaining to multiple complex medical problems that may be pre-existing but aggravated by the WC injury or treatment, have developed as a derivative injury, or are integral to the IW's claim through LC 3212 and presumption.

<u>The Requirement to Meet the Standard of Substantial Medical Evidence</u>

In order to meet the standard of substantial medical evidence, med-legal evaluators must formulate reports that meet the following criteria:

- A medical opinion must: (1) be based upon reasonable medical probability (2) be based upon pertinent facts and an adequate history and physical examination (3) set forth reasoning in support of its conclusions

- A medical report must not: (1) be speculative (2) be based on surmise, speculation, conjecture or guess (3) be based on incorrect legal theories or (4) be based on facts that are no longer germane

To meet the standard of substantial medical evidence, causation analysis must incorporate structured principles of causation analysis and where presumption applies, the application of labor codes that impact the determination as to whether a condition arises out of employment. In the context of direct patient evaluation and medical record review, the examiner must gather the necessary information to determine if sufficient evidence is present to define disease processes, assess the epidemiology of the disease processes, assess the patient's exposures to support work-relatedness, assess the validity of the patient's testimony, and examine all other potential relevant factors (risk factors, covariates, prior injuries or illnesses, psychological factors, other diseases, disorders and prior treatments) that are applicable to the causation analysis.

While there are instances in which this process is straightforward, there are many others in which the process truly represents "*extra* ordinary circumstances", requiring a forensic approach to *adequately*

address the questions presented by the opposing parties. The proposed changes to the QME billing process will impose severe constraints on med-legal evaluators to produce reports that meet the standard of substantial medical evidence.

The Waves of Demise

Proposing alternate solutions to the QME billing concerns that the DWC is attempting to address through the institution of draconian measures is beyond the scope of what can reasonably be accomplished in this forum. Moreover, such effort to contest the issue may simply represent an exercise in futility; given time and a lack of understanding of the scope and nature of the pervasive problems plaguing the CA WC system, these misguided revisions will be pushed through, leading to the following predictable events:

- In wave I, well-meaning competent and thorough QME's will recognize immediately that they will not be able to continue performing QME's unless they are willing to nearly volunteer their services, earning perhaps $50 per hour when all is said and done. These individuals will immediately stop performing QME's and devote their skill sets to more reasonable activities.

- In wave II, the well-meaning and competent QME's that believed they could "rough it out" and "see what happens" will have learned the hard way, and will cease volunteering their services.

This will leave a set of QME's that have developed techniques to manage the draconian revisions that have been set in place. These techniques will include but not be limited to use of "extended practitioners" such as medical assistants to perform the history intake (and in some cases the examination, followed by a superficial overpass by the practitioner), cheap medical review services to formulate medical record reviews (which are scanned in superficial fashion by the practitioner), production of inadequate initial reports and multiple supplemental reports that prompt depositions and more supplemental reports, all of which promote prolongation of the WC cases, disservice to all parties (the injured workers, insurance companies and employers), and increased costs.

In short, if entities within the DWC remain intent on promoting mediocrity (at best) and increased costs, they should continue promotion of the revisions as presented.

The Elephants in the Room

To state that the practice of WC in the state of CA is administratively cumbersome is to state the obvious. The barriers to the provision of basic care are numerous and often lead to delayed claim closure and litigation that would have not occurred in a system that allowed for the delivery of reasonable levels of care.

Metrics regarding cost distribution in the CA WC system are available through the WCIRB (Worker's Compensation Insurance Rating Bureau of CA). This independent private organization publishes an excellent annual report that is available for review at https://www.wcirb.com. Anyone interested in understanding WC costs in CA is encouraged to review this information. Referencing the WCIRB 2017 annual report, analysis of some basic metrics pertinent to med-legal costs is revealing.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

Consider the following:

1. Med-legal costs have risen little in comparison to other costs in the WC system, particularly when adjusting for inflation:

Entity	2013	2016
Total Paid Medical Benefits	4.9 billion	4.5 billion
% of total paid medical benefits attributed to med-legal evaluations	6%	7%
Amount spent on med-legal evaluations ($)	294 million	315 million
Dollar amount in 2013 $$ when corrected for inflation from 2013-2016	303 million	

The 4% increase costs spent on med-legal evaluations should be considered trivial when other WC cost drivers are considered.

2. Of the 3.5 billion paid in frictional costs in 2016, med-legal evaluations are the least costly of the six categories, while the combined costs for insurer claims staff and attorney fees account for 2/3 of all frictional costs.

Table: Frictional Costs in the CA WC system - 2016

Entity	% of frictional costs in 2016	Amount in $$ (millions)
Med-legal evaluations	9.6	330
Applicant attorney fees	11.7	410
Medical "cost containment" programs	13.5	470
Other allocated loss adjustment expenses (costs for defendng WC claims when there are disputes and costs of managing the cost of medical treatment)	14.9	520
Defense attorney expenses	23.8	830
Unallocated loss adjustment expenses (cost for insurer claims staff)	26.5	920

3. CA continues to lead the nation in WC insurance costs in the nation (CA: $3.24/$100 payroll vs. state median: $1.84/$100 payroll), attributed to a higher % of PD claims, prolonged medical treatment and "much higher than average costs of handling claims and delivering benefits."

4. CA has by far the highest permanent partial disability claim frequency in the country (910 claims/100,000 insured EEs vs state median of 315/100,000 insured EE's). PPD claims generate the vast majority of costs in the WC system.

5. CA leads the nation in the percentage of indemnity clams that remain open at 60 months (17% vs. state median of 5%). This is attributed to higher volumes of medical liens filed, higher rates of PD

and CT claims (including post termination CT claims), and the high complexity of handling and settling claims due to frequent attorney involvement and disputes.

6. The average cost for insurer claims staff per indemnity claim has increased 11% since 2013.

7. In CA, the costs for defendng WC claims when there are disputes and costs of managing the cost of medical treatment is far higher than any other state (10% higher than the second highest state and nearly twice the state median of 18.3%).

8. CA administrative costs are mulitples higher than any other medical benefits systems, by far.

Cost to Deliver $1.00 of Benefits	
Medicare	$0.02
Private Group Health Insurance	$0.18
WC – median state	$0.22
CA WC	$0.53

9. Rates of legal representation have been increasingly steadily since 2009 throughout CA.

SUMMARY

Given the large number of frictional cost drivers in the CA WC system, it's surprising that the monies spent on med-legal evaluations have not tripled; rather, the cost of med-legal evaluations has stayed nearly constant. While the med-legal evaluation process and associated billing practices are not without flaw, a review of CA WC cost metrics demonstrate that the issues are relatively minor in comparison to the many frictional cost drivers that plague the CA WC system. The revisions as proposed not only fail to manage the true frictional cost drivers, but also undermine one of the primary tools that assist with the containment of these costs.

To cite an example: If Ms. Smith's $10 wrist splint had not been denied by an ill-conceived UR process that cost the employer $400 for a single review, she may not have litigated and gone on to develop elbow and shoulder pain that then caused the contralateral development of compensatory wrist, elbow and shoulder pain, which evolved into a chronic pain syndrome, prompting long-term NSAID use, which led to the need to perform an extensive work-up for gastritis/esophagitis and consideration that her long term poor dentition was aggravated by chronic reflux esophagitis aggravated by the underlying NSAID use; the chronic pain, poor dentition and loss of employment were thought to promote stress and depression, as well as an aggravation of her underlying hypertension and diabetes. Several superficial med-legal evaluations down the road (none of which met the standard of substantial evidence and moved the claim forward), Ms. Smith sits at home in the midst of a disability mindset, taping popsicle sticks to her wrist, perseverating about the use of the wrist splint she never received.

> **"As soon as you step back and focus on the big picture, you easily make new choices, discover the peace that comes with greater patience, and formulate creative, effective strategies to move in the right direction."** - *Brian Biro, Motivational Speaker and Author*

Any agency that is truly intent on the resolution of problems of this complexity would enlist stakeholders throughout the CA WC system (a group which includes individuals that actually have

experience in the *performance* of med-legal evaluations) in a meaningful set of forums to *transparently* address the multiple issues that are driving the need to revise the med-legal process. The system is broken, but will be further damaged if these reckless revisions, previously kept "underground", make their way to the surface.

Paul R. Pirruccello, DC, DABCO May 18, 2018

I am opposed to the proposed changes to the QME Fee Schedule. The amount of time and effort it takes to review records, take a thorough history and examine an applicant and, then, create a detailed and admissible medical legal report goes well beyond what would be fair and equitable with these proposed fee changes. It is my opinion that the quality and attention to detail will be diminished greatly with these proposed changes. I would ask that these changes not be adopted. Thank you.

Nima Yavaria MD May 18, 2018

As a QME Internist whose reports require significant history and detail, I strongly feel that limiting the report preparation time to 3 hours will prevent me from adequately discussing the claimant's injury and provide medical justification for my findings. I can only see this resulting in an increasing amount of requests for supplemental reports to address the resulting inadequacies and it will lead to lower efficiency which will lengthen these cases which will ultimately harm the injured worker. The common complaint from all of the workers I have examined is the length of these cases and the longer they're drawn out, the more difficult it is to obtain accurate facts and address the injuries.

Zan Lewis May 18, 2018

ML 103: Can examples be given of " circumstances uniquely specific to the actual evaluation being performed which made the complexity factors applicable to the evaluation." The examples would assist in understanding what the DWC considers " uniquely specific."

ML 103 (6): causation
Since the defendant controls whether an injury is accepted or denied, the following language is suggested. Twenty days prior to the evaluation the defendant shall notify the physician in writing, the excepted and non-accepted body parts for each date of injury and shall state whether or not the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits. If the issue of medical causation is a disputed medical fact then addressing and providing an analysis of the issue of medical causation shall be a complexity factor in billing the evaluation.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

ML 104 (3): It is suggested that the following language be inserted between the first and second sentence. The defendant in unrepresented claims and the parties in represented claims shall provide the physician on or before 20 days prior to the evaluation a cover letter or cover letters and all medical records that are to be reviewed as part of the evaluation. They defendant on or before 20 days prior to the evaluation shall in writing state whether or not the issue of medical causation is a disputed medical fact the determination of which is essential for the adjudication of the claim for benefits.

This information will allow the physician to articulate the factors and extraordinary circumstances relevant to the evaluation that justify the request for an agreement that an evaluation involves extraordinary circumstances.

ML106: it is suggested that the second sentence be clarified by adding in at the end of the sentence " reviewing information and medical records, preparing the report, and doing medical research." This will clarify the type of services for which that they physician shall be reimbursed.

Bradley Bower, MD, QME May 18, 2018

If the intent of the DWC is to completely disrupt the med-legal (ML) process and to promote further pervasive mediocrity if not chaos throughout the CA WC system, then the DWC should proceed with submitting these reckless proposed revisions for legislative review and ultimate approval.

As a QME in Internal Medicine, I am accustomed to receiving boxes of medical records, most often poorly organized and containing multiple redundancies. After sorting, I am required to review these documents and utilize the information to create a ML report that meets the standard of substantial medical evidence. To meet the standard, the examiner must gather sufficient evidence to define disease processes and assess epidemiology, the patient's work exposures, validity of the patient's testimony, and all other potential relevant factors. The proposed changes to the QME billing process will impose severe constraints on med-legal evaluators to make these assessments.

If these misguided revisions are pushed through, well-meaning and competent QME's will apply their knowledge and skill sets elsewhere. This will leave a set of QME's that have developed techniques to manage the draconian revisions that have been set in place, producing suboptimal reports that do little to bring cases to closure.

To state that the practice of WC in the state of CA is administratively cumbersome is to state the obvious. The barriers to the provision of basic care are costly, numerous and often lead to delayed claim closure and litigation that would have not occurred in a system that allowed for the delivery of reasonable levels of care.

ML evaluations are not the cost driver. Metrics regarding cost distribution in the CA WC system are available through the WCIRB 2017 annual report. Analysis of some basic metrics pertinent to ML costs and frictional costs is revealing:

1. The cost of ML evaluations has risen only 4% since 2013 when adjusting for inflation.

2. Of the 3.5 billion paid in frictional costs in 2016, ML evaluations are the least costly of the six categories (9.6% of total), while the combined costs for insurer claims staff and attorney fees account for 62% of all frictional costs.

3. CA continues to lead the nation in WC insurance costs. This is attributed to a higher % of PD claims, prolonged medical treatment and "much higher than average costs of handling claims and delivering benefits."

4. CA has by far the highest permanent partial disability claim frequency in the country.

5. CA leads the nation in the percentage of indemnity clams that remain open at 60 months (17% vs. state median of 5%).

6. The average cost for insurer claims staff per indemnity claim has increased 11% since 2013.

7. In CA, when disputes are present, the costs for defendng WC claims and containing medical costs is far higher than any other state (10% higher than the second highest state and nearly twice the state median of 18.3%).

8. CA administrative costs are mulitples higher than any other medical benefits systems, by far (well over twice the WC median state value).

9. Rates of legal representation have been increasing steadily since 2009 throughout CA.

SUMMARY

Given the large number of frictional cost drivers in the CA WC system, it's surprising that the monies spent on ML evaluations have not tripled. While the ML evaluation process and associated billing practices are not without flaw, a review of CA WC cost metrics demonstrate that issues related to ML billing are relatively minor in comparison to the many frictional cost drivers that plague the CA WC system and provision of care. The revisions as proposed not only fail to manage the true frictional cost drivers, but also undermine one of the primary tools that assist with the containment of these costs.

Any agency that is truly intent on the resolution of problems of this complexity would enlist stakeholders throughout the CA WC system (a group which includes individuals that actually have experience in the *performance* of ML evaluations) in a meaningful set of forums to *transparently* address the multiple issues that are driving the need to revise the ML process.

Julius Young
Boxer & Gerson LLP

May 18, 2018

I respectfully urge the DWC to reconsider the proposed regs for the following reasons that were outlined in comments in my workerscompzone.com blog:

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

The California Division of Workers' Compensation has jumped the gun in posting proposed changes to the California workers' compensation Medical-Legal Fee Schedule.

As this blog is being written, a multitude of physicians and stakeholder groups have participated in a DWC online forum on the proposed regs. The majority of those warn of adverse effects, as well as some possible unintended consequences. Those comments demonstrate that **there is a significant risk that there could be a large negative impact on QME availability in the system, as well as an adverse impact on the quality of QME reporting.**

This is something that should be of concern to my friends in the employer and insurer community and not just to doctors and applicant attorneys. If it become more difficult to get timely reports, cases may take longer to resolve. If report quality suffers, the system may be impacted in many ways.
But let's pull back for a moment and look at the bigger picture. What are some of the recent studies telling us?

The June 28, 2017 WCIRB "Report on 2016 California Workers' Compensation Losses and Expenses" lists Medical-Legal evaluations as paid losses of $0.3 billion in CY 2015 (out of $4.9 billion in overall paid medical losses) and $0.3 billion in CY 2016 (out of $4.8 billion in overall paid medical expenses). Exhibits 1.1 and 1.2 to that WCIRB report note that Med-Legal evaluation payments for CY 2016 were 7.1% of total medical costs paid. Exhibit 1.4 to that WCIRB report shows an increase in the percentage of total medical payments for Med-Legal from 2013 (when the percentage was 5.7% of CY medical costs paid) to 2016 (7.1%). Other exhibits attached to that WCIRB report show some shifts among numbers and costs of reports among various medical specialties.

The WCIRB "2017 State of the System" report includes a different metric. In that report it is noted that as a percentage of "2016 Paid Frictional Costs", Med-Legal costs were 9.6% of the overall frictional cost pie (compared with 23.8% for defense attorney expenses, 13.5% for medical cost containment, 11.7% for applicant attorney fees, 14.9% for other allocated loss expense and 26.5% for unallocated loss expenses).

Also in the mix of studies on QMEs was the February 2018 CWCI study, "Changes in the QME Population and Medical-Legal Trends in California Workers' Compensation", by CWCI researcher Stacy l. Jones. Findings of that study included that the total number of QME providers dropped by 20 percent between January 2012 and September 2017. Of those, 82.8% voluntarily non-renewed their QME certifications.

An earlier report, prepared by UC Berkeley researcher Frank Neuhauser for CHSWC in 2010, had noted that between 2005 and 2010 there had been a 45% reduction in the number of active QMEs. In an 2017 update to his 2010 study, Neuhauser claimed a 17% drop in the number of QMEs between 2007 and 2016.

As far as the costs of reports, Jones of CWCI noted that "*After increasing for seven consecutive years, the number of comprehensive (ML104) medical-legal evaluations-the most detailed and expensive reports-began to level off in 2015."* Jones noted that ML 104 reports as a percentage of total med-legal service declined since 2014 (from 34.6% in 2014 to 33.6% in 2015, 31.4% in 2016, and 25.8% as of mid-2017).

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

The average paid per med-legal service was basically flat between 2014, 2015 and 2016 and declined somewhat as of mid 2017 (per Exhibit 2 chart in the WCIRB report). However, Ms. Jones at CWCI did report that there was a notable increase in payments for supplemental med-legal evaluations and supplemental reports. And she noted that there were a number of other issues pertaining to the QME system which merit further study.

In his October 2017 presentation to CHSWC, UC Berkeley's Neuhauser found increases in average QME income and the total cost of reports, but was comparing 2016 with 2007 figures as a benchmark. CHSWC commissioners raised a number of questions about the study and the Neuhauser update has not been approved by a CHSWC vote yet.

Putting all of these data points from the various studies together, it hardly looks like a crisis of med-legal costs is plaguing the comp system. That's not to say that there may not be providers who are abusing their timekeeping and billing (something I don't doubt). However, an analysis of the 2016 and 2017 WCIRB charts and the 2018 CWCI study does not indicate a runaway problem with Med-Legal costs at the moment.

What makes the DWC timing in proposing new billing regs now so puzzling is that RAND has not issued a long awaited report on the QME system which was commissioned by CHSWC.
A fact sheet on the RAND study at its inception several years ago provided these following explanations:

"This study will assess whether changes should be made in the various reports required from primary treating physicians and in the fee schedule for medical-legal expenses under California's workers'compensation (WC) system. The study is being conducted in conjunction with a separate evaluation of the impact of Senate Bill (SB) 863 provisions affecting medical care provided to injured workers."

"The reports and the fee schedule allowances have not changed for a number of years and the utility of the reported information and the pricing structure need to be reassessed to assure the policies are consistent with efficient program administration. Similarly, the fee schedule allowances for medical-legal evaluations and reports have not been updated since July 1, 2006 and need to be reviewed."
"We plan to use interviews and focus groups and an environmental scan of other WC programs to develop findings and recommendations on whether the policies for WC-required reports and medical-legal evaluations should be modified. For the WC-required reports, our focus will be on how the reports and specific data elements are used, reporting burden, and whether there are alternative sources for the information and collection processes. For medical-legal evaluations, our focus will be on how the medical evaluations are conducted, the level of effort and complexity relative to evaluation and management visits, how complexity differs by type of impairment, whether the reports could be made more efficient for the users, and whether refinements are needed in the definitions of the complexity levels of the evaluations".

As I prepared this post I did some digging about the status of the RAND report. I was told by someone in the know that the report "is close to finalizing".

Under these circumstances it would appear prudent for the DWC to pull the proposed regulations til everyone can see what RAND recommends and until RAND's conclusions can undergo scrutiny by CHSWC and public comment.

The available data show no crisis sufficient to justify rushing into interim changes.
For a number of years now the DWC has claimed that it is focused on making data driven policy changes. But in this instance **the DWC would appear to be getting out ahead of their skis before RAND has delivered its research.**

Also, RAND could well benefit by looking at the stakeholder comments on the proposed regs, since those comments give plenty of insight into the concerns of the QME providers.

Don Williams, MD May 18, 2018

Why are deposition fees at such a low rate? Why do bankruptcy attorney fees set by the state at a higher rate than doctor fees for depositions?

Please raise testimony fee rates.

Don Williams, MD May 18, 2018

Why do we have to repeat the Disclosures for every report, but we cannot repeat the literature references.

Desai David, MD Psychiatry QME May 18, 2018

I am against proposed fee schedule, as it will be unworkable for many psychiatrists. Many doctors will think of quitting QME work, if changes are coming in place. There has been no increase in fee schedule for long time & now DWC is trying to cut it to a level, that will be unacceptable for most doctors.

Sandra Klein PhD May 18, 2018

I am a QME that performs neuropsych and psych evals. In my first comment I addressed the proposed 3 hour report prep limit for ML 101 and 106 reports. I now realize the proposal intends to limit all ML104 reports to 3 hours as well. I wonder if the authors of this idea really understand what is required in our reports and how complex they are. A typical case for me involves an injured worker with a

concussion, depression, PTSD and a prior history of ADHD. This requires thorough history, testing, analysis and multiple impairment ratings. I try hard to produce a report that addresses all required issues and questions. As a result I get few requests for supps and depos. To suggest that I could prepare these reports in 3 hours is ludicrous . Any change in the billing code should be preceded by careful review of actual reports, the myriad required report components and discussion with experienced, well respected QMEs.

Diane Przepiorski, Executive Director May 18, 2018
Lesley Anderson, MD, Chair – WC Committee
Peter Mandell, MD, Chair – Medical-Legal Committee
California Orthopaedic Association

The California Orthopaedic Association appreciates the opportunity to submit comments on the proposed changes to the Medical-Legal Fee Schedule and on other areas of the fee schedule that we believe need clarification. We appreciate your review and consideration of these comments. We have also mocked up our proposed changes in our attachment.

1. 9794 (a) (1) – Reimbursement of Medical-Legal Expenses
   We commonly receive complaints from upper extremity orthopaedic surgeons evaluating a carpal tunnel injury that the AMA Guides to the Evaluation of Permanent Impairment – 5th Edition – recommends that an evaluator use a particular test to establish the injured worker's level of impairment. Some of these tests are not included in the MTUS; thus, claims administrators and/or utilization review companies deny reimbursement for them.
   Yet the AMA Guides recommends the tests as appropriate for impairment evaluations.

   Since the AMA Guides is the controlling document for Medical-Legal evaluations and determining levels of impairment, when there is a conflict between the MTUS and the AMA Guides, we believe that the AMA Guides should prevail for Medical-Legal evaluations. Thus, we are recommending that Subsection (1) be amended to clarify that diagnostic imaging and other tests recommended by the AMA Guides help to establish levels of impairment be approved.

   Other restrictions on not performing and billing for duplicate tests would apply to this section as well.

2. 9794 (d) – This section requires the physician to submit a disputed billing to a second review prior to invoking the Independent Bill Review process, however, it puts no requirement on the claims administrator to respond in a time manner or even to respond at all.

   We recommend that the claims administrator be required to respond to a second review within 15 working days.

3. 9795 (c) Required elements of a Medical-Legal Report
   We understand that the Division has concerns that physicians are not routinely addressing all

required elements in a Medical-Legal Report. To clarify the elements which must be included in order to make it a ratable report, we would support adding the list of required elements contained in the DWC Physician Guide in these regulations. Please see the mock-up of the regulations for the elements.

4. ML-100 – Missed Appointments

This has long been an area of complaint. Physicians set aside significant amounts of time for Medical-Legal evaluations. When an injured worker does not show up for the appointment or the appointment is cancelled at the last minute, the physician is not able to fill that open time with another evaluation. They have also spent additional time preparing for the evaluation. Physicians generally have a missed appointment policy which includes the amount that will be charged should the injured worker not show up for their evaluation. That policy is communicated to the claims administrator. In spite of being notified that there will be a missed appointment fee, many claims administrators and/or utilization review companies fail to pay these fees. When challenged, the judge generally awards the physician the missed appointment fee.

We urge the Division to establish a missed appointment fee at $250. If the physician believes this is not adequate reimbursement for the amount of time set aside for the evaluation, they would be required to notify the claims administrator of their missed appointment fee.

5. ML-101

Many commenters in the Public Forum are complaining that this change would restrict a physician from billing no more than 3 hours for report preparation – citing voluminous records or review of videos, etc. In a careful reading of the description of ML-101, we see that the Division is envisioning that the time billed for reviewing records would be separate from report preparation.

This has made us realize that there is confusion over what is included under "report preparation." We would urge the Division to clarify this issue. We also believe that there are legitimate circumstances where 3 hours of report preparation is not sufficient time for the physician to report on all issues. In those instances, we believe that the requesting parties should be able to approve additional time. Otherwise, we fear that physicians will limit their report preparation time to a maximum of 3 hours whether or not their report completely addresses all issues. This will certainly lead to requests for supplemental reports and delays in resolving disputed issues. We are recommending proposed language change in the attached draft.

6. ML-103

Billing an ML-103 evaluation has become overly complicated. We would certainly support relooking at the entire system of billing a ML-103 evaluation, in an effort to simplify and streamline the system and more appropriately acknowledge the work involved to resolve disputes. This would also help avoid misunderstanding of the rules.

Should the Division undertake additional review of the criteria for ML103, we would be happy to participate in this effort.

Should the Division decide to stay with the existing system, we offer the following comments:

(2) Record Review

We find the proposed language, "All criteria except the amount of hours must also be satisfied to

use record review in combination under subdivision (4) and (5) of this code, to be confusing. We urge the Division to recraft this sentence to more clearly state their intent. This language is also found in (3).

(3) Medical research
The limitation on a physician being able to cite particular medical research only once every 12 months, is unreasonable. We believe it is unrealistic to expect a physician to even remember 11 months later that they used a particular citation in another evaluation.

That said, we also understand the Division's concern that the physician should not bill each time for the medical research even if the research is used in subsequent reports. It is important to note that the medical research is usually not to educate the physician on a particular issue, but to build a case of substantial medical evidence for the other parties in that particular case.

We support the Division's effort to expand these criteria and clarify what the evaluator must do in order to have medical research be considered as a complexity factor. However, we must oppose the language precluding the physician from using the same medical research in more than one evaluation over a 12-month period of time.

(6) – Causation
Whether the issue of causation can or cannot be counted as a complexity factor has created a lot of confusion and concern over the last couple of years. It is one of the issues that have gotten the Division embroiled in legal action and caused QMEs to be removed from the system.

We believe that there are some underlying principles that should govern whether causation can be considered a complexity factor. Causation should be allowed as a complexity factor when:

a) The claim/date of injury, or any body part is disputed by any of the parties. or
b) The parties ask the physician to address the issue of causation

In these instances, we believe the physician should be able to count causation as a complexity factor. It is unfair to the physician to require and/or ask them to address causation, but not allow them to include it as a complexity factor.

If the claims administrator does not want the physician to address causation, they have the option of accepting the claim/date of injury, or disputed body part(s) and notifying the physician prior to the evaluation being performed. Then the physician would not be allowed to count causation as a complexity factor.

Also, the changes proposed by the Division which would require agreement of the parties are unworkable for the following reasons:

a) It will be difficult for the physician to even contact all parties and attempt to get agreement.
b) From the DWC language, we are not even sure who are all of the parties. Would this include the injured worker when they are not represented?
c) It's a 2-step agreement process – parties must agree that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the

claim and that the physician may use causation as a complexity factor - making agreement of the parties even more difficult.

d) The evaluation will be delayed while they attempt to reach agreement.
e) A physician is not reimbursed for the time it will take to attempt to get agreement; thus, resulting in more uncompensated time required of the physician and/or their staff.
f) It's unclear whether the Division envisions whether the applicant attorney or unrepresented worker would have to agree that the physician could count causation as a complexity factor, since they have no role in paying for the evaluation.
g) We are unsure that the injured worker would understand any of this and potentially withhold agreement because they are confused and do not understand the issues.

We realistically believe that physicians, once they see that the parties cannot reach agreement, will not even attempt to get agreement of the parties. They will simply not address causation in their evaluation. When the parties realize that they need to have causation addressed, they will need to request a supplemental report or depose the physician. More delay and wasted time will result in resolving the dispute.

To clarify when causation can be counted as a complexity factor, we recommend that causation be handled as follows:
'Causation is deemed to be a complexity factor for a denied claim/date of injury or any body part or in an accepted claim where the parties have requested, in writing, that the physician address causation. If the claims administrator objects to the inclusion of causation as a complexity factor, he/she shall notify the physician in writing, prior to the evaluation that they have accepted the injury for the date of injury/claim or all body part(s).'

(7) (B) – which adds the following language, "The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement."

We question the reference to "Maximum Medical Improvement" when the statute refers to "Permanent and Stationary." Please clarify your intent with this language. We are also concerned that a physician might declare an injured worker permanent and stationary to be able to use Apportionment as a complexity factor. This may not be in the best interest of the injured worker.

7. ML-106

Many commenters in the Public Forum are complaining that this change would restrict a physician from billing no more than 3 hours for report preparation – many cite voluminous records or review of videos, etc.

In a careful reading of the description of ML-106, we see that the Division is envisioning that the time for reviewing records would be separate from report preparation. We are proposing language to clarify this issue and to provide some uniformity between ML-106 and ML-101.

Recommended language:
"The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, medical research, and preparation of the report. Time spent in each category (review of records, face-to-face time with the injured worker, and preparation of the report) shall be documented at the beginning of the report and

tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour."

We offer the same comments regarding the prohibition on citing medical research used in another evaluation within the past 12 months noted under ML-103 above. We recommend deleting this language.

ML-103 and ML-104
In the description of ML-103 and ML-104, the Division directs the physician to clearly and concisely specify which of the following complexity factors were "actually and necessarily incurred for the production of the medical- Legal report." We believe that using the word "necessarily" is too subjective and will be open to interpretation and bias by the payor. We would urge the Division to delete the word "necessarily" in each description.

Finally, we encourage the Division to consider a cost-of-living increase for the Medical-Legal Fee Schedule. Reimbursement rates have not been increased since 2006. From 2006 to April, 2018, the CPI has increased 25.3%. Reimbursement for physicians is falling woefully behind even just the basic costs of running an office, not to mention reimbursing the physician for their expertise in evaluating injured workers.

We appreciate the work that the Division has done to prepare these proposed changes to clarify the rules applying to the Medical-Legal Fee Schedule. We believe, however, that the proposed changes could be improved by input from the community in a face-to-face meeting. Hearing the Division's rationale for the changes and allowing a discussion, we believe will lead to further refinement and improvement of the proposed changes to the fee schedule. We would urge the Division to consider convening such a meeting with stakeholders. This does not have to be a long process. Just one or two meetings would be helpful. Should the Division convene this work group, a representative of COA would be happy to participate.

8 CCR §§ 9794 – 9795 **COA edits in Blue**

§ 9794. Reimbursement of Medical-Legal Expenses.

(a)) The cost of comprehensive, follow-up and supplemental medical-legal evaluation reports, diagnostic tests, and medical-legal testimony, regardless of whether incurred on behalf of the employee or claims administrator, shall be billed and reimbursed as follows:

(1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1. Diagnostic and imaging tests recommended to be performed by the AMA Guides for the Evaluation of Permanent Impairment – 5th Edition to assist a physician in determining impairment for a specific injury, shall be approved by the claims administrator, regardless of whether the test is included in the Medical Treatment Utilization Schedule (MTUS). In no

event shall the claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report. Additionally, the claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the claims administrator, if adequate medical information is already in the medical record provided to the physician.

(2) The cost of comprehensive, follow-up and supplemental medical-legal evaluations, and medical-legal testimony shall be billed and reimbursed in accordance with the schedule set forth in Section 9795.

(3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.

(b) All medical-legal expenses shall be paid within 60 days after receipt by the employer of the reports and documents required by the administrative director unless the claims administrator, within this period, contests its liability for such payment.

(c) A claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative director using an explanation of review. Any notice of objection shall include or be accompanied by all of the following:

(1) An explanation of review shall indicate the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or other provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation of review shall include both the code reported by the provider and the code believed reasonable by the claims administrator, and shall include the claim's administrator's rationale as to why its code more accurately reflects the service provided.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement pursuant to Labor Code section 4622(b)(1) that the physician may seek a

second review by the claims administrator of the reduction of billing of the medical- legal expense. The statement shall also state the request for second review by the physician and completion of the second review process of the medical-legal expense under California Code of Regulations, title 8, section 9792.5.5.

(5) A statement that the request for second review by the physician and completion of the second review process of the medical-legal expense by the claims administrator is a prerequisite to seeking independent bill review provided in Labor Code section 4603.6.

(6) A statement that if the provider does not seek a second review and the only issue in dispute is the amount of payment, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any additional payment.

(d) If the provider disputes the amount of payment made by the claims administrator on a bill for medical-legal expenses following the receipt of an explanation of review issued under subdivision (c), the provider must request the claims administrator to conduct a second review of the bill and the claims administrator must reply within 15 working days. The second bill review request must be made according to the provisions of California Code of Regulations, title 8, section 9792.5.5.

(e) If after completion of the second review process under Labor Code section 4622 (b)(1) the physician still contests the amount paid for the medical-legal expense, the physician shall only contest the amount to be paid by requesting independent bill review as provided in Labor Code section 4603.6.

A form objection which does not identify the specific deficiencies of the report in question shall not satisfy the requirements of this subdivision.

(f) If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid pursuant to the fee schedule set forth in section 9795, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which shall also contain the following statements:

(1) The physician may object to the denial of the medical-legal expense issued under this subdivision by notifying the claims administrator in writing of their objection within ninety (90) days of the service of the explanation of review; and

(2) If the physician does not file a written objection with the claims administrator challenging the denial of the medical-legal expense issued under this subdivision, neither the

employer nor the employee shall be liable for the amount of the expense that was denied.

(g) If the claims administrator receives a written objection to the denial of the medical-legal expense under subdivision (d) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a petition to review of the denial of medical-legal expense and a declaration of readiness to proceed pursuant to section 10228 et. seq.

(h) All reports and documents required by the administrative director shall be included in or attached to the medical-legal report when it is filed and served on the parties pursuant to Section 10608 or served on the parties pursuant to Section 4061 or 4062 of the Labor Code.

(i)) Physicians shall keep and maintain for five years, and shall make available to the administrative director by date of examination upon request, copies of all billings for medical-legal expense.

(j) A physician may not charge, nor be paid, any fees for services in violation of Sections

~~(i)~~ (k) Claims administrators shall retain, for five years, the following information for each comprehensive medical evaluation for which the claims administrator is billed:

(1) name and specialty of medical evaluator;

(2) name of the employee evaluated;

(3) date of examination;

(4) the amount billed for the evaluation;

(5) the date of the bill;

(6) the amount paid for the evaluation, including any penalties and interest;

(7) the date payment was made.

This information may be stored in paper or electronic form and shall be made available to the administrative director upon request. This information shall also be made available,

upon request, to any party to a case, where the requested information pertains to an evaluation obtained in the case.

Note: Authority cited: Sections 133, 4622, 4627, 5307.3 and 5307.6, Labor Code. Reference:

Sections 139.3, 139.32, 4620, 4621, 4622, 4625, 4626, 4628 and 5307.6, Labor Code.

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

(a)) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each evaluation is calculated by multiplying the relative value by $12.50, 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 **and time spent on the evaluation are** ~~is~~ the dominant **factors** ~~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**~~. 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.

(c) Required elements of a Medical-Legal Report include:

1) **Date and location of the exam**
2) **Statement that the physician actually performed the examination**
3) **Time spent face-to-face with the injured worker**
4) **Listing of material reviewed or relied upon to prepare the report**
5) **History of the present injury or illness**
6) **Present complaints**

7) **Medical history including injuries, conditions, and residuals**
8) **Findings of the examination, including laboratory or diagnostic test results**
9) **Diagnosis**
10) **Factors of disability, subjective, objective, work restrictions, estimate of loss of the pre-injury capacity (used for injuries prior to January 1, 2005) or the impairment rating based upon the ~~AMA Guides to the Evaluation of Permanent Impairment – 5th~~ Edition.**
11) **Opinion on whether permanent or stationary**
12) **Cause of the disability (work caused/work contributed)**
13) **Current Need for Treatment**
14) **Future medical treatment where reasonably medically probably**
15) **Impairment rating based upon the AMA Guides to the Evaluation ~~of Permanent Impairment – 5th Edition~~**
16) **Apportionment of disability, if any**
17) **Reasons for opinions**
18) **Disclosure of name and qualifications of anyone who assisted in report**
19) **Mandatory declarations in its entirety**
20) **Statement that the physician did not viotate Labor Code 139.3**
21) **Original signature of physician with the date signed and county noted**

(c) **(d)** Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

CODE	*B.R.*	*PROCEDURE DESCRIPTION*
ML100	5	*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.~~ If the physician believes this fee is not adequate for the amount of time set aside for the evaluation, the physician shall
		notify the payor of their charge for a missed appointment.
CODE	*RV*	~~*PROCEDURE*~~ ***EVALUATION*** *DESCRIPTION*

ML101	5	*Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent in each category (review of records, medical research, face-to-face time with the injured worker, and preparation of the report) shall be documented at the beginning of the report and tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than 3 hours may be billed for report preparation under this code, unless authorized in writing by the requesting parties.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML102	50	*Basic Comprehensive Medical-Legal Evaluation*. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML103	75	*Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below.
		In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually ~~and necessarily~~ incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include~~

		~~copies of medical evidence relied upon:~~
		(1) Two or more hours of face-to-face time by the physician with the injured worker;
		(2) ~~Two or more hours of record review by the physician.~~ For every 400 pages of records reviewed, the physician shall be able to specify one complexity factor. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;
		(3) Two or more hours of medical research by the physician~~, using 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 this complexity factor.~~ An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;
		(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(6) Addressing and providing an analysis of the issue of medical causation, ~~upon written request of the party or parties requesting the report~~ ~~provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the~~

		evaluation; Causation is deemed to be a complexity factor for a denied claim/date of injury or any body part, or in an accepted claim where the parties have requested, in writing, that the physician address causation. If the claims administrator objects to the inclusion of causation as a complexity factor, he/she shall notify the physician in writing 5 days prior to the evaluation accepting the injury for the date of injury/claim or all body part(s).
		(7) Addressing the issue of apportionment, when items (A) and (B) below both apply: (A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injury ies to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more or more dates of injury ies involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference. (B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.
		(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
		(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML104	5	*Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances*. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for

		each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:
		(1) An evaluation which requires four or more of the complexity factors listed under ML 103. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were actually ~~and necessarily~~ incurred for the production of the medical-legal report and required for the evaluation, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon.~~ 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, unless approved in writing by the parties.
		(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician. 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, unless approved in writing by the parties.
		(3) 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. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. When billing under this subdivision of the code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

CODE	*RV*	*PROCEDURE DESCRIPTION*
ML105	5	Fees for medical-legal testimony. 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. 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 one hour for a scheduled deposition.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML106	5	Fees for supplemental medical-legal evaluations. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, medical research, face to face time with the injured worker, and preparation of the report. Time spent in each category (review of records, face-to-face time with the injured worker, and preparation of the report) shall be documented at the beginning of the report and tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than three hours may be billed for report preparation under this code, unless approved in writing by the parties. 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 thot e 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.

Barry Halote, Pd.D May 18, 2018

I read the proposed medical legal fee schedule changes. It is very distressing to see that you want to limit report writing time to three hours. As a psychologist, after transcription and other costs, and it is not financially feasible for me to produce a medical legal report. Some of my reports are as many as 30 pages long. This type of restriction would result in reports that are not substantial evidence and not admissible. It is therefore strongly recommended that this time limit on report preparation time be reconsidered and be made appropriate.

Michael Post, MD, QME May 18, 2018

Although I have previously submitted my opinions on the proposed MLFS changes, I feel obligated to provide an update on two recent panel QMEs that I performed this week. The first Applicant had a major crush injury involving multiple body parts. In this case, I was sent 15 inches of medical records. The Defendant indicated in the cover letter that they "admit the industrial injury, but dispute the extent of injury." Therefore, I presume that I am to very carefully review (page by page) the volumes of subpoenaed records and lengthy deposition to determine if the Applicant's claimed body parts were caused directly and/or as a compensable consequence of the industrial injury.

The second Applicant had a single, straight-forward injury with a ruptured Achilles' tendon, for which she had to wait 3 months to obtain her MRI and another 3 months to undergo surgical repair. She was accompanied by 8 inches of medical records in addition to a very lengthy deposition transcript. Although by her report, her past history is benign, presumably the Defendants subpoenaed the entirety of her health records in search of any glimpse of preexisting orthopedic conditions or other medical problems so as to shift the liability for some of her permanent disability away from the industrial carrier.

I do not yet know how long these two cases will take to complete, but I do know that they will definitely take much more time a flat rate ML 102 or ML 103 compensates. It should also be noted that there is no way of identifying in advance that those two cases would require so much time, as they might have instead been QMEs that came with minimal medical records. Nonetheless, I had to budget the same amount of time in my schedule to see them, and now I have to adjust how I spend my nights and weekends to review, summarize, organize, and analyze the extensive records that were provided for my review. For the reasons I presented in my initial post, these types of cases are increasingly becoming the rule, not the exception. The proposed MLFS changes do nothing to address this issue and how to fairly compensate physicians for their TIME and EXPERTISE in completing these complex medical legal reports

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I reiterate my recommendation that the DWC does NOT change the current MLFS at this time, but rather convenes an expert panel of stakeholders that can identify the substantive issues and propose workable and sustainable solutions to ensure the stability of the California Workers' Compensation system, and the rights of injured workers.

Stacey Wittorf, Legal Counsel
Center for Legal Affairs
California Medical Association

May 18, 2018

Randall Hagar
Director of Government Relations
California Psychiatric Association

The California Medical Association (CMA) is one of the nation's largest and oldest physician organizations, currently comprised of about 43,000 members. CMA's mission is to promote the science and art of medicine, protection of public health, and the betterment of the medical profession. The California Psychiatric Association (CPA) and it's 3,500 psychiatric physician members is a component of the American Psychiatric Association the oldest medical association in the country. The APA is also the largest psychiatric association in the world with more than 37,000 physician members specializing in the diagnosis, treatment, prevention and research of mental illnesses. On behalf of our members, CMA and CPA would like to thank you for the opportunity to provide comments on the Department of Industrial Relations, Division of Workers' Compensation (hereinafter, "DWC") proposed changes to the Reimbursement of Medical-Legal Expenses regulations, found in Title 8 of the California Code of Regulations.
Many of our physician members serve as Qualified Medical Evaluators (QMEs), and, as such have concerns with the impacts of the proposed changes on their ability to provide accurate and high-quality evaluations of injured workers.

General Comments

CMA and CPA understand that the proposed changes are intended to clarify existing regulations and to address alleged abuses by certain QMEs, however, they are on the whole unclear and unbalanced, in some instances significant leverage to claims administrators. CMA and CPA are especially concerned about the impact of these proposed changes on certain specialties such as psychiatry, where complex cases already require physicians to spend significant time examining claimants and both medical and psychiatric records, essential in the conduct of competent exams and reports. There are unique requirements in psychiatric exams and reporting that require both depth and complexity of analysis and

necessarily require sufficient time. For example, a psychiatrist must: identify pre-injury, peri-injury and post-injury stressors; conduct a malingering assessment; read and analyze results and consult with psychologists where testing has been conducted; obtain a family history; conduct a mental status exam; carefully document descriptions of symptoms; crosswalk symptoms to diagnostic criteria set forth in the DSM-5; and perform a differential diagnosis ruling out other possible sources of causation of the psychiatric dimension of injury.

Adding detailed reporting requirements for payment to will create further disincentives to QMEs participation to the detriment of injured workers. CMA and CPA urge DWC to provide the opportunity for additional comments and testimony on these regulatory amendments not only because a formal rulemaking process is statutorily required, but, more importantly, because of their potential to have a significant impact on the availability of QMEs in the state.

8 C.C.R. §9794 Reimbursement of Medical-Legal Expenses

CMA and CPA urge DWC to amend subsection (a)(1) to clarify that diagnostic testing indicated by the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides) are reimbursable. Although the Medical Treatment Utilization Schedule (MTUS) may not include reimbursement for such testing, QMEs are directed by 8 C.C.R. §§44-47 to evaluate impairments consistent the AMA Guides. Accordingly, DWC should amend this subsection to clarify that, where applicable, diagnostic testing recommended by the AMA Guides to establish levels of impairment is reimbursable as part of the medical-legal evaluation.

8 C.C.R. §9795(b) – Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony

CMA and CPA oppose the addition of the language in this section which would prohibit a physician from conditioning performance of an evaluation report on agreement of the parties. This language, combined with the proposed language in Section 9795(c) ML103(6) (requiring agreement of the parties that medical causation is a disputed medical fact to qualify medical causation as a complexity factor) would essentially require a physician to conduct an evaluation where he or she does not agree with the scope of the evaluation. This potentially puts physicians who believe medical causation to be in dispute in the untenable position of either evaluating causation but being unable to use it as a complexity factor or of ignoring causation, though they may believe it to be a genuine issue. Further, coupled with the proposed language in Section 9795(c) ML103(6), this language creates a disincentive for a claims administrator to agree that medical causation is at issue, as such agreement would increase their liability.

CMA and CPA further urge DWC to amend the language in Section 9795(b) that indicates that complexity, rather than time, is the dominant factor in determining the appropriate level of service under the section. While complexity factors are important to establishing the

appropriate level of the evaluation, time is also an important factor if physicians are expected to thoroughly review injured workers' increasingly voluminous medical records. Time and complexity are inextricably linked in many claims and, accordingly, complexity should not be deemed the "dominant" factor in medical-legal evaluations.

8 CCR§9795(c) – Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony

Report Preparation

Based on the comments submitted to the forum and the concerns CMA and CPA have heard from our member physicians, there is widespread confusion regarding DWC's intention in adding the language "No more than 3 hours may be billed for report preparation under this code" for ML101, ML104, and ML106. CMA's interpretation of this new provision is that a physician would still be able to claim more than three hours of record review, medical research, and other compensable activities but would be limited to three hours only in the time he or she spends on preparing the report. Thus, a physician could claim time in excess of three hours for any of these codes as long as the time preparing the report, which would not include time spent review records, medical research, and face-face with the patient. CMA and CPA urge DWC to clarify this point, as it appears to be causing confusion for those physicians serving as QMEs.

ML 103 – Complex-Comprehensive Medical-Legal Evaluation

Complexity Factor (3). CMA and CPA find the proposed limitation on the ability of a physician to claim more than two hours of medical research if he or she cites a source more than once in the preceding twelve months completely unreasonable and urge DWC to strike this provision. While CMA and CPA understand DWC's concern that a physician may cite the same source in multiple cases or reports in such a manner that does not require additional research time, there are certainly instances in which a physician may require time to arrive at the same source more than once in twelve months. For example, a physician may end up using the same source in cases that vary dramatically and require the physician to analyze the material's applicability to the claim in a completely different way. Further, a physician may rely on a source once and then not utilize it again for nearly one year. In the intervening months, it is likely that the physician would have forgotten about the source such that he or she is essentially conducting completely new research and it will take him or her significant time to do so. Thus, while CMA and CPA appreciate the abuse DWC is attempting to address, doing so using an arbitrary time limit is not the right approach.

Complexity Factor (6). As discussed above, CMA and CPA oppose the addition of language in ML 103 requiring agreement between the parties and the physician that medical causation is a disputed medical fact before the physician may use causation as a complexity factor. This limitation potentially puts physicians who believe medical causation to be in dispute in the untenable position of either evaluating causation but being unable to use it as a complexity

factor or of ignoring causation, though they may believe it to be a genuine issue. Further, this language creates a disincentive for a claims administrator to agree that medical causation is at issue, as such agreement would increase their liability, thus drawing out claims unnecessarily to the detriment of injured workers. Accordingly, CMA and CPA urge DWC to delete the proposed changes to this subsection.

Complexity Factor (7). CMA and CPA object to the inclusion of the language proposed in (7)(B) requiring a QME to find the injured worker medically Permanent and Stationary or to have reached Maximum Medical Improvement for two reasons. First, CMA and CPA are concerned that the requirement that a such a finding be made in order to use the issue of apportionment as a complexity factor may create an incentive for evaluators to make these findings. Additionally, CMA and CPA notes that the regulations relating to QMEs refer to "permanent and stationary" throughout and believes that should DWC retain this requirement, the addition of the "maximum medical improvement" language may cause confusion among physicians as to the finding required in order to include this complexity factor.

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Thank you again for the opportunity to provide input on these important proposed changes to the Reimbursement of Medical-Legal Expenses regulations. We look forward to providing additional comments during DWC's formal rulemaking process and to working together with DWC and other stakeholders to ensure that any changes to the Medical-Legal fee schedule best serve the medical needs of injured workers.

Jacqueline T. Lezine Hanna, MD, MSPH May 18, 2018
Hand and Orthopedic Surgery
Qualified Medical Evaluator

The proposed regulations create an unjust system resulting in gross negligence in advocating for the injured worker as well as undue burden on physicians attempting to perform a complete and unbiased legal examination under restricted and truncated time constraints. Physicians are further impacted by drastic cuts in reimbursement.

Pre-negotiating complexity factors in exams creates an adversarial environment between all parties and serves only to increase the time to resolve a case and create additional unwarranted insurance company denials. Often, facts not previously on record are offered by the injured worker during an exam. If those facts would warrant further examination and investigation for a complexity factor not pre-negotiated they may be left out to the detriment of one or more parties in the case. Physicians electing to include complexity factors not previously negotiated will

need to fight to be compensated for their expertise and time provided in good faith. Scores of examiners will find this process onerous and will leave the QME program.

The three hour cap in reimbursement for report preparation is arbitrary and unfair. Just the listing, (Required by the rules), of medical records reviewed often exceeds three hours. Additional time taken to create a thoughtful, complete report will not be reimbursed. This will result in incomplete and un-nuanced reports. The physician report is the primary document for the medical facts of a case. The injured worker and the parties adjudicating the case will be disadvantaged. Follow up exams and requests for additional reports and clarifications will further clog the system with paperwork and wasted time. This effectively cuts reimbursement for physicians. A glaring injustice in light of the fact that the fee schedule has had only one increase in the entire life of the program.

The proposed complexity factors include language requiring physicians to have time spent in each category. This is grossly unfair as it will drastically decrease reimbursement to physicians. As an example: A QME spends 1.5 hours face to face, 15 hours of record review and a maximum allowed report time of 3 hours. Under the proposed rules, this would not qualify for ML103 or ML104. Reimbursement will be made for ML102 leaving **18 hours of un-reimbursed time.** This is entirely unworkable.

I oppose the proposed changes and call on labor unions and medical organizations to examine the motives of the rule makers.

Don Eisner, PhD J.D. May 18, 2018

If causation is not accepted an an issue, what is the point of conducting an evaluation and preparing a report?

Anonymous QME May 18, 2018

It is my experience in doing QME exams for 22 years that there are often multiple detailed and unique factors to consider with regard to conducting objective and independent QME evaluations, that are at odds with some of the specific rigid rule change proposals. The significant responsibility to accurately conduct exams, and provide causation and analysis in assessing potential workplace events, and complex exposures to chemicals, drug effects, superimposed upon internal medical conditions, can be quite complex.

Death cases often hinge on reviewing copious records, that often come in piecemeal over time, reflecting years and even decades. This can occasionally require significant time on

supplemental reports. In these cases, there is often no face-to-face time, although spouses and family are occasionally available to be interviewed. Therefore, it is appropriate to allow trade-offs in the hours spent in various complexity factors. Addressing the issue of medical monitoring of an employee following a toxic exposure to a chemical, mineral or biological substance should be a complexity factor. Addressing psychiatric conditions is similarly complex and should be a complexity factor. To artificially limit and constrain medically necessary analysis and appropriate research is wrong, particularly with the multitude of events that can result in toxic exposure. Alternatively, I have reviewed QMEs that do not indicate what specific reference(s) were used, or why—and that is wrong as well.

Overall, I am opposed to the proposed changes, with the exception of requiring good documentation of necessary research and accurate recording of time required for the components of the exam. The weighty responsibility to conduct these exams ethically must be preserved.

Daniel Lee May 18, 2018

I have not heard any reasonable explanation from DWC for reducing the current fee schedule. Who is actually paying the QMEs?

The insurance.

So what is the real reason why the DWC must stick their neck out and propose such drastic changes? What is the down side if they do not propose the change? Unless the state bears the financial burden it doesn't seem to make any sense.

If you force unreasonable cuts on reports then the DWC will be flooded with less than reasonable quality reports which is likely to increase depositions. Is the DWC planning to regulate the reimbursement for deposition in the future too??

We need transparency as to who is likely benefit from this proposal because we all know who it is that's going to get hurt.

Anonymous Ortho May 18, 2018

I am a practicing orthopedic surgeon and also have been active in performing QME's for the last few years. I am board certified and have a background in clinical research. I have reviewed the new proposals and have been privy to several comments by other practitioners.

Briefly, I have been taking care of treating work compensation cases throughout my career. Treating a work comp patient is laborious, fraught with delays, and is a battle from the beginning

in an attempt in obtained appropriate care. I have seen the clinical side of this endeavor deteriorate to an extent that I have been no longer been able to accept treatment cases in work comp. The minimal reimbursement does not cover the cost of treating the patient and doing the required and endless paperwork, which is onerous. The cases on referral are often complex and deal with multiple orthopedic problems and diagnoses. Obtaining approval for accepted indicated procedures is onerous and cumbersome and fraught with abuse from the insurer's side. Accepted appropriate science backed treatment supplied by me for the patient's care is mostly denied by insurance carriers with unknown representatives or independent medical evaluators that are trained to say No without good reason and often are not board certified in my field of orthopedic surgery, and often are not a full time practicing physician, and are often are not within my field. I requested an MRI on an obvious knee meniscal injury to confirm my clinical diagnosis, and it was denied for weeks with the patient limited to crutch use, and was finally approved after letters written and complaints to the carrier. Now the patient has a substantially higher risk of developing premature arthritis due to the damage done by weight bearing on a knee that should have had surgery weeks prior.

In work comp, it has been my understanding that the patient's have rights that they have earned when injured to receive fair and honest care in an appropriate time frame. They have given up their right to sue their employer. The current system puts the treating physician at risk due to denials that are inappropriate and leaves the patients underserved and also mad that they are not allowed to receive the care that they legally should receive. Most treating orthopedic surgeons do not want to treat work comp patients at this current time. The treating work comp system is broken; decisions are put into hands of the unqualified and under qualified. That is a given. Assembly line work comp companies have sprung up, like US Health works, that limit the care of the patient's, deny the majority of the patient's complaints and run them rough shod through their assembly line clinics and then provide them with limited MMI evaluations as to cut down their costs.

Now the QME process requires quite a bit of a physicians time to fulfill all the requirements of generating a report. The doctor has to travel to specific locations close to the injured worker if he generally wants to be busy performing QME's. This requires lots of unreimbursed time and additional staff expense as well. It is not unusual to travel up to 1-2 hours or more to see the patients in satellite offices. This travel time is not reimbursed but also takes time away from the physician's treating practice, which is required for most QME's. A QME must be spending adequate times as a treating physician to qualify in most cases to perform evaluations. Educational requirements also need to be fulfilled. Other rules also must be fulfilled to do QME's and I will not go into them.

An exam of a patient takes a minimum of one hour and often takes up to two hours or more for me to obtain the needed information required in the process. As an orthopedic surgeon, I am often required to evaluate more than one injury, each of which requires it's own history and examination and comment re causation, apportionment, future medical, etc. Often, there are no directives from an attorney or carrier as to why the patient is to be examined and the patient's history has to suffice. Often, there are no medical records to review prior to the appointment.

They just don't show up even in cases where patients tell me that have waited 3-6 months to obtain an appointment. When letters are received from the parties, they often differ as the actual extent and nature of the injuries to be evaluated, whether approved or not.

There is no question that the system is flawed and takes lots of time to wade through the process. With the onerous proposed new regulations the system will be fatally flawed. Masses of doctors will quit. I will be unable to put the time into the reports, which require detail and expertise. I will quit as I cannot work for free or go negative. The patient's will suffer as the process is broken and the workers compensation system will crash. Can't get a proper evaluation if the qualified doctors are not available.

Which also leads me to the topic of medical research. Medical research is the keystone in evaluating these injuries and explaining the pathology discovered on the physical exam which is in turn correlated with the diagnostic studies. In my opinion, when discussing medical research, each article provided should be discussed as to the relevancy of the seminal papers that address the patient's diagnosis and prognosis. The statement that the same articles cannot be used within in one year is idiocy at its best. As a university trained physician, I was always taught to substantiate my treatment recommendations based on the current research and the seminal papers that address the best treatment and diagnosis of the patient's condition. Each case is different and should be treated as such, especially in my field as I am often dealing with multiple body parts that may or may not be work related in nature and a comment about each is mandatory. Science is the key to the treatment and is often changing as to the most current and appropriately performed published study. Some of the best articles where published 30-40 years prior and the practitioner has to be familiar with not only the current treatment requirements but the best and the latest, which implies that the seminal papers will have to used on more than one case during a years time. It is ridiculous to limit pivotal papers from being used to justify treatment and to support medical opinions. It is my impression that most QME reports must include the latest and best research to substantiate our medical opinions. Each paper should be discussed as to relevancy. Legally, in the treatment of patients, all treatment decisions have to be based on scientific articles that support or deny a diagnosis or treatment regimen. The articles should originate from the doctor's specialty, especially when surgery is a factor. Often times currently QME's are being used as a justification for treatment or not in disputed cases. A qualified evaluator must be familiar with the current and past literature in my field to provide a supportive document in these cases, and provide yes or no answers based on science, and not on pure speculation.

It is obvious that the insurance industry is involved in pushing for changes in the system and wants to eviscerate the current system. In the process, the injured worker and his representative's will not only suffer but will be abused by this newly proposed system, especially in my field of orthopedic surgery. We have high malpractice payments as treating, operating orthopedic surgeons and overhead to meet, it will not be practical to perform these evaluations.
Of course, economically I will be forced to drop out of the system. As I will not be able to even cover my overhead doing this kind of work. It does not take an idiot to realize the system is being gamed and the intent is to abolish the current system, continue the abuses of the injured

worker, and destroy the careers of medical legal experts who are currently active in providing fair and current opinions based on the current requirements.

[LAST PARAGRAPH REDACTED]

Andrea R. Bates, MD, Ed, S, MBA May 18, 2018

I have enjoyed working as a QME physician for many years. I've noticed in recent years a tremendous uptick in applicants' attorneys and defense attorneys seeking to apparently throw out my reports if it may be in their favor to get a new QME panel and report.

In an effort to write an extremely high-quality report that can stand up against all this new scrutiny, I have spent more time ensuring that my reports are not tossed aside. I need to be extra thorough in my explanations. I need to have a very detailed history and examination from the injured worker. I need to thoroughly investigate my positions with respect to my report's findings. As a QME Panel physician, I often get deposed or get supplemental requests these days, even though my reports are high-quality and I am frequently used as an AME, I have to be able to defend my positions.

If I do not defend my position appropriately, my case is thrown out and the injured worker needs to start over again with a new QME panel physician and process. I am concerned for these injured workers because seriously, they are the ones who have to put up with the treachery of our over-litigated system. It's not their fault and the injured worker is frequently taking it personally, that their old employer is "against them" or that "the adjuster is against them" citing how many years they devoted to their employer, etc., when really their over-litigated case likely has nothing to do with any of that. You know that. It has to do with our Worker's Compensation system.

With the changing climate of the past few years, I have even had to develop office procedures as to how we proceed with scheduling depositions because lawyers can take a lot of time setting up depositions and then cancel at the last moment, stating that I am "unavailable" for a deposition even after my giving multiple dates, etc., I have had attorneys even seeking to overly involve and implying to depose my staff and obtain her notes about scheduling appointments so they can check to see if the opposing attorney called to schedule an appointment etc. this is how strong the environment is to throw out QME Panel reports that an attorney finds is unfavorable to their case.

For a number of reasons, being a QME physician has become very time-consuming. I think it would be dangerous to impose restrictions and new regulations to the doctors because it will be harder to fulfill our obligations as a QME doctor. We are required to explain our reasoning position etc. It's just not possible to write a high-quality report in this atmosphere of intense litigated pressure against the doctors if these time restrictions are imposed.

It seems that to save time and money, money should be invested to be sure that the QME has resources available so that the report is not thrown out etc. because having to start over from the beginning is quite costly everybody involved especially the injured worker.

I have been a practicing physician for over 25 years, I am on the faculty of University of California Davis Department of Psychiatry since the late 1990s. I have been a medical director in multiple hospitals, and I have worked as a Joint Commission Surveyor. I have been blessed with a stellar work history and I continue to actively practice psychiatry with patients. In addition to this, I enjoy my QME work. I feel that I stand for the truth of the case as it applies to California Worker's Compensation law and my job is to defend that truth. Please let me do that by allowing me the resources available to do it adequately. I have plenty of time to do other things but when I write a QME report it needs to stand.

Best of luck to you as you come up with approaches to best help injured workers and streamline our overly litigated process. Please make it more difficult to throw out QME reports but please allow the physicians to write their reports in the high-quality that is required in our times.

Neil B. Steinberg, PhD May 18, 2018

As a QME Psychologist, the proposed revisions for QME evaluations report writing are not reasonable. These reports require discussion of causation and apportionment based on causation supported by reasonable medical evidence and percentages. The reports must include Objective Factor Psychological test result and interpretations, history of injury, and several other time-consuming subjects. Typically, this report writing requires five to six hours. To spend less time would compromise the accuracy and effectiveness of the reports and under-serve the employers and applicants.

Please do not limit the compensable time for report writing as it is proposed.

Mark Pulera May 18, 2018

Any alleged scientific fact is a QME report is rebuttable by an appropriate scientific citation whether that citation was used appropriately in a prior QME report, or will be used appropriately again in a future QME report. In fact, this finding would be expected for studies that the scientific community deems are current, reasonable and accurate. A QME deserves access to produce the most currently, reliable and accurate report possible even with recycled citations if the citations are indeed persuasive.

Michael Kasman MD May 18, 2018
Neurology

Much has already been written about the newly proposed medical-legal billing changes.

While I would agree that research has been often egregiously over utilized, there are many changes that are not reasonable and appear capricious and counter to the concept that the medical legal report is to provide thorough, detailed, reasoned and competent answers to complex issues and substantial evidence.

Although a case might be accepted as industrial, it is not infrequent that other causation issues arise during the evaluation that the injured worker believes is related to the injury. The parties may not be aware of these and it is unreasonable to exclude this discussion and not allow as a billing factor.

The cookie-cutter decision to cap report prep at three hours is not reasonable. In complex reports, such as psychiatry, internal medicine and neurology it often takes almost that long to proofread and edit the report, let alone think about the issues and fashion a report discussion, not to mention the history and review of records. It is as if an artist is paid for the materials in a painting, the formulation of the idea of how the painting should look and preliminary sketches and not be paid for the final portrait that is the lasting representation of his/her art. The report is the why of the evaluation in the first place and to allow billing for the face to face and review of records but to short-change the meat of the evaluation (the conclusions) is short-sighted and will lead to inadequate results and the need for supplemental reports and depositions at least, and worst, reports that do not do justice to the injured worker or the carrier.

This also applies especially to supplemental reports. It is not uncommon after an evaluation to receive a legal box of records that not only requires extraordinary time to review but also to dictate and analyze. The requirements to summarize all the medical records provided and to do this and formulate a report and to proofread/edit it and be paid only for three hours of work is inappropriate, unfair, and frankly ridiculous. No professional, no matter what field, would or should work for nothing and not be reimbursed fairly for time spent.

About the issue of causation, for decades, SCIF and other carriers, as well as defense attorneys, routinely request discussion of causation and many applicant referral letters do too. IF there was an issue of cost of medical-legal reports, one would think that certainly the defense would not include the "causation" clause, since it "allowed' a route to the 104. This simple fact, and that billing has never, in my experience, been questioned about the "causation" issue in these cases, indicates that the industry as a whole welcomes and encourages a robust discussion of this issue, even if the case is accepted.

Regarding "fixed" prices for the report preparation, I would like the readers to recall how "thorough" their private physicians are in the settings of HMO/Kaiser, where there is only an allotted time to spend for each individual case and whether the patient there can voice all the important information/questions in their minds. Similarly, to tie the hands of the QME in the amount of time spent for analysis, dictation, and correction of a report limits the quality and depth of the product and risks omission of valuable information and study.

Jeffrey L. Young, MD May 18, 2018
Legislative Chair, California Society of Physical Medicine & Rehabilitation
Past President, California Society of Physical Medicine & Rehabilitation
Senior presidential advisor, California Society of Physical Medicine & Rehabilitation
Former Qualified Medical Evaluator

I am writing you on behalf of the over 500 specialists in physical medicine and rehabilitation regarding the proposed changes to 8CCR §9794-9795.

Our comments are as follows:

1) §9794 (3)- the wording is vague and exclusionary. While the intent is to limit what can be done within the confines of a medical-legal evaluation, this has already been discussed elsewhere in the regulation and only serves to give discretionary veto power to the insurer over what they will reimburse.
2) §9795 (b)- This places any dispute over payment to the discretion of the adjuster. For example, if the evaluator requests the adjuster agree to pay an additional amount for reviewing 10 boxes of medical records because the fee schedule only allows billing for a basic evaluation, the evaluator is forced by this section to perform the evaluation and accept whatever payment the adjuster gives.
3) ML101- this section limits report preparation time to 3 hours. In some evaluations involving multiple injuries to different body parts and several different injuries, more than 3 hours could be spent in report preparation. This proposed change arbitrarily limits the time spent for report preparation. This will result in evaluators asking to review the case and turning down complex cases. It could also cause evaluators to leave the panel.
4) ML 103 and 104- this section places the burden of proof on the evaluator to justify their use of this billing code. This adds more unbillable time to the report and assumes the physician is already guilty of fraudulent billing and has to prove he/she is innocent.
5) ML 106- the wording under this code makes the billing under this code almost impossible. Again, the wording requires the physician to justify the use of this code only under very extreme and complex cases. The wording of this entire

section essentially limits billing to the lowest code except under the most complex circumstances. Additionally, even if the report qualifies for billing under this code, the physician must spend additional time writing an unbillable section of the report dedicated to justifying the use of this code.

Overall, the changes to the medical legal fee schedule limit billing to the lowest level except for the most extraordinary of circumstances. The changes criminalize the evaluator by making the evaluator provide justification for billing above the minimal code. Any disputes to the reimbursement places the physician in a gauntlet of administrative review and paperwork. The time and cost it takes to undergo a bill review provide another obstacle to the evaluator. Dispute resolution is unfairly slanted toward the payer. The result of these changes will be that less physicians will want to continue doing medical legal evaluations. Other physicians considering becoming a QME will feel these regulation changes will act as an additional deterrent to doing medical legal evaluations. It could also cause doctors who derive their main income from doing QMEs to leave the state.

Please consider our comments during your deliberations.

Dr. Naeem Patel May 17, 2018

I would like to thank all the doctors of have commented on the proposal of changes. In my opinion I feel that the changes will have more of a negative effect as oppose to a positive effect. Making these changes will have some QME doctors withdraw their names form the QME panels. The doctors who have commented on this topic are the best of they do and the DWC and WCAB need these doctors to write the reports to help settle the cases in a timely fashion. I feel that if these changes are passed and approved than it will have ripple effect and the system will eventually fail. Please reconsider this issue before good QME Doctors leave this process.

M. Yaser Elatrozy, MD May 17, 2018

I would like to express my concern regarding some of the proposed changes to the QME med-legal fee schedule. I recently decided not to renew my QME based on underground regulations being implemented and given that rates have not kept up with inflation in over 10 years, QMEs are already substantially underpaid for their efforts and additional efforts to restrict time paid for report preparation and research times in addition to convoluted complexity factors would further reduce the quality of reports.

There is no reasonable way to write a quality psychiatric QME report or any other report for that matter after reviewing sometimes thousands of pages of records and testing in under 3 hours, Cover letters from the attorneys involved routinely have pages of questions to be addressed. This requires sometimes an incredibly lengthy amount of time to prepare such reports.

I'm not alone in my concern as noted in the comments submitted thus far, I know of many qualified QME physicians who will not be renewing their licenses given the issues outlined. I would hope that the DWC reconsider such changes to avoid further losing competent QMEs.

Niveen Gorgy DC, QME May 17, 2018

In response to the proposed changes of 9794 and 9795 the following are my comments the issues at hand. Changes are made in italicized print below.

Regarding § 9794. Reimbursement of Medical-Legal Expenses.
(3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.

Clarification needed, it seems to state that one cannot bill OMFS codes along with ML Evaluations, i.e. cannot bill for x-ray taken in conjunction with orthopedic ML evaluation/report. Language is confusing.

(b) All medical-legal expenses shall be paid within 60 days after receipt by the employer of the reports and documents required by the administrative director unless the claims administrator, within this period, contests its liability for such payment.
ADD -
Failure to contest the charges will result in self-imposed penalty and interest charges as noted in §10111.2 (b)(9), §4622 (a), and §9792.5 (b) that must be paid within 30 days after initial 60 days have expired.

(b) The fee for each evaluation is calculated by multiplying the relative value by $12.50, 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.

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

Clarification needed based on whom are considered parties, does this mean the treating physician, attorney, injured worker, adjuster, DWC information and assistance officer, etc.
Of note in 2004 when the code was modified under SB 899, the relative value has not been updated since despite inflation. If one uses the US Inflation Calculator the $12.50 relative value should now be $16.58 based on a cumulative rate of inflation of 32.6%.
The ML100 code should be changed to from communication purposes to a compensable ML code. Allowed amount should be $250 which is for 1 hour of time/unit allocated for the appointment. If the inflation calculation above is applied, then the new amount should be $331.59 per hour/unit.

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.

ML101

5

Follow-up Medical-Legal Evaluation. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than 3 hours may be billed for report preparation under this code.

To place a maximum limit in the amount allowable for report preparation are unreasonable and a blatant restriction of trade in preventing physicians to spend the necessary time required to provide a detailed evidence-based medical report and to be in compliance with CCR §10606. Physicians spend many hours of critical thinking on each report to coming to an opinion. Cases that have CT claims, several dates of injuries, and several body parts can result in more than 3 hours of critical thinking in order to come to a conclusion that can be expressed clearly and concisely for nonmedical personal to read and understand.

In addition, the average medical transcription cost in the US are $0.14 per line, with approximately 52 lines per page resulting in an expense of $7.28 per page. An average medical report that is complex will result in costs on average of 25 pages $182 about 25% of recommended amount. The DWC is not taking into consideration the costs or demands. If medical records provided are in excess of 1,500 pages the listing/summary required are going to lead to larger reports resulting in higher costs to cover the transcription of a report. The 1,500 pages may be summarized in about 50 pages which will lead to an expense of $384, which now

is about 50% of what one can billed. All aspects of report prep have to be taken into consideration.

(3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code; The above changes are unreasonable and a blatant restriction of trade in preventing physicians to spend the necessary time required to provide a detailed evidence-based medical report and to be in compliance with CCR §10606.To limit the medical research used to once every 12 months is completely ludicrous. Medical research does not change overnight, that is why medical textbooks are written once every 1-2 years sometimes longer. Medicine is slow moving in regard to the research available as far as what is accepted in the medical community. Furthermore, to restrict its use on one case for every 12 months harms injured workers who may have suffered similar injuries that the nonmedical personal will not have access to in order to have a full understanding of the medical issues at hand to make a proper determination, which is a detriment to the injured worker. An example would be the shooting in San Bernardino in 2015 at the Center for People with Developmental Disabilities. If the injured workers underwent an AME or QME evaluation and several injured workers' were referred to one physician, that physician would only be allowed to

ML103
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Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth below.

Provide the information/research on PTSD for one of the injured workers, while the rest would have to rely on the knowledge of the nonmedical personal who again are not medical experts nor have the experience to fully understand what the injured worker may or may not be going through, that is why the AME or QME was chosen. If the DWC wishes to eliminate or reduce research then they should reimburse the physicians rate that their colleagues who are expert witnesses are billing which on the low end $350 per hour for evaluations, and median initial retainer of $2,000, thereby eliminating the need for research and reports issued on the experience of the physician with no flat rates just hourly. Thereby treating the physician as the medical expert that he is truly being utilized as in the Work Comp arena.

(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision; This is not based on what the code when initially written stated, and again a restriction of trade on how a physician spends their time to come up with an accurate medical

opinion. To limit this as suggested will lead to incomplete evaluations/reports. Example if a psyche evaluator has not been provided the medical records and has to spend 6 hours with an injured worker who has poor recollection of events due to head trauma and also considered a poor historian with the use of an interpreter to only allow an ML102 is completely and utterly irresponsible of the DWC. Medical Research should be the only complexity factor that should not be allowed to be used as a stand-alone complexity. Face to face and review of records should be allowed to be used as stand-alone factors. By making all 3 complexity factors to be used, it will create some providers to apply medical research to reach the above complexity factor which in some cases is unnecessary.

(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation; Causation needs to be in line with the current en banc decisions and regulations and not subject to the changes recommended or as previously written. Under §10606 causation is part of the required elements of a medical-legal report as Cause of the disability (work caused/work contributed). It is also implied, based on the above, that prior agreement has been granted since it is part of the process. Under the Physician's Guide to Medical Practice in the California Workers' Compensation System Fourth Edition, 2016 under Chapter 3

Compensability lists key concepts with Causation being one of the key concepts. Under Analyzing Causation, this section list 3 factors that need to be established in order to make a causation determination:

1. What pathological condition(s) (and disability) are present?
2. What relevant work exposures were present?
3. What other causes might produce the disease (i.e., non-industrial exposures)?

The recommended changes are in direct conflict with §3208, §3208.05, §4663, and §4664. Nowhere above is there any mention of disputed medical fact or agreement by parties as a determining factor in addressing causation.

7) Addressing the issue of apportionment, when items (A) and (B) below both apply:

(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injuries to the same body system or body region as delineated in the chapter headings of the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more or more dates of injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.

(B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.

The issue of Apportionment displays a blatant ignorance of en banc decisions and Laws of California Workers Compensation, and definitions as described by the DWC. Complexity factor of Apportionment should not be based on AMA Guides, AMA Guides are to be used for rating purposes and not apportionment issues. Required elements under CCR §10606 states Apportionment of disability, if any. Under the Physician's Guide to Medical Practice in the California Workers' Compensation System Fourth Edition, 2016 Apportionment of Disability states that apportionment is a legal concept and applies only to permanent disability. Existence of underlying disease or pre-existing injury does not automatically justify apportionment to those factors, but the issue should be addressed. The definition of Apportionment: A way of figuring out how much of an employee's permanent disability is due to his or her work injury and how much is due to other disabilities or causes. Arising out of and occurring in the course of employment (AOE/COE): An injury must be caused by and happen on the job.

The recommended changes are in direct conflict with CCR §4664 as well. In all of the above information provided there is no mention of apportionment having the current criteria met in order for it to be addressed, therefore, illogical to apply the AMA Guides, and the number of body parts or number of injuries as a determining factor for addressing apportionment.

ML106
5

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. 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.

Section (B) should be eliminated as this is in conflict with CCR §9794 (a)(1). If a physician has to obtain authorization the timeframes in obtaining the authorization to when the final results are made available to the physician can be several months from initial request. To assume that a physician will be able to recollect the facts of the case afterwards is completely unreasonable. Physicians should be allowed to review their previously expressed opinions and

review the results and issue an updated report is essential to provide evidence-based medical report and be allowed to be properly compensated for their work.

To place a limit on the amount of report prep are unreasonable and a blatant restriction of trade in preventing physicians to spend the necessary time required to provide a detailed evidence-based medical report and to be in compliance with CCR §10606. Many hours of critical thinking are spent on providing the reports and coming up to an opinion. Cases that have CT claims, several dates of injuries, and several body parts can result in more than 3 hours of critical thinking in order to come to a conclusion that can be expressed clearly and concisely for nonmedical personal to review and understand.

Of note average medical transcription cost in the US are $0.14 per line, with approximately 52 lines per page resulting in an expense of $7.28 per page. An average medical report that is complex will result in costs on average of 25 pages $182 about 25% of recommended amount. The DWC is not taking into consideration the costs or demands. If medical records provided are in excess of 1500 pages the listing/summary required are going to lead to larger reports resulting in higher costs to cover the report prep. 1500 pages summarized in about 50 pages will lead to a bill of $384, which now is about 50% of what one can billed. All aspects of report prep have to be taken into consideration.

Karin Vandervoort, PSYD, QME May 17, 2018

In the paragraphs below, I have drafted my serious concerns regarding the proposed changes to the California med-legal fee schedule. I am a QME and Licensed Clinical Psychologist. While I have concerns across many of the categories, there have been excellent rebuttals made by other authors. I have elected to speak to the primary concern that I have as it pertains to my professional domain.

I have been a QME for only a few years. In that time, I have consistently written reports that range from 50 to (over) 100 pages by necessity based upon the complexity of the cases, the body part, the examinees histories, and the medical records (that can range upwards of 1500 pages..). In the first six months of my work as a QME I was deposed twice and not again. I believe that because of the thorough nature of my reports that include clear and substantial exposition of my reasoning regarding the pertinent questions and support from research and objective factors, my reports have been well-received.

The inherently complex body “part” that is the human psyche requires that the QME conducts and integrates into the report a comprehensive psychosocial history above and beyond the history of injury, treatment, and presenting complaints and functional deficits. Next, the utilization of lengthy psychometric testing to provide valid objective measures and the extensive formulation required to develop a report to meet the criteria of SME is arduous and time consuming. I can state with reasonable medical probability that there is no way to do all of this in 3 hours. I spend

significantly more time dictating the first draft! This dictation does not even yet include the clinical formulation/integration section, the med-legal opinions rendered, or the psychological testing which I write up manually **after** I have edited the dictation for several hours. To produce a report of quality in three hours is utterly impossible and unworkable. Indeed, the sweeping generalization of three hours across all body parts and disciplines, report complexity, etc begs the question how the DWC arrived at the determination of three hours for report prep. It does not seem plausible that expert opinions or consultation were utilized and brought to bear despite the fact that QMEs, ourselves, are subjected to those very requirements in order to render valid our recommendations and opinions.

Should this change to come to fruition, I cannot afford to volunteer this much time for free for the DWC; I refuse to violate the ethical responsibilities of my licensing body, as well as the rights of injured workers under the grand bargain, to draft reports that are poor substitutes for substantial medical evidence. Furthermore, it is difficult to imagine that any quality evaluator would be able or willing to work under these terms. Instead it would take something of a hack--someone using templates to draft generic reports and/or someone who has little understanding of or expertise in their subject matter. Poor quality reports will only add to the number of depositions, prolonged periods of disability and case litigation, as well as other unintended consequences.

There is already significant time spent for which I am unable to bill such as the review of med records already received in cases where I am conducting a follow up examination or drafting a supplemental report in response to a new question posed by an attorney in the case. Finally, I would also add that I utilize (expensive) robust psychometrics in every exam in order to be able to both parse out and objectively support my conclusions as they pertain to opinions regarding causal factors and/or factors to be apportioned. I forecast that with reduction of report preparation time, simple self-report measures will be substituted (BDI, symptom checklists, etc) that have no robust validity scales, and no way to objectively capture characterological aspects, longstanding psychopathology, malingering, etc. Self report measures tell the examiner exactly what the examinee wants them to know; these exams are not robust enough to factor in the problematic aspects associated with med-legal / forensic evaluation. In order to analyze and speak to these elements in a way that can arrive at a comprehensive picture of the psyche and motivations of the individual who is being evaluated, it requires time and the ability to invest in comprehensive materials that assist the evaluator to arrive at a valid profile of the individual as it pertains to the questions at hand. Many times this picture includes reduced permanent disability. In other words, although I am speaking to the importance of the injured worker's right to access QMEs to render thorough medically probable opinions, these evaluations do not in any way guarantee that injured workers will receive the outcome they want.

In light of the results of the RAND study regarding decreased permanent disability costs, as well as the high profits that the insurance companies are enjoying, I respectfully request greater clarification of the rationale, reasoning and logic behind these changes.

Lee C. Woods, MD May 17, 2018

Having reviewed the proposed changes to the medical legal fee schedule, it is evident that these proposed draconian changes will result in irreparable harm to the Worker's Compensation system in California when considered in the context of the mission of the division of Worker's Compensation:

"… Minimize The adverse impact of work-related injuries on California employees and employers…"

Based upon the proposed measures it will be nearly impossible for cases addressed by AMEs and QMEs to thoroughly, to the standard of substantial medical evidence; be evaluated, examined and concluded in complex medical cases once having been hamstrung by such measures, which would threaten the very standards of the mission.

As an Orthopaedic Agreed Medical Examiner and Qualified Medical evaluator The undersigned is routinely confronted with detailed time-consuming complex comprehensive examination's involving the near entirety of the musculoskeletal system including the entire spinal column and multiple joints and extremities in conjunction with multiple dates of injury and extensive medical records. There is not a possibility of addressing the entirety of these cases of such magnitude and reach conclusions based upon reasonable medical probability and substantial medical evidence, with reasonable medical certainty, in order to fairly and accurately "minimize the adverse impact of work-related injuries" on all parties in the face of the proposed changes.

Indeed, it is more reasonably probable that the recommendations, if invoked, Will only exacerbate an already complex system with promulgation of incomplete, flawed, inadmissible examinations, histories and conclusions which will not stand up to scrutiny unless the DWC also intends to simultaneously cheapen and lower the standard of it's then so-called mission and purpose. If such is the Case, the DWC should be upfront and announce that it has abandoned its original mission and announce that it's new actual mission is to:

"...MAXIMIZE The adverse impact of work-related injuries on California employees and employers"…

The undersigned would like to suggest that a more sober, sanguine And realistic approach, acceptable to all parties without sacrifice of the DWC's mission be proposed for consideration.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

Michael Amster, MD
Interventional Pain Specialist
NorthBay Center for Pain Management
Adjunct Assistant Professor
College of Osteopathic Medicine
Touro University California

May 17, 2018

I have been a QME provider for over a decade, actively doing evaluations since 2012. I take great pride in my work and spend significant face to face time with the applicants to provide a very thorough evaluation and comprehensive reports. I have never been a QME mill and limit myself to 4-5 evaluations in a full day, only 3-4 days a month, so that I can provide the best quality reports for the parties.

I have grave concerns about the proposed changes created by DWC. I believe if these billing changes happen, the QME system will quickly collapse. If that is the goal of the DWC, that goal will effectively be achieved if this rule is implemented. Myself and many other high experienced and qualified QMEs will leave the system. It is humanly impossible to provide quality evaluations and supplemental reports being limited to only having 3 hours to prepare a report.

1) Limit to three hours of report preparation. Bottom line – this is not possible for most reports. I often receive massive banker boxes of records for complex cases (my record being 3 totally full boxes with over 15,000 pages of records!!! See attached photo). The number of records has a direct correlation not only to the amount of time it takes to review records, but also to the amount of time it takes to process all this information and to write a report. More records equals more complexity and more writing time. When writing these lengthy reports, my final reports are often over 100 pages in length. How is it possible to write a report of this complexity and length when only given 3 hours to do so? It isn't possible!!! QMEs will leave the system. And those who stay will rush to produce inadequate reports, which will inevitably result in costly supplemental reports, depositions, and litigation.

As I have become a more experienced QME, I am chosen for the bigger the cases and the number of records I receive has grown dramatically. Now, a typical case is closer to 5,000 pages of records. There is a direct correlation between the amount of records and the amount of report preparation time, as well as record review time in order to facilitate a fairer billing schema. Otherwise, it becomes inherently unfair for the most experienced QMEs who are receiving more and more complex and record-heavy cases. In addition, attorneys and adjusters typically will dump massive numbers of records without prior review for duplicates, leaving the cost of the labor to cull-out duplicates to the QME. This is not a small, insignificant problem. It is highly task-intensive and a time-consuming process. I typically receive the massive duplicate record dumps for subsequent re-evaluations and supplemental reports over and over and over again. This is a cost of my time as a QME.

2) 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.

This is the only billing code that does not have a three-hour report preparation limit and is intended, on the surface, to provide a billing code for large, complex cases.
You may as well eliminate this as a usable billing code as written for the following reasons:
a) Adjusters and defense attorneys WILL NOT agree in advance to obligate their company or client to any billing code. I heard this over and over and over again with regard to extraordinary circumstances over the last two years from my staff. A QME is not allowed to talk to adjusters and attorneys to make the case. Non medical staff is trying to obtain this. With the recent DWC prohibition to bill for report writing time for ML104 type I and II, my office attempted to get extraordinary circumstances for reports with massive records. My staff spent an incredible amount of time trying to get the parties to sign this agreement, with failure over 50% of the time. The typical argument they kept giving my staff was - "I cannot obligate my company or my client to any billing factor before the evaluation is conducted." My perception is that the parties have no interest in signing this and there is no benefit for them to grant this to the doctor providing the report. It is a rare adjuster or attorney who will sign these requests, without having to beg and request again and again. My experience is that obtaining extraordinary circumstances is essentially an unobtainable billing code.

b) The idea that adjusters and attorneys will voluntarily make the effort to determine that a case meets extraordinary circumstances and inform the QME on their own, in advance of the appointment, is a thought process not based in reality. The reality is, the QME and his/her staff will make the determination based on the receipt of records and cover letter that a case will meet extraordinary circumstances.

c) The rules regarding the sending of records make it impossible in many cases to know whether or not a case will meet extraordinary circumstances BEFORE the appointment. I often receive massive number of records the day before, the day after and later. The rules state that the QME can receive records up to 10 days after the appointment and is required to include those records in the report, as long as the report has not already been written. Therefore, by requiring that agreement must be made for extraordinary circumstances BEFORE the appointment effectively eliminates it as a usable billing code.

d) I know that very few QMEs have ever been able to bill under extraordinary circumstances unless they have a staff person who is willing to persistently pursue it. No attorney or adjuster is going to let the QME know in advance that they have an extraordinary circumstances case. In fact, my staff tells me that 100% of the attorneys and adjusters they have spoken to about extraordinary circumstances, did not know about it, nor did they care. The response always has been, if it is ML104, just bill ML104.

e) If the DWC really wishes to make this billing code available to QMEs, they need to create a regulation that compels and requires adjusters and attorneys to respond to inquiries about the potential for extraordinary circumstances.

f) There is no regulation regarding the measurement of what constitutes extraordinary circumstances. How many pages or inches of records? How many primary physicians? And so

forth. At this point, it is up to the QME to make that determination, which then in-turn has to be explained by the QME staff to attorneys and adjusters that the doctor "believes" that the case will constitute extraordinary circumstances. That is, of course, only if we are lucky enough to receive the records in time BEFORE the appointment to make the request.

g) This billing code may as well not exist as it is written in such a way as to inherently preclude any use of it, thereby forcing QMEs to bill at a much lesser rate with a limit of three hours of report writing time. More experienced QMEs who get the larger more complex cases will be hurt the most and be forced to leave the system due to cost-overruns. If this is the goal of the DWC, then this billing code, as written, will certainly achieve that purpose.

3) Supplemental Reports and Late Records

Approximately 30% of my initial evaluations do not have records at the time of evaluating the applicant. Records often come a month or two late, sometimes numbering in the many thousands of pages. It is absolutely impossible to complete a supplemental report when being limited to a three-hour report writing time. Your new time limit of 3 hours will produce inadequate reports because it is impossible for any human to review thousands of pages and to produce a report in 3 hours.

4) Two or more hours of medical research by the physician, using 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 this complexity factor. This is unclear as to the use of words "ANY" or "A" as capitalized in the prior sentence. Does ANY prior medical report refer to any report written in any case or just the case the QME is working on? The use of the word "A claim" does not specify that you are talking about a specific case. How does the DWC intend to interpret and enforce this billing code? QMEs deserve an answer to this question so they are not blindsided by unexplained interpretations of this billing factor.

5) Addressing and providing an analysis of the issue of medical causation, provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation. As a QME, I am not allowed to talk to adjusters or attorneys directly. My staff does this and they aren't the ones producing the reports. This rule will effectively eliminate causation as a billing factor unless you change the regulations to require and compel the adjusters and attorneys to provide a written causation statement. And the only way that can be implemented will be to allow the QME to refuse to set the appointment unless they receive a statement about causation. Another problem with this proposed rule - the parties will often say they want the QME to determine causation because they are unsure about causation until the claimant is medically evaluated. This rule regarding this billing factor requires that the parties must determine the matter of causation for themselves before the evaluation. I've seen reports written by the primary physician who states they think a QME should determine causation. There are some cases where the claimant has not been seen by any physician prior to the evaluation. This rule assumes that the adjusters and attorneys have enough

medical knowledge to know ahead of time whether or not there is medical causation and this is an argument that they must have before the evaluation. This rule will effectively eliminate causation as factor. If that is the goal of the DWC, that goal will effectively be achieved if this rule is implemented.

Finally, why a 3 hour time limit? Where did the DWC come up with 3 hours? What research do you have that states a ML104 report should take only 3 hours to write? Why not limit report writing to 1 or 2 hours? 4 hours? 5 hours? 10? Where is the evidence for this time limit? And if you are going to limit report writing, you should also limit face to face time to 1 hour? Or 2 hours? Seriously, where did the DWC even come up with a 3 hour "number" as a time limit for report writing? What evidence do you have to support a highly complex evaluation with 3 hours of face to face time and 5000 pages to review should only take 3 hours to complete? What evidence do you have that a supplemental report with 5,000 pages to review should take only 3 hours to prepare? There is NO human that can possibly do this. Thus you are forcing QMEs to either resign, to work for free after 3 hours, or to produce poor quality and incomplete reports that will bog down the system with additional supplemental reports, depositions and litigation.

In summary, I propose that the DWC considers convening a panel of stakeholder experts to thoroughly examine the issues, and draft a carefully considered MLFS revision, rather than rely on the current proposal.

Anonymous May 17, 2018

The proposed changes to the Med-Legal Fee Schedule are unworkable. These changes will likely lead to substantial increase in unresolved claims and a significantly extended time frames before the injured worker is able to resolve his/her case and/or get back to work. Furthermore, this will likely push more QMEs out of the current system. We have already lost a significant number of QME providers due to the DWC's misinterpretation of the existing laws in the past 4 years. These providers were no longer willing to accept undue disciplinary actions. This issue was finally corrected by the Howard decision. We now have an unambiguity in correctly interpreting/applying the current regs. What is the purpose of creating a new chaos?!

Although, I understand that regulatory agencies are not obligated to recommend proposals based on evidence-based research data. However, it would be more desirable to have data supporting this proposal rather than being based on certain individual's specific preferences! In this context, it is worth reviewing CWCI's current study. It concluded the following: "The study also notes that after climbing steadily from 2007 through 2014, the average payment per med-legal service leveled off in 2015 and 2016, with data from the first half of 2017 suggesting the average may now be declining." It deeply concerns me if we end up ignoring these fact-based statements and

thus, jeopardizing the correct handling of an entire process. The proposed changes, if implemented, will likely negatively impact the quality of each med-legal report. These reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to recommend a non-workable proposal, the DWC must not have the necessary data to make an informed judgement since the majority of the cases could not meet these restrictions.

Trying to cut corners to meet an illogical time-frame is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Masami Hattori MD May 17, 2018

I perform QME to be active participant in WC field. Even the current reimbursement does not warrant the time and energy spent. If the proposed fee schedule is implemented, this will further exacerbate the dilemma. I only do QME half a day a month because dedicating more time would be detrimental to the practice.

I probably will reduce the time commitment further with the proposed fee. Pretty simple decision for me.

The pain field is already short on QME and this fee will exacerbate the problem

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Michael C. Meehan, MD May 17, 2018

I believe the fee schedule would best be accurate regarding hours spent and degree of difficulty. Proper compensation for complicated case is advised. The level of compensation should be commensurate with the difficulty of the report as well as the number of hours it takes to provide a well reasoned and documented report.

Anonymous May 17, 2018

I have been certified as a Psychological QME in California since 1998, and have performed hundreds of evaluations during that time frame. I strongly agree with Dr. Julie Armstrong (see

her comments above), who very accurately summed up the situation regarding psychological and psychiatric QME evaluations by including the highly-detailed protocol which QMEs with this specialty are admonished to comply with, in accord with Title 8: California Code of Regulations Division 1: Department of Industrial Relations Chapter 1: Industrial Medical Council Article 4: Evaluation Methodology Section 43. This protocol requires assessing not only the current symptoms and etiology of the claimed injury, but also: an extensive examination of other potential causative factors, including those related to developmental/family history; occupational history; history of prior injuries; educational history; complete medical history; prior and/or current psychiatric history of treatment, hospitalization, and medication; legal history; potential non-industrial stressors; potential personnel issues; detailed mental status examination, discussion of causation, disability, apportionment, future treatment needs, etc. In order to provide objective and substantive evidence, psychometric testing, which also typically involves more than 3 hours to administer. Score and interpret, is also a necessity, in my clinical opinion. In one recent QME exam I performed, I was asked to assign percentages of causation to no less than 23 different factors occurring in the workplace, and indicating whether or not each factor comprised a personnel action or not--this alone took several hours in itself--without even getting to discussing any of the other multitude of aspects which needed to be addressed in my report. As one can readily see, the complexity involved in assessing all of the potential contributing factors in a psychological injury claim makes performing any such evaluation in 3 hours an impossible undertaking. The ONLY situation in which I can imagine a report being prepared in 3 hours is possibly a Supplemental Report involving minimal records, and addressing relatively non-complex issues. It is apparent that whoever thought of this 3 hour limit has obviously never authored a psychological or psychiatric QME evaluation report.

Maged Botros, MD, QME, Psychiatry May 17, 2018

We all agree on the fact that the Works Comp system is designed to use facts and science to deliver justice and fairness. We are very proud that our system has recently been filled with very well qualified and skilled clinicians and providers. We have diversity among our providers, both in academic and clinically based providers. Every provider is bringing a wealth of information and decades of medical experience.

The proposed changes to the Med-Legal Fee Schedule billing are misguided. The changes will result in a substantial increase in unresolved claims and significantly extended time frames before the injured worker is able to get back to work. Currently, the number of QME providers in the system has been decreasing, while the number of QME panel requests is on the rise. These new regulations will undoubtedly push many more highly qualified physicians to leave the QME process at the expense of the injured worker. The causation complexity factor is written in such a way that insurers are given a veto power to pay QMEs for their time. No reasonable physician would agree to work under such conditions

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This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. These evaluations are complicated and, similar to federal and state health reimbursement, the decision of how much time is appropriate is best left to the judgment of the Physicians. Our reports are used to discover facts that are relevant and important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three hours, the DWC is trying to cut corners to meet an illogical timeframe that is not in the best interest of the employer, injured-worker or any stakeholder. These regulations should be authored with the input from QME Physicians.

David A. Gonzales, DC May 17, 2018

The unintended consequences QME amendments will impair detailed work often required by the QME to understand and reflect on an employees impairment of the whole person. Complex claims require time by the examiner to properly account for the factors incumbent in the QME reports.

These proposed amendments will discourage present QME doctors from remaining in the system, as well as discourage new doctors from joining the system. I believe it is time to review how the QME process is functioning and understand the need to eliminate waist. It is also time to reflect on what the QME provides to perform a comprehensive service that requires time, expertise, and adherence to procedure that benefits all parties. Compromise to how the QME doctor functions will have unintended consequences that will be punitive to the employee and interfere with a level playing field in this Workers' Compensation system.

Please review and upgrade the system, but not at the compromise to the doctor's doing a very difficult job for all parties concerned.

Kelly O'Neill, PhD, QME May 17, 2018

I am pausing my Psychology P-QME report writing at the proposed 3.0-hour report preparation time limit to write this note. I am deep into writing the report and formulating my conclusions. My day will be mostly consumed with this report. I am feeling pressured because at the 3.0 hour mark I am nowhere near having completed a report that meets my obligations as a QME. If I were to complete this report in 3.0 hours, I would no doubt be called into hours of depositions to answer questions not answered, or not answered sufficiently, in my report, or to clarify information accidently overlooked in my effort to finish my work in 3.0 hours. If I write a report within the proposed 3.0 hour time frame I WILL have to cut corners, which will mean skipping over and leaving out information that would likely be very valuable to the attorneys, judges, and doctors.

Also on my mind now, is the idea of spending most of today preparing this report and not getting paid for doing so. Should the proposals become regulations, in all likelihood, I will not be paid for my time spent today thoughtfully preparing this report. Rather than spending my day writing a report that I will not be paid to prepare, I will be forced to work elsewhere, outside the Workers Compensation system. Although I love my QME work, I do not have the financial means to avail myself to work for free.

I strongly agree with others on this forum that the chances of obtaining pre-authorization from the parties agreeing that the evaluation will constitute extraordinary circumstances, and therefore allow me to bill for a ML104 report, is highly unlikely. What would be the incentive for the insurance carriers and defense attorneys to give prior authorization? None that I can see. Even in cases where there is absolutely no question that the case is extraordinary, obtaining the preauthorization will likely prove elusive. There are only benefits for the insurance and defense attorneys to not provide pre-authorization; by not providing pre-authorization, the insurance carrier has a good chance of saving money…but only at the expense of obtaining a solid, medically sound report and at the expense of the injured workers and moving them out of the Workers' Compensation system in a timely manner.

The proposed changes regarding causation, if implemented, would certainly make the causation complexity factor obsolete or nearly obsolete. I cannot envision a scenario where all four requirements can be met. The inability to meet the requirements will stem from what I anticipate will be great difficulty obtaining the required prior agreements from the parties.

I would like to address another concern I have regarding to the proposed changes to the causation factor. I am psychologist and oftentimes, causation may not be disputed when the applicant enters my office. During the interview, however, prior conclusions regarding causation may be called into question based on additional, not previously divulged, information reported to me by the applicant. I have conducted many evaluations where I am the first physician to hear information that could potentially impact prior conclusions regarding causation. In such scenarios, even though I now have information that will likely bring causation into dispute, and I will spend a good deal of time and brain power explaining causation in my report, I cannot use the causation factor because I did not have a prior request from the parties to address causation.

I strongly oppose the proposed changes to the QME fee schedule as I believe the changes will result in inadequate and poorly formulated reports, legal injustices for the injured worker, cases languishing in the legal system, and large amounts of money spent deposing doctors to get the information needed to settle a claim and move the injured worker out of the Workers' Compensation system.

Bobbie McDonald, PsyD, QME May 17, 2018

I can see the value of some of the proposed changes including regulating the use of research as a complexity factor; however, some of the other changes suggested do not appear to have been clearly thought out. For instance, the idea that any QME can reach all parties, even with repeated attempts, prior to an evaluation taking place was clearly conceived of by someone who has not attempted to call a workers' compensation attorney or adjuster. At times it is nearly impossible to even get records for the case, despite several calls and attempts. Also, to have the QME call each party and discuss the case in this manner about whether it is an accepted claim and then requesting that the party put forth some form of agreement to the QME regarding providing findings of causation seems like a slippery slope toward **ex-parte communication**. It does not seem advisable that the QME discuss anything about the case in this manner. Thirdly, in an unrepresented case, is the QME expected to get some sort of agreement from the injured worker that they want the QME to provide a finding regarding causation? Again, this does not seem fully thought out. Many cases involve injuries that are in dispute, particularly in psychiatry and psychology, which is the main reason for the QME evaluation, and yet, if the parties do not provide some sort of agreement as to the QME providing findings on causation before the evaluation, then should the QME not provide this at all in the report? It seems that the basic elements of a QME report are to 1) Provide a diagnosis if one exists. 2). Provide a finding regarding causation, and 3). provide findings as to whether there is any permanent impairment (WPI), and apportionment of such. Without the first building block, how can the remainder be discussed. Chapter 4.5. Division of Workers' Compensation, Subchapter 2. Workers' Compensation Appeals Board--Rules and Practice Procedure, Article 9, and the Physicians Guide, Table 12-1. Required Elements of a Medical-Legal Report indicate that a *required* element of a QME report is to provide "cause of the disability (work caused/work contributed)," distinctly differentiated from (also on the list), "Apportionment of disability, if any," which makes clear that the QME is to provide a finding as to causation. Is the QME who does not get approval beforehand and then does not provide findings on causation then in violation of providing a complete medical legal report as defined in the Physicians Guide?

As for the report writing time, this arbitrary number of hours (a maximum 3 hours) is also ill-conceived. In psychology and psychiatry, there are many other factors that can weigh into the cause or maintenance of a psychological disorder. As a psych QME, in addition to gathering standard information regarding the history of the present injury or illness, present complaints and medical history including injuries, conditions and residuals, it is also important to gather other information that a QME in another specialty may not find relevant. This includes any personnel actions and their impact; any history of traumas dating back through childhood; any history of past psychological problems or treatment; any psychological, social or legal history that may indicate non-industrial psychological conditions such as learning disorders, drug or alcohol disorders, or personality disorders; and any non-industrial medical, legal or psychosocial issues that may be playing a contributory or predominant role in the current psychological condition. In order to provide this type of comprehensive report that can be considered medical legal evidence, the report is much more complex and takes a longer time to formulate and write. Additionally, the same report must contain well thought out and reasoned findings including explanations of how and why any factor has been ruled out as causative to either the injury or the disability. The Physician's Guide indicates that it is not enough that a doctor provide an opinion; in order for a

report to be considered medical legal evidence, it must provide sound and supported reasoning for such findings. This often includes not only a discussion of possible causative factors, but also a discussion of records, which in some cases can be extensive, and how these records were considered and support the findings. The Physician's Guide states: "For each opinion, provide a clear description of why the opinion was reached. The evaluator should also provide explanations for any unusual findings. This should be done throughout the report, in the appropriate sections." Producing a report that does this and can be considered medical legal evidence takes much longer than three hours to reason out and write. Even without an included record review, a psychological QME report is 40 pages on average (for reference a standard single-spaced page is considered to have an average of 500 words)—if the QME doctor were to type this in three hours, this would require him or her to type at a rate of 111 words a minute—this does not even take into consideration any time for actually formulating the findings and sentences to be written. This is completely unreasonable and will only result in shoddy, incomplete reports that are of no use to the attorneys or judges presiding over workers' compensation cases.

The poorly formulated arbitrary number of hours for report writing time is also demonstrated by the fact that both ML104 for a comprehensive evaluation and ML106 for a supplemental report provide the same maximum number of hours. Three hours might be more in line with an average number of hours for a supplemental report (unless there is a large amount of additional records to be reviewed and discussed), but is completely inadequate for an evaluation or re-evaluation report. Unless the DWC is also willing to limit the number of pages of records submitted to the QME for review; limit the number of injuries to be assessed by the QME; limit the number of years of a CT claim; or limit the number of past or non-industrial factors in an individual's history , then it is unreasonable to limit the number of hours of report writing. There has been growing concern regarding the diminishing number of QMEs and these poorly considered changes will only result in further atrophy of available experienced QME doctors.

Fardad Baroumand, MD May 17, 2018
Member of DWC Subject Matter Expert (SME) panel

I am one of the physicians on the DWC Subject Matter Expert panel. In our meeting of 5/14/2018, we discussed the proposed changes to the Medical Legal Fee Schedule (MLFS). In brief, we have a major concern and a suggestion in reference to these changes, which are discussed below.

Our concern is the following: many of California QMEs would be unable to continue medical legal work if they are not reimbursed for the time they genuinely spend to perform these evaluations. Of the physicians in our panel, more than half stated that if the proposed changes are approved they will be forced to terminate their medical legal activities. It is noticed that many of

the forum commentators have expressed similar intents.

We have received concerning statistics on percentage of California QMEs who have left the system during the past 2-3 years, and suspect that the proposed changes would lead to exiting of a significantly larger proportion of the remaining QMEs. We are not certain that the department would have effective means of addressing such a provider shortage, and are concerned that this would lead to a major dysfunction in the system.

We are being told that inappropriate use of the MLFS by a proportion of providers has resulted in a significant increase in medical legal expenses (especially time based charges; such as ML 104, ML 101 and ML 106). We agree that no provider should be allowed to bill for the time they have not genuinely spent. But we also feel that payers are agreeable to reimburse QMEs for the time they truly spend.

One of the problems with the existing MLFS is that it tries to estimate the amount of reasonable and necessary time based upon indicators such as complexity factors. Anyone who has completed a few medical legal evaluations clearly recognizes that the time needed to complete an evaluation has a limited correlation with the complexity factors listed in the MLFS. The proposed changes to the MLFS are expected to further increase this disconnect.

A better solution might be utilizing means of tracking the time spent by the evaluators, in a verifiable and objective manner. For instance, many private companies or government organizations use internet based applications to track the time spent by their independent contractors. Such applications monitor the activities of each contractor "live", and even frequently audit the contractor (by means such as popups, screen messages, etc.). Several safeguards embedded into these applications reduce the potential for abuse; down to a negligible level. Time logs are stored in a central system and are accessible by the desired entities. These systems require only minimal cost for operation and maintenance, and can easily be installed and maintained by a third-party provider or even DWC itself.

If such a platform becomes available, providers would be able to login to the central system and chart the time spent for each of the associated activities in a "live" manner. Many providers – including myself – already use computerized time tracking. Offering a standardized and verifiable system can significantly alleviate the concerns of payers and providers alike.

Finding a perfect solution for California Medical Legal Fee Schedule seems extremely difficult or even impractical. However we strongly believe that a time tracking system, compared to any edits made to the MLFS, is likely to cause significantly less complications.

Joel Berger, MS, DC, DABCN, QME May 17, 2018

This letter is in response to the new proposed Med-Legal Fee Schedule. It appears that the objective with this proposal is not to improve workers' compensation, but rather cheapen it. The QME doctor is the lynchpin to the whole system. The QME is the conduit for the judge, as well as the medical providers, insurance company and the patient. Being in that place we are automatically prone to be challenged by all parties involved, we can't hide or shrug that responsibility off, therefore we, as QMEs must be prepared to defend ourselves and our positions. Speaking, at least for myself, I make every effort to give the most accurate assessment of that injured worker including his past medical history, which by itself plays into the complexity of being accurate. Taking on that effort and responsibility, instead of being rewarded we are punished.

In review of some of the things being challenged. One, for instance, the no more than 3 hours can be charged amendment. Let me ask you, how was this actually based?? I think that the DIR should answer that. Be transparent about how you came up with this as well as other issues. I would love to challenge that, by having several people from the DIR, give them 200 pages each, have them review the records, write the germane issues, then review their work see how long it takes, Perhaps they would have a better understanding of what it's like to be in our shoes, something I'm sure they have no idea about. Another one is that we can't use the same cited source in a 12 month period. Let me ask you if the cited source is appropriate why not use it?? The purpose of the report is for accuracy if an article fits a patient's dilemma then why not use it? It's actually appropriate to. This comes across as a direct fabrication of not having to pay for a QME's effort in order to save a few shekels.

These proposed amendments come across as simply devising a pseudo method in not having to pay QME doctors for their time, assessment, experience and expertise. Sure as a fallen rock will aim itself toward the earth, this proposal will result in the loss of QME doctors from all specialties to leave (if not already) in droves thus increasing the load of the QMEs that remain who will undoubtedly work harder for less until they leave this flawed system. This proposed method, will, in time, collapse on itself.

My suggestion is that all people involved that is the insurance companies, lawyers and yes active QME doctors from all specialties be at the table and work this out so that it is more equitable for the doctor and the injured worker, which is why we exist in the first place.

Edward L. Spenser, MD May 17, 2018

I am writing in opposition to the proposed changes to the Medical-Legal fee schedule. Previous commentators have addressed the problems arising out of an arbitrary limitation on the number of hours billed for preparation of complex medicolegal reports, which speak for themselves and need not be repeated here.

However, I would draw special attention to other proposed changes which more fundamentally weaken the QME system. The proposal to require agreement between the physician and the "parties" that the issue of "medical causation" is a "disputed medical fact" in order to use causation as a complexity factor, coupled with disallowing the physician from refusing to perform an evaluation without such agreement, essentially serves to eliminate the ability of the evaluator to use causation as a complexity factor. One can imagine a request by the physician for authorization to use causation as a complexity factor going unheeded, precluding its use under the proposed guidelines.

In any event, it would appear that the determination of whether “medical causation” is a “medical fact” is a medical question that should be made by a licensed physician as opposed to a medically untrained layperson operating as an insurance claims adjuster or attorney.
Given the relative infrequency with which the apportionment complexity factor is applicable, the restriction of the causation complexity factor is likely to render many evaluations ineligible for time-based billing at ML-104 and eligible only for reimbursement at the fixed-rate ML-102 or ML-103 levels.

These fixed-rate reimbursement scenarios represent payment for fewer than four hours of work, regardless of time spent. Since payments to QME physicians are the only point at which funds enter the QME medico-legal ecosystem, the proposed regulations essentially contemplate that QME physicians would accept a de minimis payment for their expertise and work product, if indeed any monies are left for the physician after the overhead costs necessary to meet the statutory requirements for report contents.

It is difficult, further, to imagine a scenario in which it is economically viable for QME physicians to maintain a network of satellite office locations in medically underserved areas under conditions where the funding for such overhead expenses is reduced by 50% or more with no corresponding decrease in the expectations for the work product.

In this, I believe the DWC has vastly overplayed its hand and has proposed these regulations under the fantasy that QME physicians are a captive audience, unemployable on the open market. Even the most committed QME would find the prospect of paying overhead out of pocket from other sources to work for free for the DWC to be untenable. In reality, the economic challenges facing the worker's compensation system are the same as those applicable in other areas of medical practice: an increasing demand for services and a flat or decreasing supply of physicians. QME physicians facing the proposed new fee schedule environment would have no choice but to discontinue all unreimbursed medicolegal work at once, to the detriment of injured Californians.
Given that such an outcome is foreseeable, it is possible that the DWC seeks to implement major policy changes through these means. If the goal of the proposed fee schedule changes is to make it mathematically impossible for physicians to participate, and thereby bring about the collapse of that part of the system in which independent medical expert reporting is used to resolve disputed medical issues, then such a goal should be made clear to the public so that all

stakeholders may participate in dialogue about necessary changes to the worker's compensation system.
The proposed
fee schedule changes can only be considered as an attempt by the DWC to hold QME physicians hostage to force major systematic changes without careful consideration and public discussion of the consequences. Such dishonest and indirect manipulations should be rejected as unacceptable by the public and the legislature.

Ghan S. Lohiya MD, MS, FACOEM, FACPM May 17, 2018
Toxicology QME

I compliment DWC staff for their untiring efforts in ensuring that the injured workers receive the benefits they deserve while eliminating waste. I hope you find the following comments useful as you revise the rules.

Toxicology QMEs often require ML104 fees for the following reasons:

1. Face to face time: Considerable time is required to obtain a detailed history of job activities and exposures. The industrial activity is often unique to a given job and factory. Detailed inquiry about smoking, alcohol and drugs is essential as those chemicals can affect the industrial toxicity.

2. Records: It is necessary for the QME to personally review records page by page. This work can't be relegated to clerk due to errors of omission and commission.

3. Research: There is usually exposure to numerous chemicals. One has to research the toxicity of each chemical. Material Safety Data Sheets are useful but generally provide limited information, and may be outdated. Although the QME is supposedly an expert in the field, the scientific literature is constantly evolving and the QME must study the most up to date publications identified from a PubMed or ToxNet search. It is well-known that older science is sometimes debunked by later studies. For example, studies in the 1980s linked gasoline exhaust to brain cancer (glioblastoma multiforme) but subsequent studies of the same study population revealed no such link, and indicated that the prior finding was a random event due to chance.

4. Report Preparation: Report requires discussion of the toxic effects on each organ, references to research publications, and comments on conflicting opinions. Therefore the report is usually long, and the QME has to personally prepare it. Therefore report preparation time should be payable at the ML104 rate.

> Note also that since 2006, the allowed ML104 fee has remained fixed at $250 per hour. It is high time that this rate is increased to $400 per hour. For comparison, other professionals charge much higher hourly fees: attorneys $400-$800, CPAs $300-$400, surgeons $500-$1000 and so on. Then and then only QME work will remain competitive to attract well-qualified new QMEs.

Lawrence Barnett, MD May 17, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Callum Eastwood, PsyD, QME May 17, 2018
Senior Director, Behavioral Medicine
Pain & Rehabilitative Consultants Medical Group

I am concerned regarding the DWC's effort to concretize the "shadow regulations" for which they recently received an unfavorable ruling in court. While I appreciate the intent to now make explicit and concrete those interpretations of the regulations the DWC was attempting to enforce, it is now much more apparent that the motivation for these changes has nothing to do with insuring quality medical-legal evaluations or timely resolution of injured workers' claims. Instead, it appears that most of the proposed revisions are intended to serve the interests of the insurers in containing costs of medical-legal evaluations. According to the recent RAND assessment, however, costs of California medical-legal evaluations are some of the lowest in the country, and regulation and code changes over the past decade have succeeded in reducing these costs. Simultaneously, worker's compensation insurers are recording records profits. If we follow the money, I believe indications are strong that the DWC is attempting to primarily serve the interests of the insurers rather than honoring the grand bargain with injured workers.

Curtailing the medical-legal evaluator's ability to spend adequate time on report generation and putting the burden of addressing questions of causation upon receipt of authorization from both parties will seriously compromise the interests of an injured worker to receive evaluations that constitute significant medical evidence. As a psychologist QME, I do not believe there is ever an initial evaluation for a psyche injury in which causation is not the primary question, but I consistently see adjusters and/or defense attorney's omitting that specific request in their letters of engagement. They will leap to asking about MMI status and apportionment (which both

require causation to have been established), but will not ask about causation. They are contesting it, though, for in the medical record, you can see denials of psychological treatment because "liability for the psyche is currently contested." So, in short, an insurer plays the game of denying access to treatment to an injured worker due to psyche being a not accepted part of their claim, but then doesn't explicitly request the QME to determine causation, thus undermining the injured worker's chance to get access to treatment is warranted. These omissions of request for determination of causation may be less intentional than I describe and simply be errors or due to ignorance, but the impact on the worker is the same … a denial of treatment. An alternative that would shift the impact of such "errors" from the injured worker would be to assume that causation is ALWAYS a valid question in an initial medical-legal evaluation, and the parties have to explicitly state they are not contesting causation and want the evaluator to instead opine on MMI status, apportionment, future treatment, etc.

The other modification that seems intended to limit the utility of an evaluation is the report preparation limit to three hours. A typical psyche QME is between 45-80 pages, with many being significantly longer. Injured workers complete an extensive interview with the evaluator, with often over 4 hours of face to face contact and all the data that entails. Additionally, psychological testing takes a couple of hours to administer. Add in medical records, research, and testing results to integrate, formulation of medical legal questions, and creation of the report, and a three hour time limit seems ludicrous. The three hour time limit seems to have been arbitrarily arrived at (again by whom?) and not reflective of a time study, average report length (given a psyche QME), or frankly an adequate sense of what is actually involved in the creation of a quality medical legal evaluation. Were QMEs asked how long reports typically took, or were insurers asked for what time they were willing to pay? Was there any data collected before this time was chosen as a limit? Were different types of evaluations considered? I recognize a desire for an upper limit, but if we are talking about a complex psyche evaluation, a three hour limit would only allow the most basic information to actually be included in the report and seriously compromise an injured worker's right to quality medical-legal evaluation.

I respectfully request that the DWC suspend its intention to implement the regulation changes as written, for they seriously compromise injured workers rights, and will also likely further deplete the already diminishing pool of QMEs. Please engage in a process of working with QME's as opposed to seeing them as the "bad guys."

Karen Sims, Claims Operations Manager — May 17, 2018
Claims Medical and Regulator Division
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.

Recommended text changes are indicated by underscore for additional language and ~~strikeout~~ for deleted language. We will use the term "employer" to encompass insurance carrier, claims administrator, etc.

§9794. Reimbursement of Medical-Legal Expenses

Comment:
State Fund seeks further clarification on Section 9794(a)(3). This section is unclear on the consequences and responsibilities if other charges are billed.

Recommendation:
State Fund recommends amending Section 9794(a)(3) to read: "No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report; and neither the employee nor the employer shall be liable for any charges billed in violation of this section."

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

Comment:
The meaning to the last sentence of Section 9795(b), 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", is unclear.

Recommendation:
State Fund recommends amendment as follows: "~~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 any prior agreement of the parties required under provision of this regulation."

Comment:
Section 9795(c), ML103 subsection (6), requires prior agreement between the parties and physician that the issue of medical causation is a disputed medical fact in order for medical causation to be considered a complexity factor. This may not always be practical, as each party may choose to submit its own letter outlining the issues for the physician to address in the evaluation. Furthermore, per Section 9795(b), a physician may not condition performance of the evaluation on receipt of said agreement. As a result, a physician is unlikely to comment on medical causation, because the physician is unable to bill for it, unless there is an explicit agreement between all parties. This will inevitably cause unnecessary delays in requesting supplemental reports and scheduling depositions.

Recommendation:
State Fund recommends the language be amended to require an agreement be made between the physician and the requesting party or parties.

We thank the DWC for the opportunity to participate in the rulemaking process and we offer our ongoing support of DWC's modification to text of proposed Medical-Legal Fee Schedule regulations.

Charles A. Filanosky, Ph.D., ABPP May 17, 2018

I have reviewed the changes proposed to the med legal fee schedule and I am writing to express my concerns.

I think it's quite clear: Limiting the amount of time one can take to complete a report is the same as limiting the amount of quality that you want within that report. When it comes to such critically important matters as whether or not an injured worker receives appropriate care that can support functional recovery and improve quality of life, cutting corners is not in anyone's best interest. When people don't return to work, when they don't get better after injury, everyone pays, the person, their family, society, and it's more than just a few hundred dollars.

In my time as a QME I have watched the worker's compensation system retract. Less care for injured workers, less conditions evaluated (e.g. TBI) and less time for less QMEs to do more paperwork that's increasingly complex. It is 100% going in the wrong direction.

I am advocate for quality, and I think there is much meaningful reform that can occur. The approach that I've seen thus far, and this is just the latest in a series of such measures, undermines quality and impacts the lives of real people.

Given the need to summarize the chart and address so many issues, reports are necessarily lengthy. 3 hours when the circumstances are just right is simply not enough time to write a 20 page report with complex opinions, detailed reasoning, and references to boot. I would be interested in knowing how this number was selected; it seems arbitrary and "to a reasonable degree of medical certainty" it is not based on the average amount of time billed for report writing for psych, which is my specialty. At least now that my real specialty of neuropsychology has been arbitrarily eliminated.

Please reconsider this ill conceived plan. If you involved your stakeholders, the QME community, I am sure we can work together to provide a meaningful, realistic plan that doesn't sacrifice quality but maintains efficiency and is in the best interest of injured workers, those we are here to serve in the first place. This current plan, as stated, should be scrapped.

I appreciate your time and attention.

Don Williams, MD May 17, 2018

Frequently, a literature article is sited to reinforce an Apportionment opinion so that a deposition can be avoided. It takes time to look it up and put the reference into the case. But if it can only be reference once per year why bother. Just wait for the deposition.

Gregg M. Baringoldz, PhD, QME May 17, 2018

I am writing to express my significant concerns related to the proposed DWC changes. While relatively new to the QME area, the rationale for these changes escapes me in terms of QMEs providing meaningful and just services to injured workers. Severely cutting back on the time authorized to complete reports, and redefining issues pertaining to causation would appear to promote less thorough examinations and reports. Less thorough evaluations and reports will be unfair to injured workers, and render QMEs unable to effectively address and communicate essential details to attorneys, adjusters, and triers of fact. While these changes appear to be costly to injured workers in terms of not receiving thorough evaluations, the benefits to payers in terms of reduced QME reimbursement for evaluations seems obvious. So, if the goal of these changes is to reduce the accuracy of QME evaluations at the expense of injured workers, reduce the number of QMEs in the field, and to artificially reduce upfront costs for payers (but increase the likely expenses that will be generated from increased requests for supplemental reports and monies paid for depositions to clarify abbreviated issues in abbreviated reports), then I suppose that these changes would help meet these goals. However, if the goal is to provide better services for the evaluation of injured workers, the proposed DWC changes are way off the mark.

Dr. Mark Pulera, QME May 17, 2018

I have been performing QMEs in Neurology since approximately 2006. Many of my colleagues have made eloquent statements demonstrating the unreasonable nature of the proposed DWC changes regarding medical-legal reimbursement. I agree with them, but will not reiterate the issues here. Rather, I will share some of my personal experience as a QME.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

In approximately November 2017, I personally contacted the DWC regarding a sudden, unexpected increase in the number of new panel QME requests I was receiving. QMEs have no control of how many and when the receive new panel QME requests. Furthermore, QMEs such as myself are obligated to see new panel QME requests and issue a report in a precise timeframe. I must emphasize, also in an unpredictable manner, QME case can have 7,8,9 or more than 10,000 pages of documents the QME is obligated to review and analyze. A QME of has to complete multiple cases each with thousands of pages for the QME to analyze within a certain timeframe or face disciplinary action.

Any and all statements made by the QME in the report are subject to the highest possible level of human scrutiny. QME's are routines challenged by attorneys, applicants, employers and judges. If the QME report is not scientifically sound enough, the QME report could be disqualified. Therefore, the QME is not only entitled, but obligated to utilize as many current, accurate, and reliable scientific studies as possible.

Keep in mind I brought up this issue of sudden, unexpected increased in new panel QME requests with the DWC in 2017, under the current Medical-Legal Fee schedule which can reimburse QME's per hour of work when appropriate. If a QME does not compete a report in the required timeframe, the report and the QME may ultimately be disqualified. I was concerned I could not physically complete all of the sudden, new QME requests in the required timeframe, which could jeopardizes my credentials as a QME.

In 2017, the DWC responded to my concerns that I couldn't meet the demands of the sudden, new, unpredictable increase in panel QME requests by informing me I simply have to perform any and all QME requests within the specified timeframe or face possible disciplinary action. The DWC made no attempt to offer an additional solution.

In addition, I asked the QME if the regulations currently made this necessary, then perhaps the DWC could consider changing the regulations to make this situation more reasonable and appropriate for QMEs. The DWC acknowledged my request in 2017.

Then, in 2018, the DWC issued proposed changed for medical-legal billing reimbursement. I anticipated this could be the opportunity for the DWC to address this unreasonable demand to complete unlimited work in a limited timeframe. Instead, first, the DWC confirmed the mandatory nature of panel QME request and offered no solution to help the QME manage potentially unlimited requests to complete work in a certain timeframe.

Second, the DWC decided to limit the reimbursement of medical legal-reports. Therefore, in response to my request to the DWC to make panel QME requests more reasonable, the DWC keep mandatory requirements of performing QMEs but drastically reduced the compensation.

I must say, this was not the response that I had anticipated to the request that I made to the DWC in 2017.

I would point out, one mandatory new panel QME request may have 10,000 plus pages. Again, there is no way of knowing. Simply transcribing 10,000 pages, let alone finishing wthe report could easily take 30-40 hours, or essentially one work week of a QME. According to the proposed DWC changes, a QME could receive only reimbursement at ML-103 for approximately one week of work.

Anyone reading this letter knows that reimbursement for an ML-103 may not cover the QME's overhead for 1-2 days. This situation can happen repeatedly. How fair and reasonable is this proposed change to QMEs? A QME could not even cover overhead in these circumstances.

I need to address the proposed changed by the DWC regarding scientific citations in medical legal-reports. First, it must be acknowledged that the is a generally accepted standard of providing scientific citations in reports that is widely accepted in the scientific community. With all due respect to the DWC, the DWC does not appear to embrace the standards of the scientific community regarding citations.

Current DWC requirements indicate the QME must provide excepts as part of a scientific citation. This requirement is directly contradictory to scientific principle regarding citations. The scientific community favors brevity and efficiency. Especially with today's technology, the scientific community states that only the standardized, brief citation is necessary to include in a report without any providing any excepts. This is because the actual details of the study are generally accessible with the standardized citation provided and adding excepts is cumbersome and unnecessary.

But the DWC's approach toward scientific citations is drastically different that the scientific community in another way. In science, like many other walks of life, certain scientific investigators produce certain scientific studies that are simply more accurate, reliable and persuasive than other studies. Other scientists find out which are the most accurate and reliable studies, and often use these studies repeatedly to support their scientific position whenever appropriate. **This is actually a mandatory feature of scientific studies. Studies that do not do so would be less persuasive, less accurate and less reliable. In science, there is no penalty for using the same persuasive and reliable studies over and over again. In fact, a scientific study would be amiss if it deliberately avoided relying on a previously published study to make it point.** Also, a QME should not take credit for the other scientist's work, so a reference is required. Therefore, a QME report that avoids certain studies because the QME used the study to support a similar scientific concept in a previous report would also be inappropriate, inaccurate and unreliable.

I would also like to emphasize the need for including reliable, accurate, current scientific studies in an a QME report. As state, any fact asserted by a QME is subject to the highest level of scrutiny that is humanly possible. The topics addressed in a typical medical legal report such as how stress affects medical illness often remain highly controversial and matters of unsettled science. The most accurate, reliable information may best be obtained by experienced,

competent review of the relevant scientific literature. Sometimes this is best accomplished by utilizing the best study repeatedly in cases that address similar topics.

QME reports deemed to have inadequate scientific evidence are subject to request for supplemental report or deposition. Such reports may even be disqualified due to perceived lack of supporting scientific evidence. Such scientific evidence, therefore, should not be limited, especially in the arbitrary manner proposed by the DWC.

I would point out that the scientific community generally requires reports to provide the scientific reference for essentially each and every scientific fact in a report. Many QME reports currently avoid this issue by improperly not providing references for the scientific facts they assert in their reports. The DWC now wants a QME to avoid referencing a study that supports facts in their report if the reference previously used in a recent report.

Currently, whether the QME properly references the appropriate study, essentially all QME reports now utilize scientific facts that are supported by multiple studies in each of their reports that cover the same topic. The scientific community dictates these studies should be footnoted each and every time the facts of the study are stated. Therefore, according to scientific principles, current QME reports are often not properly footnoting scientific studies.

The newly proposed regulations by the DWC would increase the lack of proper footnoting the QME, making the report less persuasive, reliable and accurate. All things being equal, a study, even with reused scientific references, is generally more accurate, persuasive and reliable than a study without any appropriate scientific citations, especially with the topics generally covered in a QME, which often involve unsettled science. Analysis of the current, incomplete relevant, scientific literature is then most important.

The demand to avoid repeatedly utilize the most respected, accurate scientific studies for any reason is simply directly contrary to accepted scientific principles. Doing so would be a reason to disqualify a scientific study within the scientific community, except apparently in QME reports according to the DWC.

So why is the DWC proposing to avoid providing proper scientific references according to the standards of the scientific community? Doing so would make a report less scientifically sound and open the door for prolonged, costly litigation.

In fact, it is mandatory, not improper, to include references supporting the scientific facts of a QME report, even if those references were used by a QME in a previous report according to the standards of the scientific community. The new DWC regulations make it mandatory to avoid footnoting scientific facts as required by the scientific community. It seems like the DWC has a blatant disregard for the principles of the scientific community regarding footnoting studies.

While it has always been a challenge to perform QMEs and few, if any, cases are a "Typical QME Case", it is unclear how a QME could even continue to pay overhead expenses under the new changes proposed by the DWC.

The complex, lengthy nature of this letter belies the complex, lengthy nature of a "Typical QME Case."

Lawrence N. Borelli, MD May 17, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Mechel Henry May 17, 2018
QME Opposed to Changes

The changes to the ML fee schedule are the opposite of what makes sense in today's economy. There has been NO reimbursement increase in the ML fee schedule for over a decade and there should be. There are no increases to keep pace with inflation, let alone rising rents in major cities such as the Bay Area.

Any employee told they will be paid less each year to do more work would find another job. In many respects, QMEs are employees of the state. In my private practice, I set and determine the fees. I can adjust prices according to many factors, including: my continuing education as both and QME and a physician, training for new procedures, my office overhead and expenses, and the value of my time and years of experience. The current ML fee schedule says I should be paid my usual rate, or the ML fee schedule, whichever is LOWER. This is unreasonable and should be changed.

QMEs are investigators doing necessary work for the State of California to move Workers Compensation cases along. We are the ground workers providing medical data nobody else can. In a 45 minute-2 hour interview and exam for a musculoskeletal pain case, my job is to sort out the facts, which requires review of records, deposition transcripts and prior medical legal reports. There are frequent scars and physical findings seen on exam with no records to explain them. Many injured workers have no past medical records before the industrial claim. I must

tease this out and in that brief interview with the injured worker, gain enough trust to have them tell me what happened so my report is substantial medical evidence. This takes not only time and expertise, but an emotional investment, full attention to detail and presence to do a good job. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

The next step is to review the records, the cover letters and my history and exam findings. This review and editing can take hours, and they are not always consecutive, because I am a physician and constantly pulled in 100 directions. And my transciptionist can take over a week to get things to me. While I'm waiting for transcription, there are prescriptions to refill, last minute appointments, new appointments, depositions and of course urgent patient matters. I run codes in the hospital if I'm there when the alarm goes off, last year there were 2 in one day. I did not get to eat lunch but nobody died. I also have the clock ticking, I only have 30 days to get a QME report done, 60 days for a supplemental, or I am in trouble and my report and all the work done thus far is in vain. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

The QME/AME report writing complexities cannot be entirely discussed by anyone, let alone in under 3 hours for every report. I'd like to know who came up with this hourly time limit? It certainly wasn't anyone addressing apportionment, which has multiple aspects including outside nonindustrial factors, which I must carefully find and discuss with reasonable medical probability, prior work injuries, and similar body parts. This is why there are lectures and conferences we must all attend to keep up with and understand things for relevant report writing. Case law changes constantly. What was it like around the time we switched from the old schedule to the AMA guides 5th edition in 2005? When Almaraz passed? What about Escobedo? Now we have Hikida. This is research but we are not allowed to bill for this time, yet I must know this vital case law. It is part of keeping up our certification as a QME and writing reports, which are pertinent. If I wrote a report using the old schedule for anything after 2005, for example, it would be worthless. This complexity factor is not reflected in the current ML fee schedule and should be.

And each time the case law changes I am suddenly flooded with at least 100 requests for supplemental reports to apply it. At the very least there should be a clause giving us room for an automatic time extension. If I had the time to write asking for a time extension, filling out the proper forms and scanning a copy to prove I sent it, I'd probably have time to do the report. This complexity factor is not reflected in the current ML fee schedule and should be.

Then there is the work voucher form. This is new and required. Do I get to bill for completing and paying someone to upload, scan and send it along with the report? This complexity factor is not reflected as part of the complexity code for ML billing and should be.

And some of my reports are 50+ pages because I am doing my job as a QME properly. But if both parties don't ask me to address causation in writing in advance exactly as you now want it done, and I don't do "research" now making sure only to reference an article once every 12

months, I would only be able to bill an ML102. I still refer to the famous Bowden article for apportionment to degenerative changes, it was published in 2001, but there are not many studies of this nature done and it's pertinent for apportionment discussion. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

And now with UR, if I request a test such as an MRI to help complete my report, I must write the prescription, usually 3 times, and fax or mail it, usually 3 times, to One Call. Yes, I know for a medical legal report things shouldn't go to UR, but tell that to the adjuster who keeps faxing/mailing/calling asking me to fill out an RFA. And I cannot bill for this time. And now you want to ensure when the vital test result comes back I cannot bill for the time to review it and comment? This complexity factor is not reflected as part of the complexity code for ML billing and should be.

And if I need an FCE, or another medical specialist opinion for my ML report, I am responsible for getting it done. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

In 2006, my consultant told me it cost me $350 to see a patient. Now, she estimates it cost $625 per patient with rent, postage, scanning, electronic health records and billing, malpractice and staff costs. This overhead factor is not reflected as part of the complexity code for ML billing and should be.

There is already a severe QME shortage. The DWC is trying to recruit QMEs because there aren't enough. Usually, when you are a sought after resource, your value goes up, not down. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

Because of this QME shortage, my name comes up as a panel QME very often. This creates a new dance we do with panels scheduled more than 60 days out then cancelled. My office staff are at least 10x busier now, so I have to pay 10x more plus inflation, as most people doing more work, expect a pay raise annually. Remember, my staff MUST fill out form 110 for each appointment. Do you know how many 110 forms are filled out, scanned and saved, patient data entered into the EHR which is HIPPA compliant, and appointment notice sent by all parties, the mail opened and scanned, including medical records, and then the appointment cancelled with such short notice I cannot fill the spot? The $625 overhead cost was spent already, but no patient seen. This is happening several times a week already because of the QME time rules. If I have an opening next week, nobody will take it, because they want 30 days to get the records and cover letters ready. So I essentially can offer a panel QME spot in 30-60 days or the parties can ask for a panel replacement. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

I am already doing a lower volume of QMEs, because if I do not have time to complete my report, I am also in trouble. I have 60 days to complete supplemental reports. How do I fit this into my work flow if 3000 pages of records are sent in random boxes for two patients for

supplementals in one week, then you want to limit me to 3 hours to review it all with the last report and both parties letters and get it served in under 60 days? Adjusters and attorneys do not get into trouble for failing to send me records in advance of the appointment. All the responsibility for getting things done is mine. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

I often work nights and weekends. I am away from my children to get these reports done on time, as well as taking care of my private practice patients and covering the hospital. This complexity factor is not reflected as part of the complexity code for ML billing and should be.

The no backing out rule is illegal. I am allowed to opt out of medi-care. If **[REDACTED]** sends me a contract I don't have to sign it. I can negotiate my rates at any time as an independent contractor. I do not have to work for free or at a loss. To forbid me from entering into a private negotiation for reimbursement with an insurance company is taking away my rights and also interfering in a way that has nothing to do with me serving my role as a QME evaluator. If I were an employee of the state of California, this might be reasonable, but I am not.

And how about the affect on the mental health of the existing QMEs? We have been under fire for billing for a few years now, and you want this rein of terror against us to continue forever? I used to enjoy doing QMEs, but now every time I submit a bill, or heaven forbid, a late report, I worry I'll lose my QME license. It's already unhealthy for the doctors doing QMEs and these changes make it toxic. Perhaps the next law suit will be against the board, with all the remaining QMEs filing a psych claim against the state of California.

I went to medical school to help people using my heart, mind and skills, and a certain amount of respect and trust should come with that hard work. Now the ML fee schedule proposed changes are making it impossible for me to do a good job and be paid for my time. With the proposed ML changes, there is essentially no way for me to pay my rent and staff and continue doing QMEs. I will be very sad if that happens, because I enjoy the work. But with the current QME shortage, and putting these proposed ML changes into effect, it makes things desperate for injured workers. If I stop doing QMEs, as many of my colleagues already have, every current case I have will require a NEW QME. Who will take my place? This last aspect seems unreasonable and irresponsible to me.

Completely agree with Mike Post, MD's comments May 15, as well as Anonymous post on May 15, 2018, Starting with "The DWC does not appear to have taken the following into consideration:" The comments pertain to adjusters needing to take a billing class (and maybe read the documents submitted and not pretend they didn't get the report when it was sent and confirmed received electronically), DWC employees not being able to work for insurance companies for 10 years and reciprocal accountability on the DWCs part (esp those who enforced the underground regulations and still have jobs and probably got a cost of living pay raise this year), insurance companies, and adjusters reflects some of the spotlight on perhaps where these changes are coming from. Defense attorneys should also be included in this scrutiny and

regulation. Frequently defense attorneys send me a request for a supplemental report, date it for a month ago, but the envelop is postmarked for when it was received. I now have to have my staff scan the envelop for proof of when the letter was mailed, so when the defense attorney reports me to the DWC for a late report asking for a new QME, I can prove their letter was late and my report was timely. Physicians should not be the only responsible parties with such burden of proof. Carl Brakensiek with CSIMS also had an excellent post May 15, which I concur with.

Glenhall Taylor, MD May 17, 2018

I have been doing QME and AME evaluations in psychiatry since 2008. I would agree with my colleagues that the proposed (somewhat arbitrary) changes would be detrimental to the whole intended process of providing a fair and equitable process for both injured worker and insurer alike.

In the field of psychiatry, as has been said by many of my colleagues already, there is such complexity often required in a supplemental case formulation, that an arbitrary cap of 3 hours would either lead to an insufficiently formulated case, or require one to , in essence work for free if the interest is in maintaining our usual standard of high quality reports.

With respect to causation, I for one would object (and have objected) to non-reimbursement for my case formulation and analysis. It is the report preparation that is the synthesis of all the other reimbursed work (face to face, records review, research, testing) and it is the report preparation where the rubber-really -meets-the road! Perhaps

I was under the misguided notion that it was our medical expertise in analysis and synthesis of all the information provided that was really of value to you. Thoughtful case formulation and medical-legal opinions takes time, and has been pointed out, this cannot be limited by some arbitrary time constraint.

Additionally identification of causation in psychiatric cases is frequently not as 'obvious' to those of us in mental health as it may be to the insurers and lawyers. I guess reasonable medical evidence for causation no longer requires our reasonable medically educated opinion!

I also find the limited use of medical evidence ludicrous. For instance, if there is a seminal Cochran report on a particular subject that supports findings in a case, or a new evidence based research article on an important treatment modality, it seems absurd that only one report could benefit from an important citation. I use research to inform the parties and the judge in an individual case of the whys and wherefores of my thinking ("support and document"). I can understand the desire to eliminate the "cut and paste research bibliography" but thoughtful use of

valued medical evidence should be encouraged not deplorably limited to one time. Good research and medical evidence should be cited whenever and wherever appropriate.

Finally I have always enjoyed doing these reports, and in some small way have felt like I can provide fairness and benefit to injured worker and insurer alike. With the dearth of psychiatrists now, I can definitely do financially better elsewhere. The intellectual stimulation and compassionate but fair resolution of these cases have kept me in the game. Should you proceed with the proposed changes I for one, would likely move on.

Dr. Rod Melvin, DC, QME May 17, 2018
President & Owner of
South Ontario Chiropractic

The proposed amendments will both unfairly decrease monies that are rightfully paid for QME and AME reports but also have the affect of decreasing the quality of the reports. Good QME's will leave the system and the injured worker will further suffer.
I am categorically opposed to these changes.

Donald D. Kim, MD, QME May 17, 2018

My name is Donald D. Kim, MD and I have served as QME for over 20 years. I find it very hard to believe that the fee schedule has remained stagnant for years while my expenses have risen dramatically. Also, the way DWC has unilaterally translated the complexity factors to prevent coding for ML104 is highly disturbing!!!!

I see patients with ENORMOUS amounts of records where I spend numerous hours---only to be able to code for ML102 and occasionally 103. That is ridiculous! I demand fair reimbursement for the amount of time and effort that are put in by me (and other QMEs as well).

The way the system is currently does NOT accurately reflect the work that was put in to generate a medical legal report based on reasonable medical evidences!

I request fair REIMBURSEMENTS!!!!!!!

Diane J. Weiss, MD, MPH, QME, AME May 17, 2018

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I have worked within the field of Workers' Compensation in the State of California since 1988, 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, I well understand that the purpose of the Workers' Compensation system is to treat injured workers for their work injuries. I understand that my report must provide substantial medical evidence within the realm of reasonable medical probability, in an unbiased, fair, accurate and objective format. I am aware of the numerous changes which have taken place in the Workers' Compensation system throughout these years.

It would be impossible to over-emphasize my concerns with regard to proposed regulations related to "§ 9794. Reimbursement of Medical-Legal Expenses" and "§ 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony." Despite my 30 years of experience related to Workers' Compensation in the State of California, it is inconceivable to this psychiatrist how substantial medical evidence could be provided (let alone how injured workers could in any way be served) if the proposals were to go into effect in the form in which they were proposed to exist as of May 3, 2018.

OF SPECIFIC AND PARTICULAR CONCERN TO THE UNDERSIGNED WOULD BE THE IDEA THAT NO MORE THAN THREE HOURS COULD BE BILLED FOR REPORT PREPARATION UNDER THE CODES. THIS WOULD PRECLUDE THE ABILITY TO PROVIDE ANY SORT OF COMPREHENSIVE REPORT OF A PSYCHIATRIC EVALUATION AND/OR A SUPPLEMENTAL REPORT RELATED TO AN INITIAL PSYCHIATRIC EVALUATION, LET ALONE ONE WHICH WOULD PROVIDE SUBSTANTIAL MEDICAL EVIDENCE WITHIN THE REALM OF REASONABLE MEDICAL PROBABILITY.

In addition to already-complex existing requirements, the suggested regulations would require that reports contain more information, be even longer and more detailed, and provide additional analyses. Significant time must already be spent in order to meet such intensive requirements, which would take time away from the analysis of what happened to the injured worker, and what would be the industrial versus non-industrial nature of the case, if the proposals would be instated.

While I can appreciate the desire for cost savings and increased efficiency, the proposed restrictions on time spent/billed in producing a comprehensive medical-legal report in psychiatry, while at the same time further convoluting an incredibly complex system, would not in any way be either realistic or feasible.

Not only am I able to offer knowledgeable opinions about the proposals because of my specific experience in Workers' Compensation in the State of California, but I also do provide these opinions given that I am a Life Fellow of the American Psychiatric Association, Board Certified in Psychiatry, with over 30 years' experience evaluating and treating psychiatric patients.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

In keeping with changes in the regulations and laws, in order to offer opinions which are only based upon substantial medical evidence within the realm of reasonable medical probability, the time needed to prepare reports for Workers' Compensation evaluations and supplemental reports (at the requests of the parties) has only lengthened. As part of producing a comprehensive and thorough report of my evaluation, one which would be fair, balanced and neutral, I also must review medical records, where the report preparation time utilizes that information as relevant to the issues in the given case.

Not only have I had 30 years of experience writing medical-legal reports in the State of California for Workers' Compensation, but I have attended multiple seminars in order to stay up-to-date with best practices for doing so. These seminars have taught me how to write reports which would be considered as substantial medical evidence within the realm of reasonable medical probability, which is the only way that such reports could be provided to the parties.

There is no way to adequately communicate to the reader the distinct nature of reports related to the psyche. Whereas everything affects the psyche, nothing can be excluded. In looking at the proposed regulations, I would refer the reader to the procedure description of an ML-104, item "(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires…"

There are no body parts which could be ignored in terms of a psychiatric evaluation, whether or not the specific claim of an injury only involved the psyche. For example, a person could have headaches from "stress," as well as muscle tension, where those "body parts" are not the "psyche," but are part of the complete psychiatric presentation and evaluation.

When one would say "prior multiple injuries," I might at first think this would mean a previous claim, but, in evaluating the psyche, everything that happened to an applicant in his or her entire lifetime has to be considered and ruled in or out with regard to relevance. Those "prior multiple injuries to the same body part" might be injuries related to the specific place of employment for which the claim of injury to the psyche would be made (i.e., that a person developed carpal tunnel syndrome and pain from that while allegedly being stressed and overworked by the employer).

IN MY OPINION, THERE IS NO COMMON SENSE — AND, INDEED, NO BASIS IN REALITY — WITH REGARD TO ANY PROPOSAL WHICH STATES THAT "NO MORE THAN THREE HOURS MAY BE BILLED FOR REPORT PREPARATION," WHERE I AM ONLY ABLE TO COMMENT ABOUT THE PSYCHE. "TWO OR MORE HOURS OF FACE-TO-FACE TIME BY THE PHYSICIAN WITH THE INJURED WORKER" WOULD BE A BARE MINIMUM OF TIME TO SPEND EVALUATING AN INJURED WORKER'S PSYCHE AND THAT INJURED WORKER'S PSYCHIATRIC HISTORY.

In the 30 years in which I have participated in this system of Workers' Compensation in the State of California, there have been numerous court decisions which have applicability. For example, how could one spend more than two hours with an injured

worker face-to-face, and have sufficient time (in addition to other demands) to consider Almaraz-Guzman, Benson, and/or Rolda? However, these complicated and time-intensive concepts must be kept continuously in mind by the evaluator in order to provide a report which could be considered substantial medical evidence in a medical-legal context within the realm of reasonable medical probability.

In particular, recently, I have more and more frequently been required to provide a Rolda analysis. This is an extraordinarily complex and time-consuming undertaking. It is one requiring an inordinate amount of consideration to be fair and impartial. For starters, I would need to separate what would be for the Trier of Fact to determine, and what would be within my area of expertise about which I could opine. The "four-step analysis" does not lend itself to some kind of artificially imposed, arbitrary limitation of the number of hours (maximum three hours) spent preparing the report.

The amount of detail necessary to understand an injured worker's complaints related to personnel actions is extraordinary. One needs to record what the injured worker is communicating, not only about their allegations against the employer, but also about the structure and understanding of the system at the workplace. At all times, I need to consider the role of the employer, although I could never make a determination as to what would or would not be a lawful, non-discriminatory, good-faith personnel action, let alone be able to know when, how, or in what way an action occurred, and/or if it occurred at all. I have to consider all of this when I am evaluating an injured worker, and when, thereafter, I am preparing the report, whether or not I am asked to do a Rolda analysis.

The issue of "personnel actions" requires a great deal of time which cannot be constrained by an arbitrary, three-hour cutoff (or by any cutoff), particularly as every case is different. Such a limitation would not be realistic or relevant when it is necessary to provide substantial medical evidence within the realm of reasonable medical probability.

IN 30 YEARS, I AM UNAWARE OF THERE EVER HAVING BEEN SUCH A RESTRICTION, ONE WHICH ATTEMPTS TO CONSTRAIN THE TIME AND THOUGHT A DOCTOR NEEDS TO COME TO HIS OR HER ULTIMATE OPINIONS AND CONCLUSIONS AS REQUIRED BY THE SYSTEM OF WORKERS' COMPENSATION IN THE STATE OF CALIFORNIA. DO THE DESIGNERS OF THESE REGULATIONS WISH TO MERELY HAVE A FEW LINES WRITTEN, WHICH, GIVEN THE COMPLEXITIES, NEVER WOULD BE SUBSTANTIAL MEDICAL EVIDENCE WITHIN THE REALM OF REASONABLE MEDICAL PROBABILITY, AND WHERE SUCH A REPORT WOULD NOT MEET REQUIREMENTS?

For 30 years, I have continually learned at seminars, heard in meetings, and seen in both advocacy letters and in jointly signed cover letters, the explicit need for explanation, analysis and assessment. More and more rulings and decisions have come from the WCAB at different levels regarding the latter.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I have been asked through the years to provide more and more detailed explanations, even absent the regulations to specify in the report itself, as per "§ 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony."

With regard to the latter section, related to ML 103, "the report must include all information required to claim each complexity factor relied upon." There needs to be "a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code." This should be provided "in a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation." I would reiterate that significant time must be spent in order to meet such exhaustive requirements, which takes away from the analysis of what happened to that individual injured worker, and, ultimately, from what would be the industrial versus non-industrial nature of the case.

Apportionment is another area of great relevance. Apportionment can easily, on its own, require three hours of report preparation, depending on the case. For example, if a person has been married many times and has had illnesses and/or deaths within the family simultaneous to a work history of claimed continuous trauma to the psyche, then those "Other Factors" have to be explored and analyzed in detail.

Further, in cases where a person has suffered a lifetime history of multiple abuses, I have had various depositions where I was admonished to "bring the patient back" to obtain even more pre-industrial and non-industrial history. The latter would be in order to get a greater understanding related to whether those "Other Factors" could be shown, with substantial medical evidence within the realm of reasonable medical probability, to have played a role in that person's current psychiatric condition.
Of important note is the reality that there may be other factors which are causative of a Psychiatric Work Injury, but which are not necessarily causative of the current permanent disability on a psychiatric basis. The latter must be separately analyzed, as well.

ALL OF THIS IS AN INTEGRAL COMPONENT OF THE REPORT PREPARATION. THERE CANNOT BE A LIMIT PLACED UPON A MEDICAL DOCTOR'S THINKING IN A MEDICAL-LEGAL CONTEXT, PARTICULARLY WHERE SUBSTANTIAL MEDICAL EVIDENCE WITHIN THE REALM OF REASONABLE MEDICAL PROBABILITY IS ESSENTIAL.

Every case differs in terms of an individual's age; length of employment; types of injuries and complaints related to employment experience; various medical problems an individual has had; and problems with family members, whether in terms of interactions, illnesses and/or deaths. The latter would be some examples, but then, per Benson, in addition, there are the issues of

different Dates of Injury.

For instance, I recently saw a very involved case, where the injured worker complained of the same kinds of injuries at a recent previous employer, for which she received awards and sought medical treatment, which continued when the injured worker was claiming various injuries to different body parts, including the psyche, at the new employer. That does require more than three hours of report preparation if the need is for substantial medical evidence within the realm of reasonable medical probability.

Additionally, each case varies as to the type and volume of medical records provided. In each case, it is necessary to analyze all of the medical records which have been provided after one has taken the time to organize them, where the preparation of the report also needs to include and exclude medical records of relevance. The picking and choosing, and the review and analyzing of these records, is part of the report preparation.

It would be impractical (if not impossible) to say that, of an hour spent, two minutes here and four minutes there were spent thinking about the records, and, thus, should be billed under the medical records rather than under the report preparation.

The idea is to come to conclusions necessary based upon substantial medical evidence within the realm of reasonable medical probability about causation, about permanent disability, about maximum medical improvement, and, ultimately, about apportionment. The medical records are an intrinsic element, where, after an initial review of the records, preparing the report and looking at the whole case together requires more than three hours.

I CAN STATE WITH CERTAINTY THAT IT WOULD BE IMPOSSIBLE TO PROVIDE COMPREHENSIVE MEDICAL-LEGAL REPORTS BASED UPON SUBSTANTIAL MEDICAL EVIDENCE WITHIN THE REALM OF REASONABLE MEDICAL PROBABILITY WITH THE PROPOSED LIMITATIONS, PARTICULARLY GIVEN THE THREE-HOUR IMPEDIMENT. I WOULD ASK THE READER TO KEEP IN MIND THE LATTER AS I GIVE AN OVERVIEW OF THE PROCESS REQUIRED TO PROVIDE THE THOROUGH, EVIDENCE-BASED EVALUATIONS AND DETAILED REPORTS REQUIRED BY THE PARTIES AND BY THE SYSTEM.

In order to produce a report of a "Complex Comprehensive Medical-Legal Evaluation," the following steps are necessary, in addition to the hours I have spent face-to-face with the injured worker.

I need to first understand what the injured worker told me, where the injured worker's bias would also need to be considered as to my providing a fair and neutral opinion. The time I spend face-to-face with an injured worker is determined by the complexity of the case, the number of claims, the duration in years, as well as by the injured worker's ability to provide a clear and chronological history, which is usually extremely limited. The more time spent face-to-face, the more time is necessary to begin this one aspect of the report preparation.

With the new standards for claims, and the new decisions and laws asking for analyses, I would rarely require fewer than four hours face-to-face for a psychiatric examination. I do not think it would be difficult to communicate to the reader that, for example, if four hours were spent face-to-face with an injured worker, I would need (at a minimum) four hours to just review what went on in that examination with an injured worker, as my notes would include every minute of that face-to-face time.

In order to make sense of the medical records, I would first need to know what an injured worker was claiming. Thus, I would review my notes prior to, thereafter, looking at the medical records.

What each party is asking is not always clear and is not always the same. I need to determine what has been requested of me related to the different advocacy letters, or in terms of one jointly signed letter (where, nowadays, the latter is provided to me less and less frequently).

As has been noted, the review of the medical records is actually a monumental task, specifically when I am provided with a multitude of records, mostly outside of my area of expertise, such as physical therapy notes. Still, there may be relevant specifications within those notes, which have to be looked at. If I am provided with records, I cannot know what is or is not important until I review them. I have to first go through the records in an attempt to organize them, to see what would or would not be on the list (if such a list is provided to me), and do my best to avoid duplications, where often those are quite numerous. Many times, there are pages missing from reports, as well.
I am aware that the proposals for § 9795 do not necessarily attempt to limit the time I would spend reviewing the medical records; however, when I am preparing the report, the questions relevant to Workers' Compensation (i.e., causation and apportionment) are not questions which only involve a review of the medical records. There has to be an integration of these medical records, comparing and contrasting what each one says with what the injured worker has told me, what I have assessed, and what I have thought about.

IN ORDER TO ANSWER THE QUESTIONS ABOUT THESE COMPLEX CONCEPTS WITH SUBSTANTIAL MEDICAL EVIDENCE WITHIN THE REALM OF REASONABLE MEDICAL PROBABILITY, EXTENSIVE PREPARATION OF THE REPORT IS REQUIRED, WHERE IT IS NEITHER REALISTIC NOR FEASIBLE THAT THAT WOULD BE LIMITED TO THREE HOURS.

In terms of a case related to the psyche, I would need to review deposition(s) as part of my review of the medical records. However, in order to make sense of the deposition(s), I need to have prepared my report such that I can understand where there would be a divergence and/or a convergence of the applicant's testimony with what the applicant had indicated during my examination. Again, one might say the latter is part of the record review. However, ultimately, it plays an important role in the conclusions necessary in terms of causation as well as in terms of apportionment.

I then dictate what the patient has said to me, as I am reviewing my notes and keeping in my head what that patient has said. I have that information transcribed. There are always typographical errors, where there may be words which the transcriptionist could not hear/misunderstood, where editing is needed. It would be necessary to refer back to my notes of the initial examination (or re-evaluation) to make the required changes.

I also would need to look at certain medical records again, and think about how they did or did not conform to what the patient had indicated. There may or may not be relevance in terms of the latter.

As noted, in terms of causation as well as in terms of apportionment, "Other Factors" have essential relevance if one is to provide a report based upon substantial medical evidence within the realm of reasonable medical probability. Medical records very often do offer further information about "Other Factors" which an injured worker has not indicated. **AT THAT POINT, AS NOTED, IT IS COMPLETELY IMPRACTICAL (IF NOT IMPOSSIBLE) TO ATTEMPT TO DEFINE THE MINUTES AND SECONDS THAT I WOULD SPEND LOOKING AGAIN AT A PARTICULAR MEDICAL RECORD, WITH THE AIM OF CATEGORIZING THAT AS REPORT PREPARATION.**

I look at all of the information in my report until this point, with efforts to include that which I learned from the patient in the important categories, where it is necessary to make edits as well. Then I come to my ultimate opinions and conclusions, where, for the most part, I have explained my analysis and why I have been able to make these statements based upon substantial medical evidence within the realm of reasonable medical probability. In and of itself, that part of the report preparation usually requires no less than one hour.

The bottom line is that I need to provide a report of my comprehensive and thorough, usually lengthy, evaluation of an applicant claiming at least one injury to the psyche, which can be used as substantial medical evidence within the realm of reasonable medical probability. Besides spending the time examining the applicant face-to-face, wherein I am not only obtaining information from the injured worker, but also continually assessing how the injured worker tells me what, I need to review medical records. Utilizing my training and experience, I have to consider the two together in order to come to my ultimate opinions and conclusions.

I very much appreciate this opportunity to share my perspective prior to any final decisions/enactment of regulations.

IN ORDER TO BE REALISTIC, I WOULD ONCE AGAIN EMPHASIZE THAT THE PROPOSED LIMITATIONS WOULD PRECLUDE ME FROM PROVIDING A COMPREHENSIVE AND THOROUGH REPORT BASED UPON SUBSTANTIAL MEDICAL EVIDENCE WITHIN THE REALM OF REASONABLE MEDICAL PROBABILITY, AS IS REQUIRED IN THE CONTEXT OF A WORKERS' COMPENSATION EVALUATION IN THE STATE OF CALIFORNIA.

J. Senador, MD May 17, 2018

I want to add my voice to the overwhelming QME Community opposition to the proposed med-legal fee schedule language. Implementing this will result to significant reduction of the already depleted QME pool and will cause deterioration of the quality of reports.

With regard to the "Research issue", I would like to point out that although we are considered to be "expert witnesses", we have to back-up our opinions and suggestions with recent studies to convince adjustors, insurance companies, reviewers, lawyers and providers which are unique to each injured worker.

Please re-consider adopting this language and listen to the input from the QME community.

Dr. Rob Stone May 17, 2018

My name is Dr. Robert Stone and I have been a QME since 1998. I am concerned about the new proposed change including the cap at three hours of report preparation. After 20 years of performing these examinations I know that not all examinations are the same. Considering the importance of these reports and the detail which they must explain opinions, consider referrals, detail records reviewed and be checked for accuracy 3 hours seems unreasonably limiting. Certainly some reports will quite easily be completed within this time frame. But to arbitrarily cap these hours seems more likely to expect examiners to work for free (or less than the hourly paid amount when considering the time it actually takes to complete the report and the three hour cap) as I highly doubt that the DWC will allow us to not complete reports if we are not to be paid for the whole time to prepare them.

If the examiners are not to be believed in regards to their time spent, despite signing an affidavit under penalty of perjury, then instead of capping the hours the DWC should propose newer means by which hours can be recorded. If this is simply another attempt to get the QME process under the control of the insurance industry as they attempted some years ago by underpaying for needed reports then the DWC should stand up and defend the need for QMEs and their right to be paid for their services rendered. Independence is crucial in these reports. Simply to

arbitrarily assign a pre-determined time cap is to expect providers to work for less. The fees have not been raised for a very long time and this appears to be a manner in which to reduce them.

Consider the need for QMEs within the med legal system. and also consider the need to pay these QME's for their time. Unless of course this time cap will be applied to all parties including the attorneys, judges and office staff at the DWC.

In regards to needing two parties for causation this too seems somewhat vexing. If one party decides it is not a disputed issue but the other considers it a disputed issue then there is by definition a disputed issue. Why must we have both parties agree so that it may be used as a complexity factor? If it is disputed and we must comment, but both parties do not agree that it is disputed (consider the conflict of interest for the paying party) then we simply default to not pay for it. It would appear another attempt to underpay for reports.

Overall, these changes proposed are more about reducing costs for the insurance industry than streamlining and improving this medical-legal system. I would hope that the DWC would see this for what it is and allow industrial evaluators to be paid for their time spent. Or admit that ultimately this is about reducing costs and gaining control of this system as they attempted to do years ago when they proposed to return money in exchange for more control over the QME process. But this is not about the injured workers.

I ask that you please deny these proposed changes.

Michael Bronshvag May 17, 2018

About two decades ago, in kinder and gentler times, i suggested a 2-4-6-8 (G) method.
Maybe 3-6-9-12-15 (G) might be timely

3 - for H and P - with DATED NOTES by QME IN BLUE INK
3 - for records vocally reviewed by the QME or blue ink notes
3 - for the extra ton of records,
including those nurses notes that nobody reads
(again, voice record or actual notes in the blue ink the DWC is addicted to)
3 - for research actually read by the QME as wet ink off google, pubmed, up-to-date and printed out. (how many claims people know what the vallecula and the epithalamus are? -- aren't they happy when the QME sends that type of information?)
3 - for a report of ten pages. the QME has to pay for longer reports.

As I tell my co-religionists, war's over -Hitler lost.

Stuart Fischer, MD, FACP, FACC May 17, 2018

I have read more than 200 pages of comments from my AME-QME colleagues concerning the proposed DWC revisions. I could attempt to reiterate their arguments but that would be redundant. We all do not have time to waste.

Simply put, these revisions will not serve the DWC, physicians or the injured workers. These revisions need to be put on hold. The DWC needs to work closely with physicians performing these complex QME's and AME's, to improve the system. These revisions, for all of the excellent arguments expressed by my fellow evaluators, is nothing more than a "dirty band aid" to the system. For those of of us working in this system, trying to evaluate these injured workers, we need more than this band aid.

I urge the DWC to rescind these revisions. Work with your evaluators to simplify, and improve the system. We all have excellent ideas, just read the 200 pages.

Marvin B. Zwerin, DO May 17, 2018

Having served on the IMC and having been an AME & QME for over 30 years, I believe I have some perspective to offer on this issue.

In the past week alone I have received well over 5000 pages of medical records to review on a couple of cases.

I cannot imagine how anyone can review a claim with over 1000 pages of records, do the exam, analyze complex issues and write a report in the time frame being established. It is overtly impossible and as such, imposes an unrealistic expectation and constraint upon those of us dedicated to keeping the W/C system functioning.

Clearly, if these regulations are imposed we will lose more physicians from the dwindling QME pool or discourage new physicians to consider taking the QME exam or serving as QMEs.

Already, it takes months to get into my office for an evaluation. The timeline keeps stretching out as fewer doctors are available for QME appointments.

If the goal is to destroy the medical legal aspect of the W/C system, this proposed rule making will seal the coffin on it.

Please, rethink the obvious. No one wants to work for free. No one can do the work required of us in the time limits imposed.
No one will spend the time required to produce a report that is more than superficial junk if they cannot be paid for their time.

If the DWC staff were told they would work for 8 hours but only be paid for 3, the offices would be empty. Likewise, if the proposed QME rules go into effect it will be the end of quality med-legal reporting.

Raye L. Bellinger, MD, MBA, FACC, FSGC
Sacramento Heart & Vascular Medical Associates

May 17, 2018

The proposed amendments to the Medical-Legal Fee Schedule provide an attempt at reducing the cost of medical legal reports but do very little for quality. In fact, the purpose of such reports is to provide high quality medical writing to help both the injured worker and payor to come to some fair and lasting agreement for care and treatment of work-related injuries. In many cases, the payor disputes the claim and requires a trial. The medical report serves as a basis of substantial evidence for a trial judge to rely on and render binding judgment.

As an internal medicine physician, I deal with increasing complexity of injury with multiple internal medicine problems either as a primary injury or compensable consequence injury. Accurate report writing, report preparation and timely submission are essential to the success of the claim. In fact, if I write my report correctly, thoroughly, using best medical judgment, the claim can be settled expeditiously and save unwarranted appeals.

Unfortunately, gamesmanship by payors has made it increasingly difficult to write complete, accurate reports. One payor's work letters state that causation is not at issue and not to include causation as a factor in billing. However, at deposition, causation is disputed. Medical records have been increasingly difficult to obtain in a timely manner and report preparation is distributed across multiple supplements. According to the proposed amendments, advantage payor.

Medical research is an important factor in patients with complex internal medicine problems. For those of us who evaluate cancer, evaluation and treatment is ever-changing and citing medical research is an important factor in helping both parties understand the injury, apportionment and future medical care. Well-prepared medical research which educates all parties including the trial judge should be encouraged and compensated.

I agree that there are QMEs/AMEs taking advantage of the current fee schedule and writing "boiler plate" reports that have unreasonable report preparation charges and medical research that is not appropriate (common medical problems). Those providers should be thoroughly reviewed

and educated/warned. If compliance continues to be a problem, suspension would be the next step.

I would encourage the DWC to step back and consider the long-term consequences of proposed amendments (decreasing quality, difficulty with recruiting physicians). A more focused approach at targeting quality of report writing and placing less aggressive limits on report preparation/medical research would be appropriate.

Todd Berry, Esq. May 17, 2018
Berry, Smith & Bartell

- 9795- d "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. " If you add that, language should be added to stay: nothing herein though requires a QME to continue w/ a QME that it deems to be unfair, or may create a bias for him/herself.

- 103- (3) Requiring attachment of the materials is a copyright violations. The DWC needs to stop this practice, or at least advice the doctors of this so they can obtain permission for republication. (and on 106)

- 103 (4) (5) this new language "Any complexity factor used as a stand-alone may not be used in combination under this subdivision;" is just heartless.. If a person has a 1 hour f2f and 3 hours of record review, that was what the 104 was designed for, otherwise, what is the point? You will never meet these factors without using these stand alone ones too, so this new requirement is literally a way to prevent an physician from ever getting paid more than $625 while having to do the same amount of work. This is unconscionable, especially as they have not been raised since the inception. This would be like asking you to take on more work, but get paid what you got paid 15 years ago and and you'll never get more. Its absolutely unconscionable. Doctors need to be able to pay their overhead to maintain in this industry and they cannot do that on $625 on every evaluation

- 103 (6) new language : "provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation; Is a complete run-on unintelligible sentence and leads to so many more obscurities.

- What parties? the lawyers? the injured worker who is represented but at the evaluation w/o counsel and has no clue what the heck you're talking about? the carrier's letter? what does this mean!
- When prior to the start of the evaluation? A day before? a second before? a month before?
- which is essential to the adjudication? Isn't this the fact-finder's role?
- What benefits?
- parties agree that the physician may use the causation as a... How is this done? What if one party does not issue a statement? does this need to be in writing? how do the doctors prove this later?

THAT LANGUAGE IS A NIGHTMARE AND OPENS UP A LANDMINE OF LITIGATION. Plus, a little punctuation, goes a long way. Keep it simple. Doctors are NOT LAWYERS. Nor should they have to be, just to answer some medical questions!

- 104 (1)(2) Where did you come up with 3 hour report writing minimum? did you poll 5-7 Orthos, Chiros, Psyches, Pain Management, Neuros, etc to ask how long its takes them on average to do report writing, or did Dr. Meister guess? It makes sense to use the practitioners in the field who are doing these reports.
- 106- report writing 3 hours! Often times the parties don't send records- it could take more than 3 hours alone to dictate and prepare the record review.

Three (3) hours is not enough time for report writing. A large part of the workers' compensation system is working with low wage workers, who are often made up of monolingual speakers who often have little to no education. Their records are often confusing or sometimes inconsistent based on the lack of translators at the various locations. QMEs who are trying to piece this together and make a thorough report and from their interview of the worker alongside of these records, whether they receive them for the initial eval or for supplemental may take hours.

Dr. Aimee V. Sanchez, PhD May 17, 2018
QME in the specialty of Psychology/Clinical Neuropsychology

Please note that I've limited my workers' compensation practice to psychology/neuropsychology QME examinations and reports.

It is quite common for the issues that come to me to be significantly complex. Additionally, these examinations require a large amount of diagnostic testing which is not all computer generated, in addition to the requirement to consolidate the findings and integrate into a summative report.

Often years have passed since the original injury, and as a result, documents are often voluminous. On many occasions, I've spent a day or two just reading documents. In order to report the medical and legal documents that have been considered, as well as to describe the history of injury and relevant personal issues, the report writing alone often requires 8-10 hours, sometimes more.

I believe that the idea of limiting report writing to only three hours is unrealistic with the sorts of cases that are routinely referred to my office. No limit is appropriate in this instance. The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work.

Currently, the number of QME providers in the system has been decreasing, while the number of QME panel requests are increasing. These new regulations will likely push many more highly qualified Physicians to leave the QME process at the expense of the injured worker. This proposal arbitrarily puts a cap on the report preparation process which includes use of research without concern for the quality of each med-legal report. The evaluations are complicated and, similar to federal and state health reimbursement, the decision of how much time is appropriate is best left to the judgment of the Physicians. By trying to limit the report preparation to only three hours. In order for DWC to make an informed decision I believe they need access to real data. Otherwise, I believe the judgment is narrow in scope, and does not allow for the reality that a majority of the cases could not meet this proposed time restriction. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. The causation complexity factor is written in such a way that insurers are given a veto power to pay QMEs for their time. No reasonable physician would agree to work under such conditions.

P.S. QMEs have not received a cost of living/inflation increase since 2006.

James Harvey, Certified Specialist in Workers' Compensation May 17, 2018
By the State Bar of California Board of Legal Specialization

There is a severe and increasing paucity of QME's when compared to 10 or 20 years ago. These proposed regulations will only discourage new QME's, and will encourage existing QME's to quit.

Specifically, a 3 hour maximum for report writing is not practical. Second, expecting advance agreement for a QME to address "causation" is naive. WCAB hearings, time and expense will be needed to get the "agreement" to address causation issues if these regulations are enacted.

Finally, let's wait for the RAND report to finish. RAND should provide impartial, factual data on the current QME crisis.

I strongly urge you not to implement these changes. Thank you.

Medical Legal Experts, Inc. May 17, 2018
Medical-Legal Practice Management Organization

MLE provides administrative support to several dozen Q.M.E.s throughout California. We supply the tools, logistical services, and staffing utilized by successful Q.M.E.s. Our executive team is comprised of medical providers, former insurance adjusters and supervisors, a former disability attorney, and an MBA. We thank DWC for allowing MLE to share our unique stakeholder perspective in this forum.

Although we oppose the current proposed changes to the ML fee schedule, we applaud DWC for taking steps toward reform and for opening this rulemaking dialogue.

Across 200+ pages of commentary, our counterparts have already offered well-reasoned and specific critiques of the proposed regulations. MLE supports the majority of these insightful procedural patches; however, there is much greater need for substantive overhaul. The proposed (and existing) regulations are encumbered by false assumptions, paradoxes, and untenable demands. California's Q.M.E.s, injured workers and employers deserve better.

MLE Executive Recommendations:

- **Create an advisory task force** of QMEs, AMEs, administrative service providers, medical-legal consultants, medical board representatives, academics, subject matter experts, employers, insurance carriers, TPAs, claims examiners, claims supervisors, defense attorneys, applicant attorneys, and other stakeholders.
- **Conduct a comprehensive academic study** to determine actual Q.M.E. norms. Incorporate medical-ethical guidelines and expert testimony regarding best practices in forensic evaluations.
- **Redesign the ML fee schedule with a focus on simplicity, civility, and practicality**. Aim to create a system that won't breed loopholes, abuse, brinksmanship, waste, *pro forma* reporting, or unintended adverse consequences.
- **Replace factorial billing with a two-tiered fee structure** that combines flat rate (per evaluation) with variable (per page) components. Replace the subjective concepts in the existing and proposed rules with increased objective measures.
- **Discipline those responsible for poor regulatory draftsmanship.** As proposed regulations, the *Extraordinary Circumstances Paradox* and the *Causation Catch-22*

contribute to a sense of chaos in the workers' compensation system. All actors should be held accountable for destabilizing activities, including reckless draftsmanship.

- **Be mindful of broader public policy implications:**
  - Economically distressed and minority persons will suffer a disparate impact under the proposed regulations. Since QME work will be increasingly difficult to justify, QMEs will cease driving to underserved rural, poor, and minority communities.
  - Aggressive DWC enforcement of its *malum prohibitum* regulations often prompts unwarranted investigations by medical boards. This added toll on medical board investigators diverts resources from investigations of genuine threats to public health and safety.

Thank you for graciously considering our comments. We look forward to working with DWC to address these critical matters.

Khosrow Tabaddor, MD May 17, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Carol F. Fenner, PhD May 17, 2018

I am a clinical and neuropsychologist who has been a QME since 2008. The idea of capping report prep time to 3 hours for psychiatric cases is simply irrational. Most psychiatric reports are, on average, about 15 pages in length and require much thought with respect to integrating the info from the records, the applicant's narratives, and the psychological test results into the determination of Causation, Diagnoses complete with GAF score, and any Disability parameters. It takes well over an hour to dictate these reports let alone write them.

Perhaps if you wanted to eliminate some of the report requirements you could cap a psych report prep time to 6 - 8 hours. The requirement of writing summaries of the submitted records (very time consuming) could be eliminated. The requirement of writing up an applicant's personal and social history could be eliminated. A psychiatric report needs to be streamlined to accommodate any report prep time under a minimum of 6 hours. Anything less than that without report content changes is just plain ridiculous and uninformed decision making.

James Kinchsular, DPM May 17, 2018

I strongly oppose the newly drafted med-legal fee schedule language. Practitioners will be forced to determine if the increasing burdens and relative declining reimbursements to perform QME are worth it. The compensation model does not adequately or often times fairly account for the actual amount of time, effort, experience and knowledge physicians bring to the QME process. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Anonymous May 17, 2018

The most time consuming aspect is the time spent on reviewing the submitted records. By proposing that there must be at least a quarter hour spent on each of the three factors before the combined six hours could be counted as three factors, you would be forcing QMEs to do a quarter hour of research just to meet this requirement, or you would be forcing more QMEs out of the system all together, or you would be forcing the QMEs to accept a lower rate for records review, because especially on an accepted cases, even if you got 100 pounds of records and spent 50 hours reviewing them, you would still not be able to meet the 104 requirement, without a quarter hour of research. You would only be paid at ML 103.

Almost all carriers would simply say we would pay you what your report qualifies under the ML fee schedule. They would not agree in advance to any particular level of reimbursement. You are living in an alternative universe, if you think they would do so.

Parties do not know how much subpoenaed records would arrive until they arrive at the doctor's office, and often times they arrive a few days before or after the appt. It is again wishful thinking to require parties to know how much records there will be or how much time it would take to review the incoming records.

The new rule to force QMEs to do work without having an agreement first on how much they would be paid, would most certainly set the QMEs up for fees disputes after-the-fact over reimbursements. You are creating more liens and more headaches for QMEs.

If the QME finds a bona fide issue of causation (because she knows a little more medicine than the parties), and the parties said there was no issue of causation, what is the QME to do? Ignore it? Address it and not get paid? Address it and then try to get paid more later?

Finally, have you not done enough to get rid of QMEs in the system? How many do you have left? Why do you think so many left? How many more do you think will leave, once they find out it has become so much more difficult to get paid for their hard work?

If having fewer and fewer QMEs in the system is what you are trying to do, this proposal would do just that.

Wayne M. Whalen, DC, FIACN, FICC
Fellow, International Academy of Chiropractic Neurology
Fellow, International College of Chiropractic
Co-Chair, California Chiropractic Association Workers' Compensation Committee

May 17, 2018

We appreciate the opportunity to comment on the recently proposed regulations regarding the Medical Legal Fee Schedule (MLFS). We represent the California Chiropractic Association, and have more than 30 years of experience each in treating injured workers. We have served as AMEs or QME's since the inception of the program, and are certified by the DWC as continuing education providers for QME re-certification. One of us also served as an expert in the Howard v. DWC matter.

As Doctors of Chiropractic, we have some experience with statutes used as a bludgeon to address a small number of rogue providers which instead punish an entire profession. Fourteen years later, when nearly all stakeholders agree that arbitrary caps on chiropractic treatment are no longer warranted as a consequence of universal utilization review, the chiropractic community still labors under them. We do not wish to see a similar fate befall the QME community. We strongly recommend a more nuanced and measured approach than is evident in these proposed regulations; one in which the stakeholders have a say in crafting the regulations that affect the whole community, not one delivered by fiat which the comments to this forum have clearly denounced for numerous reasons.

We appreciate the opportunity to comment. Proposed changes are in red, our comments in blue and existing language in black.

(3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.

COMMENT:
If there are specific items under the OMFS that are being overused or abused as part of a QME or AME evaluation, the providers involved should be educated and/or disciplined.

The past two years have clearly demonstrated that the division has the means and will to go after outliers. There remains significant ambiguity in the existing language regarding consultations obtained in the course of a medical-legal evaluation, and the proposed language will lead to additional confusion and friction regarding appropriate billing for required services.

§ 9794. Reimbursement of Medical-Legal Expenses.
(b) The fee for each evaluation is calculated by multiplying the relative value by $12.50, 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. 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.

COMMENT: The proposed regulations place evaluators in an untenable position, as many commenters have noted, by requiring physicians to obtain prior agreement which is unlikely if not impossible, and simultaneously require they provide hours of service for which they will likely never be compensated. There are simply too many such occurrences now, even without these regulation changes, and it is not equitable or reasonable to ask experts to accede to these unreimbursed demands on their time.

To that end, we agree with other commenters:

1. **The language regarding ML100 (Missed or late cancelled appointments) needs to be changed to require carriers to reimburse evaluators for their time. We schedule one, two or many more hours for these evaluations and when the patient or an interpreter no-shows, or an evaluation is cancelled with short notice, that time is lost revenue. Good evaluators summarize, organize and review medical records (assuming they are sent timely) in advance of the anticipated evaluation, and is it neither equitable, fair or reasonable to expect the evaluator to absorb costs associated with that activity through no fault of their own when the evaluation cannot go forward.**
2. **The Relative Value (RV) rates for medical legal evaluations must be brought up to date. There has not been an increase in 12 years. Simple inflation would suggest an increase of at least 26%. No other stakeholder in the workers compensation system has been required to absorb 12 years of stagnant reimbursement for the services they provide.**

Labor Code §5307.6 requires the Administrative Director to adopt and revise (emphasis added) a fee schedule for medical-legal expenses …"*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 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."*

We can confidently assure the Division that experts providing "reasonably comparable work" in other medical-legal markets are paid more than the current MLFS. Given the rises in rent and salaries alone, it is difficult to see how the Division is in compliance with Labor Code §5307.6.

Labor Code § 9793 (b)

Current law requires employers to pay for all medical-legal expenses within 60 days. However, QME's and AME's must evaluate the patient, review all records, address all issues required under 8CCR 10606, and serve their report, with proof of service on the parties within 30 days. Carriers however routinely fail to comply, and despite the requirement that they pay penalties and interest, virtually never do, since the Division rarely if ever sanctions them. Some providers make the expensive and time-consuming trip to the WCAB to enforce this, but most don't as the cost rarely justifies the expense. If the evaluator is late or fails to comply in any way, they risk not being paid for their work, or even the loss of their QME status. The Division acts quickly when it comes to auditing and disciplining QMEs for one-off late reports but has turned a blind-eye to carriers systematically employing late payments as a business practice. Many QMEs report receiving admonishments from the DWC for "late reports" when in fact the reports are not late. This occurs because a party who is displeased with the report will incorrectly report it as late to the DWC. In turn, the DWC, without investigating the allegation that the report is late will presume that the lateness is true and send a threatening letter to the QME. In contrast, complaints by QMEs that carriers are not paying penalties and interest on late payments, complete with full documentation of such repeated offenses, are ignored by the DWC. The inequity is staggering.

We suggest Labor Code § 9793 (b) be amended to require carriers to pay within 15 days, which they are currently required to do for more complex treatment bills. It is unclear why the carriers have four times as long to pay medical-legal bills which are ten times simpler.

LIMITING REPORT PREPARATION TO 3 HOURS:

The Division provides no rationale for why this drastic restriction is proposed, and provides no evidence to support a contention that most if not all evaluation reports take less than three hours to complete. While some evaluations might be relatively brief, many reports exceed twenty, fifty or more pages to properly address all the relevant issues. It is simply unreasonable and unrealistic to assume that providers can typically compile,

compose, dictate (or type), edit, finalize and serve reports which constitute "substantial medical evidence" in under 3 hours, and then sign, under penalty of perjury, an attestation that they did indeed spend the time they listed in preparing the report. This is particularly true, as noted by other commenters, for physicians new to this system. We too have talked to new doctors who are embarrassed to list the actual time it took them to write their reports, and we have seen several relinquish their QME's because of it.

This revision seems to imply that the doctors in this system are untruthful, or cannot be trusted to honor their signed attestation that they performed the work they claimed. If the ultimate intent is to dismantle the QME system, or compel ethical and caring physicians to renounce their QME status, this will be the final nail in the coffin.

Frequently there are circumstances which might warrant more than 3 hours of report preparation time for follow up, supplemental and complex evaluation reports, such as when large boxes of records arrive with or without cover letters. Sometimes the issues are numerous and complicated and often the extra time required to produce a report which constitutes substantial medical evidence is not compensated under any of the other complexity factors.

Report preparation time is and should be separately reimbursable from record review, but this proposed regulation demonstrates a complete lack of understanding of the process involved in producing a medical-legal report which will meet the standard of "substantial medical evidence." Once the records have been organized, reviewed and summarized, the physician needs to organize a cogent summary of the physical examination, review tests, articulate a comprehensive diagnosis, address causation, apportionment, an AMA impairment rating, work restrictions, the need for and description of future care consistent with the MTUS, and eligibility for job displacement benefits. And serve the report on all parties. The evaluator needs to ensure their opinions are consistent with all the evidence. These issues require careful consideration of all the evidence available, and setting an arbitrary cap is simply unreasonable and untenable, and as others have noted, will result in substandard reports, or require physicians to provide uncompensated services. Injured workers deserve the best efforts of their evaluators. This regulation will prevent that.

ML103 75 Complex Comprehensive Medical-Legal Evaluation.

Includes evaluations which require three of the complexity factors set forth below. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon~~:

(1) Two or more hours of face-to-face time by the physician with the injured worker;

(2) Two or more hours of record review by the physician. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;

COMMENT: We have no issue with requiring a listing of records reviewed and a brief summary. Most high quality evaluators already do that, assuming they are reasonably compensated for their time. However the last line: (All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;) of this proposal is confusing, poorly worded and unclear. In addition, absent a definition of what is meant by "actually and necessarily incurred" and "uniquely specific to the actual evaluation being performed" it is not possible to provide meaningful comment on these proposed changes. . We recommend removing these unnecessarily vague and ambiguous terms as they do not add to the regulation and will only cause further disputes and litigation when carriers refuse to pay for, or downcode, bills alleging that they do not conform to these vague terms.

(3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;

COMMENT: As worded, this would preclude physicians from using the same or similar research documents in supporting their opinions and conclusions, even though the arguments and fact sets might be very different and almost certainly would be prepared for different WCAB cases. We believe injured workers deserve the best efforts of physicians in every case, and if revisiting a specific set of research documents applies in different cases, the physician should be compensated for reviewing them, though presumably it would take significantly less time on subsequent go-rounds. To arbitrarily preclude any compensation for doing and citing relevant research is simply unreasonable. One can foresee a scenario whether the AME/QME addressed an issue which relies on scientific evidence in case A, having the same or similar diagnostic issues in case B, stating on record to the parties, "I cannot provide the science based criteria in the case at hand because the DWC does NOT ALLOW IT."

This regulation also suggests a lack of understanding regarding the process of obtaining relevant research. Relevant research does not fall like manna from heaven. Just as

attorneys do, evaluators frequently must do a lengthy keyword search , bring up a host of articles, and then sort through them to find relevant citations. The doctor must then typically review the abstracts of those papers, and cull the list to those most relevant. She then has to obtain the full paper (often requiring a fee). Simply reading the research is time consuming.

(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;

COMMENT: SEE BELOW

(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;

COMMENT: Under this revision, in the case where a physician spent, say, 2 hours in face to face time with a patient, and there were no issues of medical causation and no need for research, but the carrier delivers a bankers box full of medical records requiring 10 hours of records review, the QME should be satisfied with reimbursement for an ML 102 at $625, or $52.08 per hour? This is simply unreasonable. The result will be that the work will not be completed, causing further delays.

We suspect that when physicians realize they are being asked to provide high-quality expert medical-legal evaluations which meet the standards of substantial medical evidence, for less than $70 per hour, the era of QME's and AME's in the California workers compensation system will be over very quickly.

Recall that the Division is required to set fees consistent with comparable work. Outside the workers compensation system, experts are compensated typically on an hourly rate, typically in excess of $350 or more per hour. QME's and AME's deserve no less, and already attest to the time actually spent under penalty of perjury. If the Division's intent is to remove doctors who are gaming the system, do that. Don't punish the rest of us who are trying to do our job. If a doctor spends four hours or six hours performing the work necessary to produce a ratable report, the doctor should be paid for it. Having doctors jump through all these unnecessary hoops adds nothing but friction to the system.

(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the

claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

COMMENT: As a number of others have already pointed out, this requirement is unreasonable, unworkable and unnecessary. We frequently have difficulty in getting even one party to provide a cover letter outlining the issues in dispute prior to the evaluation, and there are no legal requirements for them to do so in any event. This change will simply ensure that the issue of medical causation Is not used as a complexity factor, because the carriers have no incentive to do so, and there are no consequences for either or both parties failing to respond to the evaluator's request. Since causation is frequently a threshold issue, this regulation change further punishes injured workers in the system. In addition, it simply adds another uncompensated burden on the evaluator and his staff to try to get a carrier or attorney to return a call or answer a fax. It doesn't happen now, and this requirement will do nothing to address that reality as it will impact the injured worker's entitlement to benefits.

Another issue is that not infrequently a bona fide issue of causation arises during the course of an evaluation which the examiner might need to address. Commonly, there is no way to discover this prior to the evaluation. Are we to simply ignore it if we have no prior authorization by both parties?

Alternatively, the burden should be placed on the parties: absent a specific directive that causation is not to be addressed, the evaluator must assume it should be.

(7) Addressing the issue of apportionment, when items (A) and (B) below both apply:
(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injuryies to the same body system or body region as delineated in the chapter headings of the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more or more dates of injuryies involving two or more body systems or body regions as delineated in that Table of Contents. ~~The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.~~

(B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.

COMMENT: This regulation should be completely gutted and reworded. Physicians in other venues (IME work for example) rarely have to address apportionment, and when they do, they are compensated for their time in doing so. If there is more than one injury to a body part, or multiple body parts, apportionment should be a complexity factor. As

worded, this portion of the fee schedule is so complex and convoluted, it all but guarantees disputes every time it is invoked.

There is presently no regulatory or labor code mandate that the patient needs to be MMI/P&S to be paid to address apportionment when it is required. There are times when an evaluator must provide an impairment rating and provide apportionment to that impairment when a patient is not MMI/P&S, and there is no valid reason to not pay the doctor for the extra complexity related to these services because of patient status.
A common example of this is when one or both attorneys request that the evaluator provide an impairment rating and apportionment, prior to the patient becoming MMI or P&S, such as when a patient wants to settle the case by C&R for a number of reasons, such as illness in the family or a desire to return to their home country. Clearly, paying the evaluator for these services in such circumstances is reasonable, proper and equitable.

ML 105
The fee schedule should be clarified to address that expert deponents are entitled to reimbursement for the time it takes them to review and sign their depositions.

ML 106 …
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.

COMMENT: We have previously addressed our issues with the limitations regarding report preparation time. The limitation of billing a maximum of two hours of medical research is arbitrary, capricious and not based on any sound evidence, as discussed above. Precluding a physician from billing for medical research previously used in a report on another patient a year ago does not mean the physician doesn't need to spend the required time to again find the research, ensure the facts of the current case are relevant and related to the research, and that the research is germane and necessary to support an opinion as substantial medical evidence. This regulatory proposal appears intended simply to reduce costs to the carriers at the expense of providing comprehensive reports that will be considered substantial medical evidence.

A more reasoned and reasonable approach would be to simply require that the physician articulate why the research was necessary to address a specific disputed issue. Carriers would be free to challenge that assertion based on bill review, and the burden would be on the physician to support his or her entitlement to that billing.

Thank you for the opportunity to comment. We welcome a chance to work with the Division to refine and improve the MLFS regulations.

Stephen E. Francis, Ph.D. May 17, 2018

My name is Stephen E. Francis, Ph.D. I am a pain psychologist and a neuropsychologist. I have been a QME since 2007. I have read the over 200 comments and others have made some excellent points and well articulated them. I agree with my colleagues who have left comments already. If the DWC is reading these comments, you may have noticed that no one has chimed in stating 'What a great idea!" There is a reason for this. These proposed changes represent one more attempt by those at the DWC and the insurance companies who want to eliminate the QME system for handling cases of industrial injuries. And in effect, the DWC if they pass these changes will force very good doctors to leave the system. Like my colleagues, I take being a QME very seriously. Often, these are complicated cases, with multiple injuries. As a psychologist and neuropsychologist, I need to take a detailed history. We all do, regardless of our specialty. As a note the erstwhile AD Christine Baker eliminated the specialty of Neuropsychology several years ago and two attempts to appeal to Gov. Brown failed.

NO ONE can get a report dictated and proofed in three hours. As a psychologist, I certainly can't. Case law has evolved and if I am to consider Almarez/Guzman and Escobedo, it takes me much longer than three hours. Limiting report writing to three hours is a misguided attempt to control costs coming at the expense of a well authored report and at the expense of the injured worker whose life hangs in the balance of a med-legal opinion.

As doctors, we have been taught since our earliest education and training to back up our opinions with research. There are seminal papers in every field. The DWC may accuse me of using boilerplate, but every time I see an electrical injury, I cite the same two papers by the leading expert in the neuropsychological sequelae of electrical injuries. To state that I can only cite that paper once per year is ludicrous.

Snow at the beach is more probable than getting opposing counsels to agree on causation. Once more an attempt by the DWC to employ what they tried to do last year with their underground regulations.

In sum, the proposed changes if passed as they are now written, the DWC will achieve their intent of destroying the current QME system, forcing excellent doctors who have been QMEs for years and understand the relevant case law to resign. Fewer new doctors will apply for QME appointment.

And injured workers will suffer. A semi-veiled attempt to misguidedly control costs will backfire and become one more mess. California leads the country by example in a number of areas. Please stop trying to make this system worse and make it a national example.

M. Geiger MD May 17, 2018

The proposed Med Legal regulatory change limiting physicians to 3 hours of report preparation time is completely unjust. Many Med-Legal evaluations are extremely complex, involving multiple body parts (sometimes a dozen body parts) with multiple injuries industrial and non-industrial, spanning a lifetime, often with huge boxes of records. Sometimes the medical records do not correlate with the history provided by the injured worker. Sometimes different treating doctors provided conflicting information. It is absurd to penalize physicians assigned complex cases some of which require enormous amounts of time beyond review of records to be reimbursed for only 3 hours of works.

Absolutely no one is fooled by the proposed changes that essentially eliminates reimbursement for time spent on complex cases or for discussing causation, which a QME is compelled to do in order to consider issues of apportionment.

Gloria Von Dolson May 17, 2018

The proposed changes are impractical and unworkable. Please don't try to change the existing law in this way. If changes are necessary, it would be much better to adopt the flat rate and per page reviewed payment plan proposed by Steve Ounjian **[Comments are contained in this document].** He manages California Medical Legal Specialists out of Fresno and has proposed an excellent solution

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Sohail Ahmad May 17, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

John Santaniello May 17, 2018

As a QME I am against the proposed med-legal fee schedule changes. These proposed changes will cause a diminution in the availability and quality of the med-legal system. When fees are cut service is diminished whether it applies to running a hotel, restaurant or the med-legal system.

Gordon Engel, MD May 17, 2018

I strongly oppose the new reimbursement fee language. I am a new QME and doing evaluations because I am retired and enjoy patient contact despite my own medical disabilities. Dealing with more complexities and time at a computer may be all it takes to drive me away from doing this work.

Please listen to the docs in the trenches before implementing changes to "fix" things. Remember, simpler is usually wiser.

Traci Hinden, Esq. May 17, 2018

I thought of another reason why 3 hours is not enough for putting together report writing. A large part of the workers' compensation system is working with low wage workers, who are often made up of monolingual speakers who often have little to no education. Their records are often confusing or sometimes inconsistent based on the lack of translators at the various locations. QMEs who are trying to piece this together and make a thorough report and from their interview of the worker alongside of these records, whether they receive them for the initial eval or for supplemental may take hours.

I have represented monolingual, little, to no educated workers my entire career of 13 years. I started as an Applicant's attorney and was representing them as hearing representative in my father's office for 2 years before that. I am fluent in Spanish. I often found interpreters paraphrasing at deposition or translating improperly and had to stop depositions because of it. At medical facilities, the physicians often use their staff who are not trained properly. In my office, anyone who is hired to do interpretation, goes through a series of tests to ensure their Spanish language skills are up to snuff and we provide a dictionary our certified translator recommended. I am an anomaly. I also worked as a Defense attorney for a year, so in addition to defending 100s of depositions of these workers, i deposed many, who are often further confused by the records where their timelines are askew. In my civil practice, more than 60% of my clientele is monolingual Spanish speakers or other monolingual speakers, wading through their records and creating timelines takes a really long time, more than for our more educated, English speakers. Putting a cap on report writing severely will impact this community. Today, in my practice and for the last 3 years, when any of my monolingual speakers are deposed- i hire a "check" interpreter and EVERY deposition, my interpreter has had to correct the Defense hired deposition. I beg you not to do this as this may be seen as discriminatorily in effect toward those workers.

Jeffrey Keith Bridges, PhD, QME May 17, 2018
Psychologist

I fully understand the DWC frustrations with QME evaluators who have misappropriated and abused portions of the complexity codes for ML-103 and ML-104. Certainly I have seen examples of QME reports that regurgitated the same research/bibliography templates over and over, charging the full two hours of medical research complexity each time. As a Primary Treating Physician, I have spoken to patients who have affirmed that their QME physician charged for over two hours interview (in order to nab that complexity stipulation) without any face-to-face contact more than 45 minutes.

Unfortunately, the DWC has expanded the scope of amended proposals to the Medical Legal fee schedule such that they are now punitive, arbitrary, poorly conceived, and riddled with oversights that will impede effective QME reports into the indefinite future. This demeans the office of the DWC to capriciously punish all QMEs for a fraction of a small percentage. It does

claims adjusters no service to try to force fee restrictions to be incorporated through onerous complexity stipulations that will forestall and prohibit many QME evaluations from going forward at all.

(3) Two or more hours of medical research by the physician, using 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 this complexity factor.

What if a QME reuses research sources from a prior medical report (within the last 12 months), but also adds 50% more sources that are appropriate to the body part being evaluated? Would any research complexity hours be allowed in that case?

(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injury~~ies~~ to the same body system or body region

For psychological and psychiatric QME reports, apportionment of PD may flow from pre-existing childhood trauma, pre-existing personality traits, and concurrent emotional losses, none of which have a clear date of injury. Psychiatric apportionment in these situations is no less complex. However, under the current proposed DWC rewrite, I would not be able to utilize apportionment as one of the complexity factors merely because I could not assign a date to each injury.

Please remember that *Escobedo v. Marshalls (70 CCC 604)* requires physicians to "determine what percentage of the permanent disability was directly caused by the industrial injury and what percentage was caused by other factors". Further, *Escobedo* requires QMEs, when addressing apportionment, "may include not only disability that could have been apportioned prior to SB 899, but also may include disability that formally could not have been apportioned (e.g. pathology, asymptomatic prior conditions, and retroactive prophylactic work preclusions), provided that there is substantial medical evidence that these other factors have caused permanent disability". Therefore, to successfully present a logical apportionment analysis with substantial medical evidence, significant time must be allotted to each apportioned factor, regardless of whether a date of injury can be established. This is common within psychiatric and psychological QME reports, even when the only injury filed is for psyche.

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;

The DWC is proposing to stipulate that any ML-104 Medical-Legal report is limited to only three hours of billed time for report preparation. Please remember that psychologists and psychiatrists must not only provide for substantial medical evidence to support apportionment analysis under Labor Code Sections 4663 and 4664, but also provide for substantial medical

evidence to support apportionment percentages as required under *Escobedo*. Additionally, as Dr. Julie Armstrong, PhD, has stated earlier in her comments, every QME evaluation addressing alleged injury to the psyche must follow the complex guidelines provided under Title 8, CCR, Section 43, in order to be considered substantial medical evidence and a complete report. Unless psychological and psychiatric QME/AME reports are excluded from the three hour preparation limitation, I doubt that any QMEs will continue providing them. Virtually all of my initial or final evaluations (when records are provided for review) have been approximately 30 pages or more and require six hours of report preparation or more. It is with good reason that legislature has allowed for psychiatric or psychological QME reports to carry their own complexity code by virtue of their difficulty when providing a report that meets all components for substantial medical evidence.

(6) Addressing and providing an analysis of the issue of medical causation, ~~upon written request of the party or parties requesting the report~~ provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

Allowing causation as a complexity factor should be permitted if only one of the requesting parties stipulates. Both parties are not required to pre-agree on a request for supplemental report. Why should both parties be required to pre-agree (before the start of evaluation) for causation to be accepted as a complexity factor. Even if defense has agreed that they accept an industrial injury to the psyche, addressing the percentage of causation under Labor Code Section 3208.3 is often requested by at least one of the requesting parties. Providing AOE/COE percentage of causation under Labor Code Section 3208.3 is usually complex, requiring substantial time and it is an automatic requirement of each psychological/psychiatric QME report. Addressing the issue of causation, because of its complexity within a psychological/psychiatric QME report, must be automatically allowed as a complexity code because of the additional threshold requirements that we have to address within Labor Code Section 3208.3.

Jeffrey M. Stern
Mallery & Stern

May 17, 2018

I am concerned with the availability of a sufficient number of QMEs and believe that these regulations will result in many QMEs leaving the system. It will also further disincentivize new physicians from entering the system eventually resulting in substantially fewer available physicians in total. Applicants already deal with onerous delays and fewer QMEs in the system will only amplify these problems.

In addition, capping the number of hours for a report will result in useless reports as the reports will be unable to address all of the issues and the doctors will not be able to perform complete

record reviews thus rendering the reports not substantial medical evidence. This will further harm California's most injured workers as many times their cases are the most complex and require significant time for the doctors to fully understand the complete history including record review.

In the end, these new regulations will increase litigation and further delay the expeditious delivery of benefits guaranteed by California's constitution. I oppose these changes as they will result in a decrease in available QMEs, reduce the quality of the reporting, cause further delays thus directly harming injured workers.

Antonia Madrid, PhD May 17, 2018
Qualified Medical Examiner

There is a proposal to limit the amount of time a QME can charge for report preparation. As a psychologist, for all patient (not just work comp patients), I typically spend 8-10 hours writing up a report. To spend less time would be unprofessional, let alone incompetent. We cannot be expected to treat injured workers in a fashion that is considerably below the standard of care.

I opposed the proposed change in regulation for professional and ethical reasons.

James. T. Platto, MPH DC QME May 17, 2018

By way of introduction, please note that I have been serving as a QME since 1991 and I have been a DWC-Medical Unit approved educational provider for both Report Writing and QME continuing education since 2000, as well as having taught the Industrial Disability Evaluator Certification Program from 2000 through 2006. In this role, and as a long standing QME myself, I have performed countless QME evaluations over the years and have, as I am able to, responded to endless and on-going questions and inquiries from QMEs in all disciplines and specialties in California regarding everything from routine questions regarding process to otherwise complex and often frustrating issues involving a wide range of subjects from med-legal billing problems to case complexity questions.

As a result, 27 years of experience as both an evaluator and an educator has allowed me to observe a significant array of functional problems with the QME system, especially with regard to the remuneration QMEs receive in exchange for their intended role to analyze claims and to provide medically reasonable resolution to the frequent disputes that arise between the parties. In theory, this approach certainly makes sense and, for the most part, QMEs have done an excellent job in providing analyses in their medical-legal reports that are both admissible and that meet the standard of evidence to help the parties and judges to resolve such disputes on a rational and well founded basis.

Unfortunately, as the years have gone by, (while claims administrators continue to raise their premium rates to employers as the cost of business continues to rise), it has been many years since QMEs have experienced any increase, or even an adequate COLA increase, for their highly specialized and analytical work as medical-legal evaluators. Furthermore, given the currently 'proposed fee schedule regulation changes', there is little doubt that QMEs will find remuneration even more restricted and limiting. As a result, and as the DWC has already experienced in recent years, more and more QMEs are dropping out of the system and fewer and fewer physicians are applying to take the State's 'QME Test' to become a QME; because it is becoming increasingly clear that the remuneration for the QME's time invested in the evaluation process is unrealistically low…if not punitive…while the QME's legal accountability and the potential for inadvertent violation of the rules and regulations that are often not adequately communicated to the QME continue to expand.

Therefore, the DWC should clearly understand that the 'proposed' changes to the medical-legal fee schedule will only serve to further exacerbate the current trend of dwindling QME numbers and availability…which will only serve to further frustrate the system intended to resolve dispute resolution and therefore increase the frustration of claimants, the legal representatives and claims administrators involved, as well as the courts, which will not even allow a case for dispute resolution to be heard until a comprehensive medical-legal (QME) evaluation and report has been obtained.

The following are comments regarding the proposed rule changes and advised wording where applicable:

9794

(1) The primary flaw in the proposed language is as follows:

Who will determine if the complaints and findings warrant diagnostic testing?

Given this lack of specificity in the proposed language, will referrals by evaluators now be subject to the RFA process and to the UR and IMR processes? And, if this is true, how can this be reconciled with existing law that already allows…if not compels…the evaluator to refer out for medically necessary testing and consultation, which is NOT treatment and therefore not subject to the RFA, UR or IMR process, per CCR993(h), CCR9794(a)(1), LC4620, LC4622, and QME Regulation 32?

Advised Wording

Whenever the medical-legal evaluator determines that referral for diagnostic testing and/or consultations is medically reasonable and necessary for the resolution of disputed issues, the evaluator shall make arrangement for such referral through the Appointment Notification Form process to the claimant and parties; and the appointment shall be made no sooner than 15 days (unless

warranted by a medical emergency) in order to give the parties 14 days to object to the medical reasonableness and necessity of the referral(s).

(b) The problem with LC4622 is not the legal mandate stipulated. The problem is the repetitive and almost consistent failure of claims administrators to provide written objection consistent with the LC4622 mandate to clearly specify why a medical-legal bill is being disallowed in whole or in part. The majority of insurance carriers simply send an EOB to the evaluator rejecting payment, which wholly and summarily violates the directive under LC4622 regarding specificity of such objection under LC4603.3, which is referenced as the standard for objection in LC4622.

Advised Wording
A subsection to LC4622, or 'rule change', should clearly state that if the claims administrator is in violation of the standard for payment or objection to same as as stipulated in LC4622, payment of the medical-legal expense shall be made to the evaluator in no less than 15 days from the date that the claims administrator receives the evaluator's 'Request For Second Bill Review' if the claims administrator persists in withholding payment of the medical-legal expense.

* This proposed wording would not violate the claims administrator's right to file either a petition or declaration of readiness with the WCAB if specific objection consistent with the directive of LC4622 and LC4603.3 had been made timely.

9795
The proposed language regarding pre-evaluation written agreement by the parties and prohibition of the evaluator to condition performance of the evaluation prior to written agreement by the parties is wholly unrealistic and should be eliminated. The reason for this is simply that there is no statutory or regulatory mandate that requires the parties, (i.e., the claims administrator or the attorneys), to issue pre-evaluation letters of instruction that actually states/specifies what medical fact or facts are in dispute that necessitated the medical-legal evaluation. The proposed language places an undo and completely unrealistic burden on the evaluator with no recourse and no legal mandate that compels the parties to state what is in dispute pre-evaluation or to even respond to a written request from the evaluator to clarify what issue(s) are in dispute. Therefore, logistically, it would be virtually impossible for the evaluator to obtain such pre-evaluation agreement from the parties.

Advised Wording
Upon selection of a QME (or AME) for a medical-legal evaluation to resolve disputes between the parties, the claims administrator or its legal counsel and, if represented, the legal counsel for the claimant, shall provide a pre-evaluation letter of instruction to the evaluator that clearly delineates and defines what medical fact or facts are being disputed that necessitated the evaluation; and

this pre-evaluation letter of instruction shall be provided to the evaluator in no less than 14 days prior to the scheduled evaluation.

ML 101

The proposal to limit, or cap, report preparation time to 3 hours should be eliminated. The proposed language places a 'one size fits all' criteria on the re-evaluation process, irrespective of the complexity of the case and/or the volume of medical records that may be involved. It is not uncommon for an evaluator, prior to performing a re-evaluation of a claimant, to receive a significant volume of records that may represent records not previously provided or available, as well as new records generated since the last most recent evaluation that was performed. It is also critical to remember that all claims/cases are different, with some being significantly more complex than others. Such obvious variability should not and cannot be pre-determined monolithically by a pre-determined cap on report preparation time. At some point in the medical-legal evaluation process, the parties must defer to the medical judgment of the evaluator, (i.e., the medical expert), regarding the complexity of the case. This can be especially true in a primary psychological injury.

It must also be remembered that if a significant volume of records must be reviewed, the requirement for the evaluator to summarize such records will obviously translate into significantly increased report preparation time, which if not done would be a violation.

If the claims administrator or its legal counsel should object to the evaluator's claimed report preparation time, the protocols are already in place under LC4622 for objection to the medical-legal bill. Therefore there is no compelling necessity to place a 3 hour cap on report preparation time.

ML 103

The new proposed introductory language to ML 103 is obviously intended to underpin the proposed limitations on using causation as a billing complexity factor. (See comments on *causation* item (6) below.)

(3) The proposed language here is obviously intended to prevent the perceived practice of evaluator's 'cutting & pasting' the same research repetitively. While there is no objection to requiring the evaluator to cite the research used and to append same to the medical-legal report, it should be realized (depending upon the evaluator's specialty) that the claims administrator/defense routinely cont-tend that certain pre-existing conditions or pathologies should be apportioned to. Given this situation, evaluator's must repetitively defend their decision to apportion or not to apportion based upon the findings of appropriate and ap-lacable research. Therefore, there can be and will be repeated instances when evaluators must provide research and an explanation of same as to why or why not a pre-existing condition, (e.g., diabetic neuropathy), should or should not be apportioned to in a particular industrial injury claim that has resulted in perma nent impairment.

Therefore this language should be removed, as the claims administrator/defense always has the option and protocols in place to object to the evaluator's use of a particular piece of research as a billing complexity factor under LC4622.

(5) The problem with this proposed language regarding 'portion of time' spent in each time-based complexity factor, (i.e., face-to-face, records review, and research), is that 'portion of time' is not defined. In this regard, because evaluators/QMEs have traditionally tracked their time by quarter hours, this proposed rule language should be changed to the following:

Advised Wording
Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that no less than 15 minutes has been spent in the review or records and/or in doing medical research, as long as the time spent in face-to-face with the claimant has met the minimum time requirement standard for musculoskeletal evaluation (20 minutes), psychological evaluation (60 minutes) and all other specialties (30 minutes).

(6) The proposed language regarding *causation* as a complexity factor fails to recognize that neither CCR10606 or LC4628 requires the evaluator to address causation, (i.e., cause of the injury). The proposed language also fails to note that if an evaluator does address causation, it is because the evaluator received a written letter of instruction from a party requesting that it be addressed, which the evaluator is then legally obligated to address. Therefore, while the evaluator has the legal obligation to address causation because one party to the case has requested it in writing, the evaluator cannot use causation as a billing complexity factor simply because the other party did not also request it prior to the evaluation. This proposed language therefore places an undue burden and irresolvable conflict on the evaluator…again because pre-evaluation letters from the parties that stipulate the dispute(s) involved are not required.

If the evaluator is asked by one party to address causation, the evaluator now becomes the arbiter for determining what "is essential to the adjudication of the claim for benefits". This role and the request to address causation become no less important and no less critical because only one party to the case requested causation to be addressed. And, obviously, one party may well have a financial interest on behalf of its client to simply not ask this question. Therefore, under the proposed language, if the evaluator is asked to address causation by only one party, the evaluator now has the legal obligation to address causation without the ability to count causation as a billing complexity factor, which makes no sense whatsoever.

And, again, the proposed pre-evaluation written agreement proposal regarding causation is not supported by any code or regulation that requires the parties to specify and disclose to the evaluator before the evaluation what medical fact or facts are in dispute. Therefore, inappropriately, it falls on the evaluator…who may not even know causation is at issue before the evaluation…to seek pre-evaluation agreement that causation be addressed. Obviously this makes no sense whatsoever and essentially means that the proposed pre-evaluation agreement standard for using causation as a billing complexity factor will never be met.

Typically, most pre-evaluation letters of instruction from the parties pose this question: 'Doctor, is the claimed injury (and/or body parts) consistent with the biomechanics of the injury?' Again, the evaluator must now address causation based upon the question, but the evaluator is unable to meet the complexity factor billing standard for causation because there was no specific request to address 'causation'.

Furthermore, the parties do not currently comment on whether or not the QME is allowed to use various complexity factors for billing purposes, as they are not required to do so and the applicant's legal counsel has neither the specific fee schedule knowledge nor motivation to do so on behalf of their client, which leaves only the claims administrator and its legal counsel whose vested financial interest is to limit or reduce expenditures to the extent allowed by law.

Therefore the language for causation to be used as a billing complexity factor should read:

Advised Wording
If one or both parties request in writing that causation be addressed or if one or both parties asks in writing if the mechanism of injury is consistent with the claimed injury or if the evaluator discovers a bona fide issue of causation in the evaluation.

ML104
The only problem with the proposed rule change to ML 104 is the same as described above under ML 101, as follows:

The proposal to limit, or cap, report preparation time to 3 hours should be eliminated. The proposed language places a 'one size fits all' criteria on the evaluation process, irrespective of the complexity of the case and/or the volume of medical records that may be involved. It is not uncommon for an evaluator, prior to performing an evaluation of a claimant, to receive a significant volume of records. It is also critical to remember that all claims/cases are different, with some being significantly more complex than others. Such obvious variability should not

and cannot be pre-determined monolithically by a pre-determined cap on report preparation time. At some point in the medical-legal evaluation process, the parties must defer to the medical judgment of the evaluator, (i.e., the medical expert), regarding the complexity of the case. This can be especially true in a primary psychological injury.

It must also be remembered that if a significant volume of records must be reviewed, the requirement for the evaluator to summarize such records will obviously translate into significantly increased report preparation time.

If the claims administrator or its legal counsel should object to the evaluator's claimed report preparation time, the protocols are already in place under LC4622 for objection to the medical-legal bill. Therefore there is no compelling necessity to place a 3 hour cap on report preparation time.

ML106

It is completely unacceptable to place a 3 hour cap on supplemental report preparation time for essentially the same reasons stated above under ML 101 and ML 104. Furthermore, and importantly, it should be remembered that ML 106 supplement reports have no pre-defined content. Request for a supplemental report from a party can range from simple clarifications to requests to review large volumes of additional records and reconsideration of opinions and conclusions on any or all of the issue previously reported on. There are only 2 time elements that determine the billing for an ML 106 supplemental report: (1) The evaluator's time spent in reviewing records (if any are provided) and (2) the evaluator's time spent in preparing the supplemental report. Depending upon the nature of the request and/or the volume of records (if any) sent for review, a supplemental report can take an hour or less to write or can require a substantial number of hours to complete above and beyond 3 hours.

Again, if the claims administrator/defense objects to the appropriateness of the ML 106 supplemental report billing, protocols are already in place under LC4622 for objection.

Lastly, it must always be remembered that the claims administrator, which controls the remuneration purse strings for the payment of medical-legal expenses, is NOT a neutral arbiter. The insurance carrier has an obvious vested financial interested in paying out as little as possible to both the claimant and to the medical-legal evaluator/QME. Yet critical decisions involving such payments are left to the discretion of the claims administrator, whose judgment on such matters can only be challenged after-the-fact following many weeks, if not months, of bureaucratic protocols. Unlike the evaluator, who must sign a disclaimer on every report that he or she has no financial conflict of interest involved in the case/claim being evaluated, the claims administrator has no such conflict of interest disclaimer requirement despite its obvious financial vested interest.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

Karen L. Wrubel, DPM, FACFAS May 17, 2018

I am writing in opposition to the proposed changes to the Medical-Legal fee Schedule.

I am a board certified podiatric physician with over 30 years of experience in private practice. I only began work as a QME a little over two years ago, and perform 2-3 evaluations per month; a very small part of my practice. My decision to add this work to my practice was based on learning that the QME process was created to improve and speed adjudication of cases for the benefit of injured workers. This process was born of the need to bring careful, high quality, comprehensive evaluations and reports, qualifying as substantial medical evidence, to adjudicating judges.

In two years, I have not had any question from insurer bill reviewers about my fees brought to my attention. I have spoken with dozens of QMEs who have reported the same thing. Certainly the current bill review process exists for exactly the reason of curbing unreasonable fees. If indeed a generalized problem exists, it has been unproven and even unstated by the stakeholders, except of course, the DWC.

This proposed change to the Medical-Legal Fee Schedule appears to be a solution in search of a problem; and a draconian one at that. It is clear the intent is to limit the evaluations to a lower level to decrease the QME cost. However this would also decrease the quality of the evaluation and report and result in longer adjudication times, more litigation and less benefit for the worker who should be at the center of this process.

These changes if implemented would surely decrease the number of doctors performing QME exams, making it more difficult for injured workers to find an appropriate specialist. The proposed changes require the doctor to spend more time justifying his or her work and would pay for less time, at a cap of three hours of report preparation. It is impossible, in my experience, to achieve both a quality report and a drastic discount in the fees paid.

Similarly to many other doctors, I often receive 1000 pages or more of records to review, and often the day prior to the exam which has been scheduled for more than 6 weeks. Many times I receive additional records weeks after the in-person evaluation. The idea that I would always receive agreement to a level of service or a specific medical fact from all parties in advance is highly unrealistic.

Both high quality and reasonable cost are achieved by the current process. No evidence to the contrary has been provided. The recommendations by the DWC, while perhaps offering a short term savings, would soon result in poor quality and would upend the intent of the legislature in creating the current process, ultimately abdicating the legislature's responsibility to the injured worker.

Ashton Wolfson May 17, 2018
QME Office Manager

- The proposed interpretations by the DWC serves no other purpose other than limiting a QMEs ability to do his job and bill for his work. The interpretation does not meet the standard of real world QME conditions. The result would lead to QME reports with incomplete information, which would to lead to more litigation on more cases

- The proposed modifications would further complicate an already complicated and over regulated QME work flow. The result would lead to QMEs dropping out of the QME program

- The proposed DWC CAUSATION modification would also lead to incomplete reports that would prolong the workers comp process for both TPAs and injured workers. The result would lead to increased costs.

- The reality is the proposed changes will further increase costs, waiting times, and include QME reports that have poor or incomplete information . The end results speak for themselves.

- If all the proposed DWC changes are passed I can say with certainty there will not be enough QMEs to accommodate the large demand of evaluations in the future. Many QMEs will drop out of the program and No Future QMEs will want to work under the DWC's proposed conditions. The result will be longer waiting times for appointments for injured workers, more TTD for Claim Administrators, more costly litigated cases. If DWC feels theyre helping reduce costs in the Work Comp system by these changes, theyre very mistaken

- if all these proposed changes are implemented in their current form, the five QMEs that my company manages will most likely dropout out of the California QME program. The result will be five more QMEs dropping out of the system and longer waiting times for more injured workers

- If the DWC's proposed changes are passed there will be a mass exodus of QME s and their providers exiting the system. The results will lead to more doctors and providers leaving the system, leaving injured workers stuck in an already flawed system
- Efforts should be made to streamline and simplify the QME workflow ie. Electronic submissions of reports...Not further complicate the process with senseless regulations

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Anonymous May 17, 2018

I oppose the newly drafted medical legal fee schedule language. It will adversely impact the pool of QME's and the quality of reporting. Please reconsider the language used and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy. Thank you for your time and consideration.

Alexis Link, MD, Co-Director & CEO May 17, 2018
Patrick Link, MD, MPH, Co-Director & CFO

Our company provides management services for physicians who conduct psychiatric medical-legal evaluations in the California workers' compensation system. We currently serve six psychiatrists, including the two company owners. This letter serves as our company's response to the proposed changes to 8 CCR § 9795(c) published on the online DWC Rulemaking Forums on May 3, 2018.

Report writing hours: DWC has proposed to limit billable report writing hours to three (3) hours under the following circumstances:

- ML101 billing code used;
- ML106 billing code used;
- ML104 billing code used because at least four of the complexity factors applied;
- ML104 billing code used because there were prior multiple injuries to the same body part(s) being evaluated and at least three complexity factors applied.

The three-hour limit was not proposed for the following circumstance:

- ML104 billing code used because the physician and the parties agreed, prior to the start of the evaluation, that the evaluation involved extraordinary circumstances.

While we commend DWC for not placing hourly limits on other billable activities, the three-hour limit on report writing devalues this critical activity. The greatest benefit of the medical-legal evaluator to the workers' compensation system is his or her ability to articulate, in precise and concise language, a clear formulation of the clinical and medical-legal aspects of each case. In our experience, imprecise language in medical-legal reports is one of the main reasons cases are unnecessarily prolonged. Confusion created by imprecise language leads to unnecessary depositions and the unnecessary involvement of other consultants.

Many of our physicians are highly experienced medical-legal evaluators who are frequently selected from panels because of their clear writing and accurate, thoughtful analyses. They only rarely complete a report in three hours or less. They are unlikely to become more efficient in their report writing because they are already very experienced, and they are unwilling to submit reports that have not adequately and correctly addressed the clinical and medical-legal aspects of a case.

Their time is valuable, and having it be uncompensated may disincentivize them to participate in the workers' compensation system. Instead, the system is likely to draw to it physicians who are willing to write reports in a rapid and sloppy manner, potentially leading to system delays and poorer outcomes for injured workers.

Barriers to the use of the medical causation complexity factor: DWC has proposed to only allow the medical causation complexity factor to be used when "the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation."

Eight-five (85) times since mid-2017, our company has attempted to obtain, in advance of evaluations, exactly this kind of agreement from the parties to our medical-legal evaluations. We have obtained a response from the applicant's attorney 11 times (13% success rate) and from the defense attorney 21 times (25% success rate). We have obtained a response from both parties to a case only 4 times (5% success rate). Both types of attorney have been reluctant to respond for several reasons, including that they are unfamiliar with the medical-legal billing regulations and are typically uninvolved in billing and payments for medical-legal evaluations. Defense attorneys have often deferred to the claims adjusters, and applicant attorneys have often deferred to the defense attorneys, even when we receive a response. Applicant attorneys have been particularly reluctant to respond, perceiving that it is not their role to tell the defense how much to pay for a medical-legal evaluation.

We have not attempted to obtain permission from unrepresented applicants to bill under the ML-104 code. We do not perceive unrepresented applicants to be able to agree or to disagree with this, and we do not believe the regulations should imply that unrepresented applicants can be asked whether a medical-legal evaluator may use a specific billing code.

As the proposed regulation changes exist currently, billing more than three hours for report writing would only be allowed if the parties agreed in advance that a report qualified for the ML-104 billing code; however, for the many reasons noted above, we believe it is inappropriate to ask the parties to agree in advance that a report qualifies for the ML-104 billing code. Unrepresented applicants are totally unqualified to be asked this question, and workers' compensation attorneys are often uneducated about the billing codes and see billing as the purview of the insurance companies. Our experience shows that adding the proposed regulation changes to the medical causation complexity factor will dramatically reduce the use of this complexity factor for reasons that have nothing to do with whether medical causation remains an unresolved legal issue in a workers' compensation case. This would be inappropriate and would create a significant disincentive for physicians to participate in the workers' compensation system as medical-legal evaluators.

Vagueness and inconsistency of added language: DWC has proposed to require physicians using the ML- 103 billing code to "clearly and concisely specify which … complexity factors

> were *actually and necessarily incurred for the production of the medical-legal report and were* required for the evaluation, and the circumstances *uniquely specific to the actual evaluation being performed* which made these complexity factors applicable to the evaluation."
>
> Using similar but inconsistent language, DWC has proposed to require physicians using the ML-104 billing code to "clearly and concisely specify which … complexity factors were *actually and necessarily incurred for the production of the medical-legal report and* required for the evaluation, and the circumstances which made these complexity factors *uniquely and specifically* applicable to the evaluation being performed.

In the proposed changes for the ML-103 billing code, the words "uniquely specific" describe circumstances of the evaluation being performed; whereas, in the proposed changes for the ML-104 billing code, the words "uniquely and specifically" describe the applicability of those circumstances to the evaluation being performed.

The words "specific" and "specifically," if used, should refer to the same thing across the two billing codes so as not to create confusion. It appears that DWC's intent is to ensure that evaluators describe the specific circumstances of an evaluation that allowed a complexity factor to apply, and that the words specific and specifically are meant to apply to circumstances.

In both cases, the use of the word "uniquely" is problematic because whether one is referring to circumstances of the evaluation or the applicability of circumstances to an evaluation, it is unlikely either is going to be truly unique. The same circumstances, and the same applicability of those circumstances, arise across cases. For example, many psychiatric interviews take over two hours because the applicant has alleged to have suffered a psychiatric injury because of more than one industrial factor: work-related physical injuries; workplace maltreatment; an excessive workload; and personnel actions. That circumstance is not going to be unique or uniquely applicable for any specific case, as it occurs frequently. We recommend that the word "uniquely" be stricken from the proposed regulation changes.

Also, in both cases, it is not clear what benefit is gained by adding the work "actual" before "evaluation" in the phrase "actual evaluation being performed."

An uncorrected typo: The following phrase continues to exist only in the section of the regulations that allow for the ML-104 billing code to be used because the parties agreed in advance that it may be used:

> "When billing under this subdivision of the code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities." (underlines added for clarity)

Presumably, DWC would still like physicians to list the billable hours for each activity every time ML-104 is used, regardless of how a report qualified for the ML-104 billing code.

C. Thomas Vangsness, Jr., MD
Professor, Department of Orthopaedic Surgery
Keck School of Medicine of USC

May 17, 2018

I am concerned about the newly drafted med-legal fee schedule language being proposed. This will effect the ability of orthopaedic surgeons to perform quality QMEs.

I would propose the creation of a panel of experts to review the current and proposed fee schedule.

An improved med-legal fee schedule will improve the quality of reporting and ultimately provide better medical care for the injured workers in the state of California.

Craig C. Joseph, MD

May 17, 2018

Superficially, the goal of the newly proposed regulations is to fight fraud and to save money for the insurance companies—those reasons are cosmetic public relation gimmicks embedded in trickery. The ultimate goal of the newly proposed regulations is to eliminate QME's and AME's. There is an absence of benevolence – it's all malevolent toward the medical –legal doctors .I will now provide a typical itemization of expenses in a doctor's office in the workers' compensation system .

1.RENT—24,0000-60,000 dollars per year. 2.ELECTRICITY—12,000 dollars per year.3.RECEPTIONIST WITH MULTIPLE DUTIES—44,000 dollars per year.4.XRAY TECHNICIAN—60,000 dollars per year.5.NURSE—50,000 – 96,000 dollars per year.6.PHYSICIANS ASSISTANT—80,000 – 120,000 dollars per year.7.MALPRACTICE INSURANCE—depends on specialty, but can reach approximately 50,000 – 100,000 dollars per year.8.WORKERS' COMPENSATION INSURANCE. 9.PERSONAL INJURY INSURANCE , 10.HEALTH INSURANCE FOR EMPLOYEES.11.PENSION FUND CONTRIBUTIONS FOR EMPLOYEES AND ASSOCIATED ACTUARIAL EXPENSES.12.BILLER / BILLING SERVICE.13.TRANSCRIBING SERVICE. 14.XRAY EQUIPMENT. 15.PURCHASE OF MEDICAL EQUIPMENT.16.COMPUTERS . 17.PRINTER / PRINTERS .18.FAX MACHINE / MACHINES.19.PHONES. 20.HOLIDAY PARTY / PARTIES.21.HOLIDAY GIFTS.22.

FURNITURE.23.FEES FOR ATTORNEYS . 24.COLLECTION AGENCY. 25.HEARING REPRESENTATIVE.26.COUNTERACTING DWC DISCIPLINE. 27.DRUG ENFORCEMENT AGENCY LICENSE.28.WORKERS' COMPENSATION / QME AND AME APPOINTMENT / REAPPOINTMENT FEES. 29.CONTINUING MEDICAL EDUCATION. 30.CALIFORNIA MEDICAL LICENSE / MEDICAL BOARD OF CALIFORNIA.31. HEAVY DUTY COPYING MACHINES WITH WARRANTY / INK / TONER/REPLACEMENT PARTS / PAPER. 32. MARKETING . 33.CERTIFIED PUBLIC ACCOUNTANT 34.PURCHASING OF MEDICINES TO DISPENSE FROM OFFICE BECAUSE INSURANCE REFUSES TO CERTIFY THEM.35.EARTHQUAKE / FIRE INSURANCE. 36.HIPPA COMPLIANCE .37. MANAGED CARE COMPLIANCE . 38. OTHERS, DEPENDING ON THE SPECIALTY . HOW IS A DOCTOR SUPPOSE TO COVER OVERHEAD / EXPENSES IF YOU IMPOSE YOUR NEWLY PROPOSED REGULATIONS ? THE DOCTOR WILL NOT BE ABLE TO COVER EXPENSES AND THE DOCTORS WILL DROP OUT OF THE SYSTEM ---THAT'S WHAT YOU WANT—TRY BEING UP FRONT AND TRANSPARENT !!!!!!!!!! THERE IS AN ENORMOUS AMOUNT OF FRAUD ---WHY DON'T YOU SIT DOWN FACE TO FACE WITH MANY DOCTORS---THIS IS INFORMATION THAT MOST DOCTORS WILL NOT PUT IN WRITING OR IN EMAILS. I VOLUNTEER TO MEET WITH YOU !!!!!!!!

Payam Moazzaz, MD, QME May 17, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Anonymous May 17, 2018

As a QME in California, if I am not fairly remunerated for review of info I will respectfully not participate as a QME.

Hyacinth Ezeani, DDS May 17, 2018

Bottom line is that the injured workers is not getting a fair deal.

Dara Saghafi May 17, 2018

I have been a QME since 2004 and I am writing this letter with great concern for the proposed changes by the DWC on the current Medical-Legal system.

Surely, there is no dispute that the proposed changes to the Med-Legal Fee Schedule are merely meant to reduce overall costs for QME evaluations. Yet, it is obvious that only 2 possible outcomes will emerge: QMEs will quit performing this often arduous work or reports will be substandard and will not meet substantial medical evidence. In either scenario none of the parties involved will be well served. Limiting report preparation time to 3 hours or less will, in majority of cases, yield reports that will ignore much of what is in the medical records and will result in unsupported opinions that will miss essential factors that need to be taken into consideration in analysis of causation and apportionment. Presently, some QME reports simply contain statement of opinion without any rationale provided pertinent to the case. These reports will have statement such as "the injury is industrially caused" or "permanent disability is 50% industrially caused and 50% due to pre-existing factors", without any additional explanation, discussion, or rationale. If these are the type of QME or AME reports DWC and all parties would like from here on, then the new proposed fee schedule will be successful in obtaining such reports. Otherwise, if thorough and well reasoned reports that actually directly considers all submitted records it should also be expected that such report will require appropriate time for analysis of all issues.

It is not uncommon that in a corner of an obscure sheet of medical record (which may be a family physician's hand written report from years ago) that can result in a determination that an otherwise "obvious" work injury was in reality pre-existing and therefore not industrially caused or its related disability should largely be apportioned to non-industrial cause. Such meticulous attention to detail requires time and detailed analysis of all issues and is often not a feasible in 3 hours.

If DWC is going to institute the new changes then it must also include an optional avenue for a QME to bow out and reject working for free. In many cases medical records are 2000 pages or more and medical records of more than 8000 pages are not uncommon. Reviewing and analyzing these records, whether for an initial evaluation, re-examination or for a supplemental report will require the time it takes that it takes and limiting the billable time to 3 hours is entirely unreasonable. This is no different than limiting the time of surgery, ahead of time, for a trauma surgeon to operate on a multiple gunshot wound patient regardless of the complexity of the injuries or the number of organs injured. Non of the employees at DWC work for free and the same should not be expected of QMEs.

A QME physician can chose to leave the system if forced generation of substandard reports are mandated by the new proposed Fee Schedule. Other work is always available for physicians and working as an expert witness for personal injury cases is much less burdensome and is more profitable than staying in the workers compensation system. But what will the injured worker do? They have no other option but being involved in a system that continues to become more antagonistic. These fee schedule changes will only result in the settlement of cases becoming more protracted and the litigation process will linger on longer.

In addition, expecting a written agreement in advance from both parties that causation is in dispute is absurdly unrealistic. As is, we as QMEs often get a cover letter/advocacy letter from one side only and at times after the QME evaluation has already been completed. Furthermore, how is the unrepresented injured worker expected to know or go about obtaining such a written agreement before seeing the QME?

The changes that need to be made should revolve around identifying the bad apple QMEs. We have all heard of QMEs that perform upwards of 6-8 QME evaluations in half a day or generate reports that provides no discussion or rationale to support the briefly stated opinions. Why is this still being allowed?

Any improved fee schedule should ask for input from the Medical-Legal evaluators and from Defense and Applicant attorneys and from Claim Adjusters *ahead of time*. Otherwise, the current proposed schedule will result in shrinking number of QME/AMEs and or substandard QME reports will become the norm. Instead of making the system more antagonistic, less make it practical for all parties involved.

Abdo Faddoul, MD May 17, 2018
QME Urology

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical

timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Anonymous May 17, 2018

Doctors are not the slaves or indentured servants of the DWC or the insurance companies! The DWC must not enact and get rid of any proposed regulation or rule that forces doctors to accept work. This includes work that makes doctors work for free or at a substandard rate. Doctors must be free to reject any work that will harm their health, their practices, their staff and their finances. Doctors must be free to reject any work that is unethical. This includes work that can lead to reports not being substantial medical evidence, reports leading to the hampering of the process, and reports that can potentially harm the injured worker!

Dr. Sheryl Monaughan May 17, 2018

I am a Psychologist and a QME. I am against the following proposed changes. If the changes are implemented, I would not to able to properly perform QME Evaluations, if at all.

- *3 Hours Report Preparation Time:* **NOT ENOUGH TIME, UNREASONABLE**
- *Causation Complexity Factor***: UNREASONABLE**
- *Medical Research:* **UNREASONABLE**
- *No backing out:* **UNREASONABLE**

Anonymous May 16, 2018

Anyone who has treated patients in the Work Comp system and has done QME's knows how terrible the system has gotten over recent years.

We know that throughout this state, there are many unsafe and dangerous working conditions. We deal with people who have been seriously physically injured, shot at, robbed, etc. Many people working in hostile and abusive work environments. Many of these lead to highly complex scenarios.

It is not uncommon for someone to have no idea of how to navigate the Work Comp system. The system is built such that many people don't know where to go for help when injured. They may go for help at their private doctors or they get help at an occupational clinic. There are employers that work on having the injured worker not to file a claim. At the occupational clinic, they may see the wrong specialist or get treated and evaluated very conservatively. Part of the cause of this is because the MPNs are lacking in qualified doctors due to the DWC gutting the system of qualified doctors by creating a fee schedule that decreased physician reimbursement so significantly. Many of these first doctors send the worker back to work with inappropriate restrictions and limitations or even send them back to terrible work environments.

We all know that once a worker is injured, workers are at increased risk of losing their jobs. So many of the injured workers find they are now being cited for performance issues by their workplaces or they will miss many days of work. Eventually, their workplace terminates them. The workers lose their ability to pay bills, have increased physical pain and injury and develop significant psychological problems.

We all know that the insurance companies are looking to deny patient claims. Early denial can lead patients to give up on the Work Comp system and save insurance carriers money. Those who want to appeal, have to go the QME route. Some people may be lucky enough to have lawyers before this happens to help represent their rights.

Now, because of the DWC, we have this shoddy IMR system. What happens is that workers will get denied various services and procedures and there are lengthy appeals. The doctors working for the insurance companies use very weak reasons to deny a claim. Unrepresented workers have no idea how to work the IMR system will give up if they have to initial an appeal. The IMR does not interview the patient and again, deny many medical procedures and medications using very weak reasoning. But now, the worker cannot request the medication or procedure for 1 year!

So the person dwells in pain and emotional distress. By this time, many are jobless, having poor relationships with families, have little hope for their futures. This procedure or medication gets denied. That procedure or medication gets denied.
The workers go from QME to QME of different specialties. Now their lives are basically going form one doctor appointment to the next. Physical pain. Emotional pain. Denial of this. Denial of that. No longer eligible for surgery. Significant undertreated mental health issues.

The only person listing to the worker and putting together this puzzle have been the QMEs. Box after box of records. Significant complicated histories and a highly antagonistic process. The result is a lengthy report that hopefully resolves their status.

Now the DWC wants to significantly hamper the one place where workers can tell their story and the stacks of conflicting records can be reviewed. Many of us know that many workers only get correct diagnoses after a thorough QME evaluation. Now the DWC wants to place that at risk. Many people know that the only time it is identified that a person is falsely claiming injury occurs at the level of the QME. Many of us know that the only way to analyze the massive amount of conflicting medical data is through the QME process and the DWC is hampering that process.

If you want to tack high QME costs, the best thing to do is to start at the beginning. Start to work with the agencies involved in regulating business and making sure that injured workers know where to go. Work with employers to help workers keep their job. This will help to keep their premiums down! Stop insurance companies from early denial and stop UR personnel working with injured workers from inappropriate denials. Get rid of this terrible IMR process and have two doctors of the same specialty, who are on the MPN discuss the case and if the second doctor does not agree with the first doctor, the second doctor can see the patient for a second opinion. If there is still disagreement, then the procedure does not get authorized. Think of how much more accurate denials or acceptances of medications will be and how much sooner workers can get treatment. Stop this MPN process because we know that insurance companies make little effort to recruit and maintain doctors. It is even hard for doctors to know how to get on an MPN. You can have one list of doctors at the DWC of doctors who accept workers comp patients and that is your MPN. These doctors are now on a list by the state than an insurance company that has a bias to protect their company.

Now you have fewer records, less morbidity and less need for a QME evaluation. Now the QME evaluations will either be less complex over minor disputed issues or very complex in terms of very complicated cases that need this level of expertise.

Again, start with the employer and the early denials. If you delay on referrals and treatment, you will continue to get these complicated people. If the DWC thinks that cutting QME payments and therefore quality of the evaluations will help, they are incorrect. You will continue to see medication lists increase in size as the patient grows older, more need for treatment based on compensatory injuries, and greater psychiatric comorbidity.

Also, the QME process allows for the exposure of significant corruption that occurs at workplaces. Those businesses deservedly require higher premiums from their insurance companies because of what goes on at those workplaces, there are necessarily long and complicated QMEs.

Realize every QME is different. Some type, some dictate, some are young, some are old, and everyone has various training and experience. So there is a wide variance in report quality and time to complete reports, even within the same specialty. If you are concerned about a QME, talk to them and work it out. It is my understanding that someone in charge of the DWC used to actually talk to QMEs about disputes in billing. The DWC derailed into unground regulations.

There was no need to do these underground regulations. Hopefully, the state bar can look at those who were involved in the underground regulations.

As it is, the Work Comp system is designed such that it is easy for employers to get rid of injured workers, easy for insurance companies to deny claims, easy for insurance companies to deny care, easy for insurance companies to not have to provide care if there are no available care provider, and will soon (if the DWC gets its way) be easy for the insurance companies to pay less for QME evaluations and then save money by attacking unfavorable evaluations as not being substantial medical evidence.

Once things change at the DWC and there is someone with vision at the helm, maybe the focus will be towards early intervention instead of attacking QMEs. A properly functioning DWC would be helping injured workers get into the work comp system as soon as possible, helping injured workers understand their rights (very few do), get care early, and stop denials of claims and care for those who genuinely need it. A properly functioning DWC would be working on getting doctors back into the work comp system and working with QMEs to build their ranks and quality of work instead of using underground methods to target doctors.

Dr. Ramirez May 16, 2018

I have read the proposed changes to regulations regarding QME evaluations. These regulations do not serve the injured workers, will not sustain the physicians who evaluate them, and instead, appear to serve only the Insurance companies. Insurance companies will now take further control of a process that was created to be a neutral process to administer fairly the needs of the injured worker while limiting the abuse of the Worker's Compensation system. However, this legislation appears to place the controls squarely in the court of the Insurance companies. Insurance companies, by their very nature are not neutral parties.

When I took the QME writing workshop, I received detailed information on all of the requirements for writing these complex medical-legal reports. I have always endeavored to produce reports at the highest level, including all of the requested elements that make these reports truly useful in settling cases. As I became proficient, the quality of my reports improved at the same time that the cost of my reports decreased. However, many of the applicants that I evaluate in my specialty, PM&R, have complex histories, multiple injuries, multiple body parts, long medical records, complicated medical histories, and complex impairment ratings. Despite my expertise, there is no way that I could complete the required reports under the proposed changes in any amount of time that would make it tenable for me to continue doing them. Quite simply, I would not be paid for the work that I do.

I don't know any physician, lawyer, or administrator who would be willing to work without being paid. For those doctors who may choose to stay in the business of writing QME reports, the regulations would require them to reduce the quality of reports, work unpaid hours to produce them, or assign the reports to medical assistants and office workers to complete. None of these options serve the intended purpose of the QME system.

The proposed changes will hurt injured workers, drive quality doctors out of the system, or create "felons" of doctors trying to produce an acceptable product without experiencing significant financial loss.

Kent Karras May 16, 2018

The Proposals are just not realistic. Last year I was contacted more than once and requested to do QME Supplemental reports that had boxes and boxes of records that required 10s of hours of review and reports preparation. Not to mention research. Insurance companies need to step up and pay for work rendered and not force QME's to have to go hat in hand and beg for approval for work down not to mention that not allowing us to turn down this work if fair compensation is not offered give us no bargaining power. I am shocked that the DWC would be even considering changes such as these. This will only serve to decrease the number of QMEs and decrease the quality of the reports.

Dr. Michael Sachs, QME May 16, 2018

Reducing the hours needed to complete QME reports is a very bad idea. To do an accurate balanced report often requires a great deal of time--to review records which can be hundreds or thousands of pages-to do research to be sure that the conclusions are as scientific and up to date with the most recent medical information-to prepare a report with carefully thought out words that express the history provided and determine work relationship and impairment ratings-to correct the report to its final form, all takes the time as has been stated on reports. Do not make this work less than excellent by limiting hours which is not a benefit to doctors. injured workers or the state of California.

Janet Lord May 16, 2018

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I have been involved with the California worker's compensation program as both a primary treating physician and QME since 1997. Over those approximately 20 years I have watched as the program has gradually become less and less favorable toward both physicians and injured workers. I have also watched as, gradually, increasing numbers of physicians have dropped out of the program because of onerous administrative demands and inadequate reimbursement. I stopped accepting new worker's compensation treatment cases about 3 years ago. Sadly, I am not alone.

The Division of Worker's Compensation has now published "clarification" of the current regulations which, in fact, offer extension of previous regulations to limit doctors' billing practices. While it is entirely appropriate for the DWC to curb abusive billing, a balanced approach is necessary to assure that sufficient doctors remain engaged with the QME process and provide high quality, necessary evaluations. Current "clarification" is skewed entirely toward limiting the cost of QME's, without adequate consideration of the effort and expertise required to provide high quality reports.

Specifically:
Section 9795 (d): "The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section …. 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."

Under this section, the physician has no bargaining power whatever and the parties (particularly defense, who usually pays the bill) no motivation to EVER agree to a provision that would increase cost. Thus, the physician is required to provide complex services without appropriate compensation. For some physicians, this may mean dropping out of the QME program entirely.

Two sections address prior agreement:

1) ML103 item (6) Addressing and providing an analysis of the issue of medical causation and

2) ML104 item (3) allowing use of the ML104 billing code for 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.

In both cases, prior agreement implies that the physician is familiar with the facts of the case BEFORE he/she has had a chance to evaluate the case. In some cases, additional information at the time of the interview or during detailed record review, will uncover aspects of the case that suggest the need to consider causation (particularly when identifying compensable consequences involving additional body parts) or unusual complexity mandating an ML104 level report. Also, although, in theory, lawyers' letters and medical records should be available two weeks prior to any evaluation, in practical reality, they often are not. The physician often receives specific information about a case immediately before or even shortly after he/she has seen the patient. Thus, in either situation, the physician has lost the opportunity to request

agreement to bill for either causation or for certain complex cases that would justify an ML104 billing code and is required to render services without appropriate compensation.

A hypothetical case illustrating both problems is as follows:

A physician's office receives a request for Panel QME related to an accepted claim for low back pain. No specific medical information is available at the time of scheduling, but the patient is given an appointment within the mandated 60 days. About 2 weeks prior to the appointment, the doctor's office receives a letter from the applicant attorney, offering minimal medical information, but requesting a comprehensive evaluation, including discussion of causation, treatment, permanent and stationary status, permanent disability, apportionment etc. Applicant attorney indicates that medical records will be provided by the defense. Two days before the appointment, the defense sends a letter indicating that there have been multiple employers and multiple previous low back injuries. Apportionment will need to be evaluated. Defense sends about 4 inches of medical records for review. This evaluation then clearly qualifies for billing as an ML103. At the time of the evaluation, however, the doctor discovers that the patient has been using an axillary crutch to facilitate ambulation and crutch use has caused a shoulder strain injury with pain and limited range of motion of that shoulder. The shoulder injury, therefore, should be considered a compensable consequence of the patient's industrial low back injury. Thus, the evaluation should be elevated to billing code ML104. However, since the doctor had no awareness of the shoulder injury prior to the evaluation and a PRIOR agreement was required in order to use causation as a complexity factor, the doctor will not be able to bill for developing the shoulder injury as part of the evaluation and will not be able to bill an ML104.

Thus, the doctor will not be compensated for the additional extra work required for this evaluation and will not be compensated for the necessary supplemental report related to the results any diagnostic tests ordered as part of the initial evaluation.

The doctor now needs to make a choice:

1. Ignore the shoulder injury. This reduces the complexity and the amount of work the doctor has to do. There is no need to measure shoulder range of motion and no need for any further evaluations such as shoulder MRI or orthopedic consultation.
2. Evaluate the shoulder as appropriate, knowing that he/she will be providing services for free

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Satishklal May 16, 2018

I strongly oppose the new regulation on QME reimbursement pmt .It will affect the reporting requirement on the QME reports. Kindly do not make this change.

Robert B. Weber, MD, FACC May 16, 2018

I am a QME specializing in Internal Medicine and Cardiovascular Disease. After carefully studying the proposed administrative and medical-legal fee rule changes I have come to the following conclusions: physicians tend to be individuals who strive to make a significant positive impact on others with whom they interact, primarily their patients. Those physicians who perform medical-legal evaluations as AME/QME's bring to bear the same sincere caring and conscientiousness to claimants and applicants sitting in front of them in an evaluation. I am very concerned therefore that the arbitrarily conceived restrictive measures, individually and cumulatively will demoralize these same physicians. The Workers Compensation system as it stands now already in too many instances results in delayed necessary care and it is inconceivable that the net consequence of these changes, were they to remain, will not be most felt by the very injured workers that this system is meant to serve. A logical analysis should lead to the expectation that as part of provider disillusionment there will be a further erosion in the numbers of them willing to serve in the DWC system. This will magnify the delays and impediments to treatment needed by our Injured Workers.

Everyone will be adversely affected, most severely by those the system was designed to care for and protect.

I urge you then to please reconsider these proposals and to commit to engage in a constructive and open process in order to improve the system.

Charles Schwarz May 16, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Martin Krell, MD May 16, 2018
Quality Medical Examiner, Neurosurgery-Spine

The proposed new regulations including limiting Research and Report Preparation will only denigrate the quality of QME reports, cause doctors to leave the Workers Compensation field and harm injured workers.

Please do not implement the Proposed Regulations. The proposed regulations are arbitrary and not well thought.

David V. Alvarez
3DIMS, LLC

May 16, 2018

In response to the proposed changes of 9794 and 9795 the following are my comments the issues at hand. Changes are made in italicized print below.

Regarding **§ 9794. Reimbursement of Medical-Legal Expenses.**

(3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.

Clarification needed, it seems to state that one cannot bill OMFS codes along with ML Evaluations, i.e. cannot bill for x-ray taken in conjunction with orthopedic ML evaluation/report. Language is confusing.

(b) All medical-legal expenses shall be paid within 60 days after receipt by the employer of the reports and documents required by the administrative director unless the claims administrator, within this period, contests its liability for such payment.

ADD -

Failure to contest the charges will result in self-imposed penalty and interest charges as noted in §10111.2 (b)(9), §4622 (a), and §9792.5 (b) that must be paid within 30 days after initial 60 days have expired.

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

(b) The fee for each evaluation is calculated by multiplying the relative value by $12.50, 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. **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.**

Clarification needed based on whom are considered parties, does this mean the treating physician, attorney, injured worker, adjuster, DWC information and assistance officer, etc.

Of note in 2004 when the code was modified under SB 899, the relative value has not been updated since despite inflation. If one uses the US Inflation Calculator the $12.50 relative value should now be $16.58 based on a cumulative rate of inflation of 32.6%.

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.~~

The ML100 code should be changed to from communication purposes to a compensable ML code. Allowed amount should be $250 which is for 1 hour of time/unit allocated for the appointment. If the inflation calculation above is applied, then the new amount should be $331.59 per hour/unit.

ML101	5	*Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than 3 hours may be billed for report preparation under this code.

To place a maximum limit in the amount allowable for report preparation are unreasonable and a blatant restriction of trade in preventing physicians to spend the

necessary time required to provide a detailed evidence-based medical report and to be in compliance with CCR §10606. Physicians spend many hours of critical thinking on each report to coming to an opinion. Cases that have CT claims, several dates of injuries, and several body parts can result in more than 3 hours of critical thinking in order to come to a conclusion that can be expressed clearly and concisely for nonmedical personal to read and understand.

In addition, the average medical transcription cost in the US are $0.14 per line, with approximately 52 lines per page resulting in an expense of $7.28 per page. An average medical report that is complex will result in costs on average of 25 pages $182 about 25% of recommended amount. The DWC is not taking into consideration the costs or demands. If medical records provided are in excess of 1,500 pages the listing/summary required are going to lead to larger reports resulting in higher costs to cover the transcription of a report. The 1,500 pages may be summarized in about 50 pages which will lead to an expense of $384, which now is about 50% of what one can billed. All aspects of report prep have to be taken into consideration.

ML103	75	*Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below.

(3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;

The above changes are unreasonable and a blatant restriction of trade in preventing physicians to spend the necessary time required to provide a detailed evidence-based medical report and to be in compliance with CCR §10606.To limit the medical research used to once every 12 months is completely ludicrous. Medical research does not change overnight, that is why medical textbooks are written once every 1-2 years sometimes longer. Medicine is slow moving in regard to the research available as far as what is accepted in the medical community. Furthermore, to restrict its use on one case for every 12 months harms injured workers who may have suffered similar injuries that the nonmedical personal will not have access to in order to have a full understanding of the medical issues at hand to make a proper determination, which is a detriment to the injured worker. An example would be the shooting in San Bernardino in 2015 at the Center for People with Developmental Disabilities. If the injured workers underwent an AME or QME evaluation and several injured workers' were referred to

one physician, that physician would only be allowed to provide the information/research on PTSD for one of the injured workers, while the rest would have to rely on the knowledge of the nonmedical personal who again are not medical experts nor have the experience to fully understand what the injured worker may or may not be going through, that is why the AME or QME was chosen. If the DWC wishes to eliminate or reduce research then they should reimburse the physicians rate that their colleagues who are expert witnesses are billing which on the low end $350 per hour for evaluations, and median initial retainer of $2,000, thereby eliminating the need for research and reports issued on the experience of the physician with no flat rates just hourly. Thereby treating the physician as the medical expert that he is truly being utilized as in the Work Comp arena.

(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors**, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;**

This is not based on what the code when initially written stated, and again a restriction of trade on how a physician spends their time to come up with an accurate medical opinion. To limit this as suggested will lead to incomplete evaluations/reports. Example if a psyche evaluator has not been provided the medical records and has to spend 6 hours with an injured worker who has poor recollection of events due to head trauma and also considered a poor historian with the use of an interpreter to only allow an ML102 is completely and utterly irresponsible of the DWC. Medical Research should be the only complexity factor that should not be allowed to be used as a stand-alone complexity. Face to face and review of records should be allowed to be used as stand-alone factors. By making all 3 complexity factors to be used, it will create some providers to apply medical research to reach the above complexity factor which in some cases is unnecessary.

(6) Addressing and providing an analysis of the issue of medical causation, ~~upon written request of the party or parties requesting the report~~ provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

Causation needs to be in line with the current en banc decisions and regulations and not subject to the changes recommended or as previously written. Under §10606 causation is part of the required elements of a medical-legal report as Cause of the disability (work caused/work contributed). It is also implied, based on the above, that prior agreement has been granted since it is part of the process. Under the Physician's Guide to Medical Practice in the California Workers' Compensation

System Fourth Edition, 2016 under Chapter 3 Compensability lists key concepts with Causation being one of the key concepts. Under Analyzing Causation, this section list 3 factors that need to be established in order to make a causation determination:

1. *What pathological condition(s) (and disability) are present?*
2. *What relevant work exposures were present?*
3. *What other causes might produce the disease (i.e., non-industrial exposures)?*

The recommended changes are in direct conflict with §3208, §3208.05, §4663, and §4664. Nowhere above is there any mention of disputed medical fact or agreement by parties as a determining factor in addressing causation.

7) Addressing the issue of apportionment, when **items (A) and (B) below both apply:**
(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injury~~ies~~ to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more ~~or more~~ dates of injury~~ies~~ involving two or more body systems or body regions as delineated in that Table of Contents. ~~The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.~~

(B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.

The issue of Apportionment displays a blatant ignorance of en banc decisions and Laws of California Workers Compensation, and definitions as described by the DWC. Complexity factor of Apportionment should not be based on AMA Guides, AMA Guides are to be used for rating purposes and not apportionment issues. Required elements under CCR §10606 states Apportionment of disability, if any. Under the Physician's Guide to Medical Practice in the California Workers' Compensation System Fourth Edition, 2016 Apportionment of Disability states that apportionment is a legal concept and applies only to permanent disability. Existence of underlying disease or pre-existing injury does not automatically justify apportionment to those factors, but the issue should be addressed. The definition of ***Apportionment:*** *A way of figuring out how much of an employee's permanent disability is due to his or her work injury and how much is due to other disabilities or causes. Arising out of and occurring in the course of employment (AOE/COE): An injury must be caused by and happen on the job.*

The recommended changes are in direct conflict with CCR §4664 as well. In all of the above information provided there is no mention of apportionment having

the current criteria met in order for it to be addressed, therefore, illogical to apply the AMA Guides, and the number of body parts or number of injuries as a determining factor for addressing apportionment.

ML106	5	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. 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.

Section (B) should be eliminated as this is in conflict with CCR §9794 (a)(1). If a physician has to obtain authorization the timeframes in obtaining the authorization to when the final results are made available to the physician can be several months from initial request. To assume that a physician will be able to recollect the facts of the case afterwards is completely unreasonable. Physicians should be allowed to review their previously expressed opinions and review the results and issue an updated report is essential to provide evidence-based medical report and be allowed to be properly compensated for their work.

To place a limit on the amount of report prep are unreasonable and a blatant restriction of trade in preventing physicians to spend the necessary time required to provide a detailed evidence-based medical report and to be in compliance with CCR §10606. Many hours of critical thinking are spent on providing the reports and coming up to an opinion. Cases that have CT claims, several dates of injuries, and several body parts

can result in more than 3 hours of critical thinking in order to come to a conclusion that can be expressed clearly and concisely for nonmedical personal to review and understand.

Of note average medical transcription cost in the US are $0.14 per line, with approximately 52 lines per page resulting in an expense of $7.28 per page. An average medical report that is complex will result in costs on average of 25 pages $182 about 25% of recommended amount. The DWC is not taking into consideration the costs or demands. If medical records provided are in excess of 1500 pages the listing/summary required are going to lead to larger reports resulting in higher costs to cover the report prep. 1500 pages summarized in about 50 pages will lead to a bill of $384, which now is about 50% of what one can billed. All aspects of report prep have to be taken into consideration.

Bruce L. Roth, DO May 16, 2018
Psychiatry, QME

The proposed changes to the Med-Legal Fee Schedule billing are unworkable and will cause the QME system to fail. As a Psychiatric QME, I take pride in providing a thorough evaluation for the injured workers I evaluate. A majority of cases I evaluate require extensive medical record review including applicant treatment records, depositions, previous QME/AME evaluations which most often take many hours to review. The face to face time is often several hours for a full psychiatric evaluation including history of the alleged injury, taking a complete psychiatric history and performing a thorough mental status examination. In psychiatric injury claims that will be useful to all parties, the time to write a summary report reviewing all the records including psychological testing frequently requires many more than 3 hours to complete. If the proposed changes take effect I would likely not be able to provide a quality QME report and would likely not continue as a QME. The changes the DWC is proposing will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers in the system has been decreasing, while the number of QME panel requests are increasing. QME evaluations are complicated and, similar to federal and state health reimbursement, the decision of how much time is appropriate is best left to the judgment of the Physicians. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three hours, DWC will not have the data necessary to make an informed judgment because the majority of the cases would not meet that time restriction. No reasonable physician would agree to work under such conditions.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical

timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

The regulations should not be authored by attorneys who represent insurance carriers' interest without apparent concern for the best interest of the injured workers. These regulations must be authored with the input from QME Physicians.

Don Schengel MD May 16, 2018

I have recently began to perform QMEs. The system already has issues that delay care to injured workers. Rather than complicate it further, I feel it needs to be simplified. I oppose the newly drafted med-legal fee schedule language. If this proposal goes through, I will have to reconsiderd my decision. In conversations with other QMEs, the new languages will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

Bruce Dreyfuss, MD May 16, 2018

The newly proposed 9795 regulation have flaws and inaccuracies which must be identified and corrected in order to assure the Injured Worker and the Employer/Carrier are both treated appropriately.

[b] 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 <u>not the controlling factor</u> in determining the appropriate level of service. (emphasis added)

Factually inaccurate; the definition of ML103 *Complex Comprehensive Medical-legal Evaluation. Include evaluations which require three complexity factors set forth below.* There are eight complexity factors. The first five complexity factors are all based on "Time spent" performing "procedures". These five factors represent 62.5% of all the complexity factors! Clearly, the time to perform these procedures is/are controlling factors in determining

the appropriate level of service. ML104, requires ML103 and adds two more complexity factors which may be used. But as mentioned above, ML103 can rely on time!

ML103 [6]....causation , provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing...

From causation, all benefits flow. There is no issue more essential to the injured worker or employer regarding liability for the delivery of health care, temporary or permanent, total or partial disability, future medical treatment, voc rehab, work place accommodation, etc, than causation.

Causation is in dispute if both applicant and defense don't agree on it. Nothing more is needed to prove dispute.

It is assured that defense will never agree to causation as a billing factor except with an AME.

Apportionment;

ML103, [7] {A} three or more employers injuries can occur outside of the work place before, during and after employment. How is this any less complex than when injury occurs AOE/COE during employment?

three or more injury to the same body system or region See the above comment.

{B} MMI I have had cases with the carrier refusing to authorize treatment, claiming the IW's condition is due to pre-existing injury. In such circumstances, absent statement of apportionment, there will be no treatment, there will be no MMI and no P&S. Apportionment serves many purposes, determining level of responsibility for permanent disability is just one of them.

ML104 {3} *any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request.* This is a great Catch 22, it requires an evaluation before the evaluation, just to determine if an extraordinary circumstance exists. I don't know just how extraordinary a case is until I perform the evaluation!

John Finkenberg, MD May 16, 2018

It is important to understand that physicians have very limited time to evaluate and then compile the detailed reports. If reimbursement declines so will the amount of time and effort that is put into these evaluations. Ultimately the person who is done a disservice is the worker. He and his family should be entitled to the best effort possible as their existence is dependent on the report quality. Please do not put our hard working citizens at risk.

David Narang, PhD May 16, 2018

Good afternoon. I am currently a QME in the specialty of psychology, and I am writing to express strong concern about the currently proposed changes to the billing procedures. They are unworkable as written and will push myself and many QMEs out of the practice, endangering the compromise struck by workers and companies in initially creating the WC system. Of course, QMEs have already been exiting the system even prior to these proposed changes.

Setting an arbitrary limit for the number of allowable report writing hours fails to take into account any reality of the tasks required of QMEs in producing our evaluations, particularly when our reports must be sufficiently thorough to constitute substantial medical evidence and the limit proposed for hours has apparently been set with a complete absence of awareness about the time required to do so. How was this number arrived upon? The DWC has been opaque in the process of generating the proposed revisions, and the proposed changes arising from that process do not reflect reality.

Please abandon the current proposed revisions, and if desiring to revise the fee schedule, institute a process to include all relevant stakeholders in the process. That is, while feedback from insurance companies and defense attorneys should be included in drafting the guidelines, feedback from applicant attorneys and of course from QMEs (sampling the range of medical specialties) should also be included, as should feedback from workers themselves after workers have heard from all sides. That would be a reasonable process likely to produce realistic guidelines.

Dr. Richard M. Braun May 16, 2018

The current fee schedule proposals will degrade the quality of the QME Report and reduce the ability of the injured worker to be protected by an unbiased medical evaluation. Objection to the proposals include:

1.Substantial medical evidence requires explanation of an argument. This requires time to explain the issues. The argument is presented in the prep-time allowed for a discussion of the

reasoning process for subjects such as appropriate diagnosis and treatment of the patient, P&S status, an questions associated with future medical care. Restricting prep time restricts the ability of the QME to do his/her job. The patient is not properly represented by this restriction placed on the evaluator. Inappropriate care, delayed care, and the rationale for future care, are all adversely affected by limiting the prep-time.

2.Medical Research/Literature review restriction is onerous. The citations from peer reviewed Journals and Texts is vital to the presentation of substantial evidence. The suggestion that articles can't be used more than once a year is ludicrous! The cited literature forms the foundation for the medical opinion in the framework of acceptable medical decision making. These references are similar to legal citations in legal argument and every other aspect of argumentation. The references must be relevant, meaningful, and accurate. A requirement to use different references for every case would lead to massive confusion and arbitrary chaos. It is wrong and insulting to tell the physician how to reference material that he/she feels relevant to his/her argument.

3.A responsive report should address the specific questions in the letter of direction. These subjects are usually covered in the body of he report. Nevertheless, at times, over ten questions may appear at the end of the joint letter. It is polite and professionally correct to discuss the questions with answers that are relevant to the information in the body of the report. This takes time - prep time - to complete in a meaningful way. Curtailing this response is counter productive. I forces the party requesting the information to wade through the report again and the response that he/she finds nay not be perfectly congenial with the question that was raised.

Norman E. Corlew, DC, DABCO, QME May 16, 2018

There have been a number of times while performing a PQME that I have found unforeseen issues of causation. These may be prior injuries, concurrent non-industrial injuries/disease or drug/alcohol dependencies. I am reading the new restrictions on the doctor giving his/her option on causation and it appears that if an issue is found during the examination, the doctor should be given an extra the 60-90 days to complete their report. This would be due to the letters that need to be sent to all parties requesting the increase in complexity factor. Or, should the doctor file an incomplete report stating that there are other factors that have arisen but cannot be discussed yet? I have never seen a payer retroactively increase a bill for any reason, including added or newly found complexity factors. As, such I believe there should be a statement relating to the QME's findings, which lead to increased issues of complexity, unless it is specifically stated that it is not wanted prior to the examination.

Benjamin Simon MD May 16, 2018

As a QME internist/cardiologist I have great concerns regarding the proposed changes. The proposed arbitrary limit on report writing is unworkable as our cases are often very complex. In

order to provide an expert opinion to be useful to all parties and the trier-of -fact, time is required for adequate report writing.

A similar comment is important to note in regards to research. Research is performed to not only assist in formulating an opinion but also in order to educate all parties involved. Limits should not be made on research.

Regarding the changes to the ML-104 the long hours required to complete a complex case will result in minimal payment. This is just not reasonable.

The proposed changes would be a disaster for the Worker's Compensation system and qualified doctors will likely no longer agree to participate. I urge you to reconsider.

John F. Lawrence, MD May 16, 2018

Many of the cases require detailed study of the previous records and thoughtful evaluation of the client. There are frequently several areas claimed to be involved.

A careful analysis of these matters can often involve several hours of work, A slip-shot report does not benefit anyone. The new constraints on billing will in my opinion encourage limited reports and will discourage qualified QMEs from participating in the program.

Allan Bernstein, DMP MBA QME May 16, 2018
Councilman, Immediate past Mayor, City of Tustin, CA

This is in reply to your proposed changes to the Medical Legal Fee Schedule.

Causation is an integral part of each Medical Legal Report. Your proposed changes," that all parties agree "that the evaluator may use and bill Causation as a complexity factor, are draconian and unworkable. Many CL are ambiguous about Causation. To think that all parties are going to agree, in order for Causation to be used as a complexity factor, is pure folly.

The proposal of a maximum of 3 hours for ML-104 for report preparation time will certainly discourage QMEs from accepting any complex cases with alleged multiple body parts injury claims. To accept complex cases with the proposed maximum of 3 hours is definitely unfair to the QME evaluator. Some of these cases have 2000-3000 pages of medical records. To accomplish a review of this volume of records in 3 hours is again pure folly.

ML-106 Supplemental reports require, in some cases, many more than 3 hours of preparation. This is especially true for cases in which there was insufficient data to complete the calculations, for Causation, Apportionment and Impairment, for the original evaluation. For this original evaluation, a minimum ML-102 is frequently charged.

If any of the proposed changes to the Medical-Legal Fee Schedule are adopted, there will be, in my opinion, a significant number of resignations by the QME evaluators.

In summary, I am against all of the proposed changes to the Medical Legal Fee Schedule.

Ronald J. Gowey, MD, QME May 16, 2018

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Robert J. Shorr, MD May 16, 2018
Neurology

I am certain that the proposed changes in the QME billing regulations will have significant unintended consequences. Complex cases that require extensive record review, report preparation and medical research will be difficult if not impossible to analyze given the new regulations as proposed. As a neurologist, I frequently receive multiple banker's boxes of records to analyze due to the complex medical history and co-existing conditions. Unique issues arise that do need research. Just today, a claimant claimed high altitude exposure was responsible for a vascular accident. This will require some delving into the literature. Not so simple. With the proposed regulations, my decision would have to be arbitrary because there would be no room to look into the matter.

Are we to start estimating apportionment, or should we continue to do our jobs as outlined in the requirements for Medical-legal reporting? I am sure that Southwest airlines will not fly a passenger to from Los Angeles to New York for the price of a ticket to San Francisco. This will certainly apply to QMEs as well. It seems to me that we might be forced to halt the analysis prematurely due to restricted time, sort of like telling the passenger he needs to leave the plane after an hour-and no parachute.

I have no quarrel with an attempt to improve billing procedures for QMEs. But it is important to keep in mind that there is no perfect billing system and that these are not medical services but medical-legal services. Are we also going to limit the time an attorney can spend on a case or arbitrarily limit the awards based on regulation?

The DWC should cancel the current proposal and start a more meaningful and helpful stake holder panel to come up with an improved solution that properly accounts for dealing with complex claims.

The reform of QME billing procedures needs to be different from those completed for one dimensional providers such as interpreters or copy services even or for medical evaluation and treatment services, which are more time-bound and self-limited.

QMEs and AMEs provide a complex multidimensional series of intellectual services to the system that requires a more nuanced and collaborative approach.

I am further concerned that the regulations as proposed will have the same effect on QMEs as the current byzantine system of MPNs, UR, RFAs, and low reimbursement has had on treating physicians who have abandoned the system in droves. My personal experience is that I became the only neurologist in a 100 mile radius who was still accepting treating cases. The more complicated these regulations become and the more difficult it becomes to get paid for their hard work, the fewer doctors will become QMEs. Fewer QMEs will lead to the impossiblity of obtaining appointments within the regulatory time-frame.

The system as currently structured is going to lead to a need for even more complex evaluations and issues due to the inherent delays which we are all seeing. Thus there will be more need for

QME services and the cases are becoming more complex simply due to the nature of the system in general. Being unable to deal with complex issues due to time restrictions on report billing will basically leave the cases unresolved.

I am encouraged that the DWC is bringing up this important issue and starting the process. Hopefully it can be more collaborative but if not the future of QMEs will be in question.

Kari Tervo, PhD, QME May 16, 2018
Licensed Clinical Psychologist
Qualified Medical Evaluator

I am a QME in Psychology. I have reviewed the proposed changes to the Medical-Legal Fee Schedule billing. They are untenable.

First, when it comes to psychology, the three-hour cap on report preparation time is arbitrary and completely unrealistic. Mental health QME exams involve the analysis of multiple sources of data, such as an extensive pre- and post-injury history, self-report and clinician-rated measures, and often voluminous medical records. Medical-legal conclusions cannot be made without considering these sources of data, and they certainly cannot be made and written up within a three-hour limit. With that limit, mental health QMEs are essentially being asked to perform an incompetent assessment. That is unethical, and I'm sure that's not the goal of the DWC, nor is it within the best interest of any party who wishes to understand the medical-legal considerations of any case.

Second, the proposed changes essentially require that QMEs perform their work for free when it comes to causation analysis. Causation analysis is the crux of any medical-legal evaluation. Asking a QME to provide causation analysis for free is like telling a roofer that you'll pay for the frame of the roof, but not the roof itself, when the entire point of the endeavor is to provide a roof. Causation analysis is the roof of a QME evaluation, and QMEs need to be paid for this essential service.

Third, the proposed changes essentially eliminate the ML-104 designation for complex evaluations, whereas nearly every mental health QME evaluation, by its very nature, is a complex evaluation. Additionally, that proposed change will force QMEs to work for a substantially lower rate. I can't imagine it would be a point of pride for the DWC to advertise to injured workers that they only work with cut-rate physicians.

Overall, the proposed changes will result in poor services for injured workers and insufficiently-considered medical-legal conclusions to be provided to the legal parties and other physicians associated with the case. Everyone involved deserves services that are based on comprehensive

evaluations by competent and fairly-compensated physicians, not quick-and-dirty reports by cut-rate doctors.

Brain P. Jacks MD May 16, 2018

I submit the following in regards to the proposed new MLFS regulations but please note this is strictly from a psychiatric point of view and specifically in regards to the proposed limitation of report writing for three hours: there are three reasons on a psychiatric basis for reports not to be limited to just three hours.

#1 specific nature of the psychiatric report
#2 **past history of complexity factors**
#3 **need for substantial evidence in workers compensation reports**.

Please see additional for more details:

#1 **The psychiatric report** requires more detailed history for example involving work stress but also involving personal social history and not only details of the physical problems but also the psychiatric problems including frequency and severity of anxiety, depression, suicidal ideas, plans, or preoccupations, issues of self-esteem, self-respect, and self-confidence, sleep issues including number of hours of sleep per night, whether there are difficulties getting to sleep or staying asleep, frequency of sleep problems, nightmares, snoring, problems with appetite or weight, energy level, motivation, interest in things, enjoyment of things, difficulties concentrating, difficulties with memory, nervous habits, changes in personality.
Unique to the psychiatric report is the amount of details necessary and therefore the time that it takes to take and compose a complete psychiatric history.

#2 In the past one of the **complexity factors** was medical legal reporting that was done primarily for psychological psychiatric reasons. This was based on the understanding that the psychiatric examination is much more detailed and complex then other specialties require and was given special consideration. This would also apply to the psychiatric report and has been established a long time ago and recognized.

#3 For **substantial evidence** there needs to be extensive reasoning presented in detail to allow the workers compensation judge to reach reasonable conclusions based upon the evidence. If the report writing is too brief and there is not enough reasoning presented this will only delay the settlement of the workers compensation cases, and clog up the system resulting in unnecessary delays. There will be a greater need for more supplemental reports, more depositions, which will also inevitably raise the costs. Furthermore workers compensation case law specifically clarifies that a extensive evidence and reasoning needs to be presented in order to be acceptable and substantial medical evidence. Looking at the Escobedo case for example, it requires detailed

reasoning of the how and why of each of the psychosocial stressors either causing permanent emotional disability or not.

The obvious and definite conclusion is that just limiting the medical legal reporting workers compensation to three hours is is problematic and will only create more difficulties.

Samuel M. Sobol, MD, FACP, FACC, FAHA May 16, 2018

Having carefully reviewed the proposed reimbursement changes for medical – legal reports, I wish to express my most strenuous opposition to the changes proposed. Taken together, these changes would so undermined the QME process by denying fair and reasonable compensation for physician time and effort, as to degrade the thoroughness and quality of all but the simplest evaluations.

These changes would discourage current evaluators from remaining in the system, and physicians considering QME certification from applying. This would pertain in particular to physicians such as myself, in specialties where the complexities of cases tend to be greatest, due to the multiplicity of injuries or organ systems involved, and the extent of differential diagnoses tend to be the most numerous. Personally, I would give serious consideration to retiring from all further QME work.

The limitations as proposed would all too frequently undermine the physician's capacity or willingness to provide a report which incorporates the elements universally requested and required by all parties: a comprehensive history based on patient interview plus thorough record review, particularly when the records are voluminous, which is often the case. This would pertain to all cases in which ML-4 cannot be applied due to the new restrictions, and also to supplemental reports where a 3-hour limit on record review is arbitrarily applied despite the volume of records which might be presented. Limiting the record review to such an extent will seriously degrade the quality of many reports and be detrimental to the fair resolution of such cases, harming either or both the injured worker and the employer.

Finally, the ill-considered and totally arbitrary mandate to limit the use of any research reference to once in a 12-month period flies in the face of both scientific practice and common sense, and reflects the worst of mindless bureaucratic interference with a process supposedly designated to provide substantive medical evidence. It is not at all infrequent that a particular reference is the most relevant to a common problem, and occasionally may be the only pertinent reference, especially if it contains recently developed information. While its use in more than one report a year should not require extensive repeat research every time it is referenced, nonetheless the time spent in re-accessing the material, and reviewing it to find the elements which relate most closely to the case at hand, and dictating the relevant passages into the report, is time which is often

critical to providing a substantive report which explains the rationale for the conclusions reached. To imply that this time cannot be used for billing is absurd, and will discourage the use of appropriate supportive scientific information, to the detriment of all parties involved and to the Trier of Fact who is attempting to determine the accuracy and relevance of the arguments brought to bear and the conclusions reached.

Andrew Rah May 16, 2018

I strongly oppose the newly drafted med-legal fee schedule language. If the most recent proposal goes through, it will significantly and negatively impact the quality of reporting and likely decrease the QME/AME pool. I would request that there be reconsideration of the newly drafted med-legal fee schedule and find an equitable way to resolve the issues that need to be fixed.

Alexandra Clarfield, PhD May 16, 2018

I am responding to the amended limitation in the fee schedule that proposes:

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;

It is my understanding the Psychology QME reports comply with:

Title 8: California Code of Regulations
Division 1: Department of Industrial Relations
Chapter 1: Industrial Medical Council
Article 4: Evaluation Methodology
Section 43: Method of Measurement of Psychiatric Disability

And that, "To complete the interview almost always will require at least one to three hours of direct contact with the applicant by the examiner." After surveying the most recent 15 reports I've completed, I find that most of the 104s require 15 hours on average of report preparation time. And because I am new to the work and concerned that I might not be as efficient as I ought, I have rarely billed for all of the time involved. In the case of injured workers who are in pro per, additional time is required to complete the necessary forms in compliance with EAMS and that is not billable but adds an additional burden to the report process. I would be concerned about the quality of medical evidence provided by an evaluator who felt they could do the job in three hours or less and question the legal process that would arise out of such data. And I know I would not feel good about providing quality of that sort for injured workers who are often in great need and without access to alternative resources.

A Psychological evaluation, by its very nature, must explore all aspects of the applicant's thinking and subjective experience. The DWC recommends we use the Method of Measurement Evaluation of Psychiatric Disability as a guide to what information must be obtained and reported on in the analysis of every Psychology and Psychiatry case. Please see https://www.dir.ca.gov/dwc/MedicalUnit/Psychiatric.pdf for the lengthy format that is expected.

I note that it is stated specifically, "The suggested headings are not required, but a systematic, quasi-standardized report including all the relevant facts is likely to be most useful to judges." Because of the nature of a Psychological evaluation, we are required to report on negative findings.

The above information, **required in each report**, does not include the discussion and description of current impairment or disability, and does not include the discussion of psychological testing administered, and the results of those tests.

A report of this depth and level of detail could not be prepared in 3 hours. It is unreasonable and untenable to impose a limit of 3 hours on report preparation for any ML 104 report in psychology. I recommend that Psychology and Psychiatry evaluations be excluded from the 3-hour limit on report preparation. If the DWC insists on mandating a number, it is my experience that these evaluations take upwards of about 15 hours to write, edit and finalize.

Lynne Wilson May 16, 2018

I oppose the newly drafted med-legal fee schedule language. If the proposal goes through it will surely adversely impact the pool of QME's and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

James P. O'Hara, MD, MS, QME May 16, 2018

The proposed revisions to the fee schedule for medical-legal evaluations adds unnecessary complexity to an already overly complex system. There are however a few proposed revisions that stand out .

Under 9795 ML101 Follow-up medical-legal evaluation. It is proposed no more than 3 hours may be billed for report preparation under this code. This implies that the time required to author a report when the claimant returns for follow up is less complex than the initial examination.

This may or may not be the case. It has been my experience that additional injuries could have occurred or extensive medical records have been received. Billing should be based on the time required to compose a reliable, factual and well reasoned report not on some abstract arbitrary pre-set number of billable hours that may have no relationship to the work required.

Under 9795 ML 106. Supplemental medical-legal evaluations. It is proposed that no more that three hours be billed under this code. Once again ,as above, this does not take into consideration the complexity that can be encountered in the preparation of a reasoned report in this category. One can receive numerous medical records, medical research may be required in support of opinions requested by attorneys.

The suggested limitation to sources not cited in the previous 12 months is not scientifically sound nor reasonable. If an article supports the physician's opinion it should be used. How often do we see complaints of back pain in individuals with degenerative disc disease? Weekly? Monthly? Of course the same issues will come up again and again. Some classic article apply to the apportionment of degenerative disk disease. Should we not use them because we used them last week? Saying that in such circumstances an article cannot be used or the physician cannot bill for this reference is like saying we should not quote Einstein because he was quoted last week.

Let us get together as a group concerned about the well being of the injured worker and the desire to act fairly to the employer and come up with reasonable revisions based on input from the QME community.

Dr. Zachary D. Torry May 16, 2018
Adult and Forensic Psychiatrist

I am a psychiatric QME and have been performing psychiatric QMEs since 2012. Given the number of stress claims due to workplace violence or perceived harassment, these are a vital part of the Workers Compensation resolution process.

In performing a psychiatric QME, I spend a minimum of 3 hours evaluating the applicant gathering a history of the applicants's work functions, his or her present illness (comparing and contrasting to the records), a complete medical and psychiatric history, an assessment of his daily activities, a social history, and a work and legal history. I also assess the applicant's mental status and his or her credibility.

At the conclusion of the evaluation, I prepare a comprehensive narrative report to address the questions asked using my knowledge and experience in psychiatry. I support my opinions using medical and objective evidence while by assessing the applicant's life style and history. Finally, I make recommendations for treatment.

The preparation of this report is extremely time consuming. It takes an average of 10 hours, which is much more than the 3 hour limit being proposed. These cases have a significant amounts of emotional, physical, and behavioral overlap, and great amounts of time must be devoted to properly parsing these factors out in a coherent and objective way. These reports are often 30+ pages.

To limit the billing for the report preparation would not sacrifice quality of work product but rather availability of quality QMEs. That is to say that I would not limit myself to 3 hours because I am only able to bill for three hours, but I would be discouraged about continuing as a QME/AME. This ultimately injures the applicant, who is already in a compromised state.

I believe that imposing such an arbitrary limit shows disregard for my time, and therefore, for my work. Furthermore, given the complexity of the system, adding an element of finding Psychiatric QMEs once other like myself have left would cause cracks in a system that is meant to restore the injured.

Arthur S. Schwartz, M.D., QME May 16, 2018
Orthopedic Surgeon

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Please re-consider adopting this language and listen to the input from the QME community. Consider finding a more equitable way to solve whatever you are trying to remedy.

S. Michael T. Tooke, MD, MPH, FRCSC, FAAOS May 16, 2018

Having performed *qualified medical evaluations* over the past approximately 5 years*;* I consider myself a *stakeholder* in the California Division of Workers' Compensation process of claims evaluation, as it pertains to medical and disability evaluation. Based on my understanding of the term, other *stakeholders* include: workers, insurance companies, applicant and defendant attorneys, WCAB judges, and the DWC, at minimum.

The following are my comments on the current proposed changes, and in particular the current process:

The process, as it is currently unfolding, is opaque. Firstly, as a panel QME, I have never received official personal notification of the proposed changes, or the availability of the

comment forum, e.g., no written correspondence addressed to me, either via certified mail or regular mail. The only reason I even know that the current changes are on the internet, and available for comment, is that I was informed by the management services organization that I employ. As a stakeholder, I would have thought that directly informing me, and other stakeholders, would have been not only appropriate, but also required.

Nor was I ever informed directly by the California DWC of the Medical Legal (ML) coding changes, that were invoked about a year ago in apparent secrecy, and which were the subject the April 4, 2018 court supervised settlement; or of the reversal of the changes by the court. It appears to me that the DWC has a contemptuous attitude towards the doctors who are QME panelists. One would have thought that communication with physicians, and other stakeholders participating in a government-operated program, would be individual and direct, i.e., letters informing each and every QME panelist, as well as other stakeholders, of changes and the rationale for changes. In the same vain (lack of information), the current proposals are not accompanied by any prologue explaining the necessity of change, and the problems that the changes are designed to solve. Having read, re-read and digested the changes, it is completely obscure to me, from what perspective those proposals are coming; or how they are going to make the process of medical evaluation better or more equitable. The proposed changes will result in very a significant diminution of QME report reimbursement; and I am left to assume that these proposed changes, are an attack on those of us, who are performing the QME function. How the injured workers of California could be benefited by these changes defies comprehension. I have become very concerned about the possibility of conspiracy, between the insurance industry and the Disabilities Evaluation Unit, to lower reimbursement. Saving money for the insurance industry is the only possible motivation/rationale that I can discern. If there is another reason, it has certainly not been forthrightly communicated.

Based on the prior changes, which the court settlement reversed, and the currently proposed changes (presumably to undo the settlement); I am doubtful that those individuals promulgating the changes have any significant "on the ground" experience in the actual process of performing a *qualified medical evaluation,* including generation of the report. There certainly is no evidence of an information-gathering effort being made in advance of proposing these changes.

The curtailment of research, via a prohibition on billing for any citation made within the prior 12 months lacks any stated or intuitively obvious rationale, except an attempt to reduce billing via reduction of *complexity factors.*

- Firstly, from the perspective of simple logistics: Is the QME now supposed to keep a log of which research reference was used on which date on which case, and should that log be presented with each report in which articles have been referenced? This is a preposterous proposition.
- Secondly, different information may be referenced from the same scientific reference article in different case reports. To imply through this rule change, that once an article is referenced for one case, its use in subsequent cases does not require revisiting/reviewing the article is indeed naïve, not to mention unfair. I certainly cannot remember well

enough what I read 11 months ago in a 12-page journal article, to state it authoritatively in a legal document without re-reading it. That is an undertaking that takes time and effort. Without reimbursement, the use of established medical science to underpin medical opinions will simply decline.

- Thirdly and most importantly, the DWC, in its official promulgations, has emphasized the need to base evaluations on medically scientific fact. In reality this frequently means countering the *lore* embedded in the California workers' compensation medical-legal evaluation process, e.g., Carpal tunnel syndrome is caused by keyboard input work, for which there is no evidence in the occupational medicine literature. Authoring an explanation, based on review of the scientific medical literature, rather than basing it on simple opinion and *experience,* makes the report more authoritative and valuable.
- Fourthly, the proposed rules limiting research hours (2 hours on an ML-106) do not take into account that conducting a literature search, in order to find pertinent references, almost always involves reading numerous articles that turn out to not yield the information needed for the report. As a QME who frequently uses literature searches to augment my own experience, I can assuredly say that for every article I have referenced, I have probably read three.
- Fifthly, and most importantly, in a system that is relying on those of us doing *qualified medical evaluations,* I have learned much from the many literature searches I have done. The *lore,* so prevalent in the system, is frequently not substantiated, when scientifically promulgated facts are sought. Literature searches keep evaluation objective and are good for the system. They should be encouraged. I would have thought that any thoughtful attempt to improve the system of disability evaluation would have encouraged the use of scientifically derived information. Denigrating research can only lower the standard of evaluation in the system.

The proposed rules regarding the issue of the eligibility of *causation* as a *complexity factor* are extremely problematic. The following is excerpted from the proposal and applies to both ML-103 and ML-104:

(6) Addressing and providing an analysis of the issue of medical causation, ~~*upon written request of the party or parties requesting the report*~~ *provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation.*

This rule (6), as written, belies a lack of knowledge by its author(s) of the *nuts and bolts* of the process, as it actually happens.

- Firstly, the following situations are commonplace:
    - No communication from the insurer or either attorney has been received by the date of the QME – the whole purpose of the QME, be it causation or not, has not

been stated, and the QME is left to conclude on his/her own what has triggered the evaluation (The claimants almost never know).
    - The correspondence received from the defendant and/or applicant attorneys, and/or insurer do not explicitly state which/what injuries have been accepted and which are in dispute (Frequently several injuries are alleged, some accepted, some not).

- Secondly, lack of specificity by the insurer about disputed causation can only work to the insurer's financial advantage, i.e., no specific request equals no legitimate coding to include the *complexity factor of causation,* even if the report would be incomplete without discussing
  causation. This is very unfair to the QME, and is an example of the DWC and Insurer *gaming the system.*

- Thirdly, is the problem of the requirement that the *physician and the parties agree prior to the start of the evaluation that issue of medical causation is a disputed medical fact….* I do not know how a physician could *agree* unless he had reviewed the case medical records, before performing the evaluation, or had some type of unbiased prior knowledge. This proposition seems self-contradictory. I see no provision for reimbursing the physician for time he/she might spend determining that *causation is a disputed medical fact,* to which he can *agree* or not. I can certainly see considerable potential for the insurers', or the attorneys' not stating that *causation* is an issue. Ultimately, unless the DWC requires the insurer to **forthrightly and timely** inform all involved, QME, applicant, defendant and applicant attorney, what is accepted and what is not; there can be no *agreed* pre-determination of whether *causation* is an allowable *complexity factor.* It would appear that the DWC would have to become much more vigilant about controlling insurance company behavior than it currently is, for this proposition (Rule 6) to work.

In summary, there has been no direct communication from the DWC to QME panelists, or other stakeholders. There has been no statement of the perceived problems with the current system; and no solicitation of suggestions to improve the system of *qualified medical evaluation* from QME's, or any group of stakeholders, e.g., applicant and defense attorneys, WCAB judges, insurance companies. Any rationale for changing the coding system has not been stated. Is there a problem that is adversely affecting claims adjudication, and if so, what is it? These are questions begging answers, but none have been provided. Having participated in the system for 5+ years, I can attest to the fact that it is an extremely flawed system, but I don't see how the proposed changes are going to improve the system. It is inconceivable that injured workers in California will benefit from the rule changes, if they are invoked. Personally I find the work quite challenging and difficult, given that I want to do my best. If the proposed changes are invoked, Qualified Medical Evaluators will slowly leave the system as they find a more remunerative way to deploy their talents. Certainly these changes will not result in a surfeit of new recruits to the system.

Satish K. Lal, MD May 16, 2018

I oppose the newly drafted med-legal fee schedule language. If this proposal goes through it will surely adversely impact the pool of QMEs and the quality of reporting.

Jason Marcus, Esq., President May 16, 2018
California Applicants' Attorneys Association

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, medical-legal fees must be sufficient to attract qualified physicians to provide quality evaluations as QMEs and AMEs. In the last five years the availability of physicians to conduct medical-legal evaluations in the State of California has decreased dramatically by 20% (See CWCI report on changes in QME population and Medical Legal Trends, February 2018). In some medical specialties there are not even five physicians certified in the requested specialty to issue a Panel QME list. In other medical specialties, the injured worker is provided a list of physicians ranging geographically from San Francisco to Santa Ana to Sacramento while the injured worker resides in San Diego. In more rural areas, injured workers have to drive more than four hours to attend an evaluation. In addition, as noted in other recent studies there has been a 'graying' of currently available QMEs who upon retirement are not being replaced. This will contribute to a further decrease in available QMEs in the next five years.

California has a workers' compensation system based on a complex evidence based medicine standard to assist all parties, in getting accurate evaluations of work impairment, apportionment, and causation which serves to reduce frictional costs. This requires the medical experts who provide these evaluations to prepare reports with a thorough analysis of medical history, and application of AMA rating guidelines, so that the reports constitute substantial medical evidence. Doctors must be adequately paid for this level of expertise and time involved to properly prepare reports on complex claims.

The most likely outcome if the proposed revisions to the medical legal fee schedule are adopted as written is that frictional costs and therefore allocated loss adjustment expenses will increase dramatically in the system thereby raising employers' costs. Because physicians will not be adequately compensated to provide a report with a thoughtful and complete analysis, by necessity there will be an increase in doctors' depositions, supplemental reports and defense attorney fees to assure that an analysis on important issues is properly completed. Failure to

adequately compensate evaluators will lead to inadequate apportionment analyses (harming employers), inadequate Almaraz/Guzman and causation analyses (harming workers), creating further needless expense to payors, delay of resolution of the applicant's case, and ultimately an increase in employer expenses and premiums.

Further, a medical legal fee schedule that is inadequate to compensate physicians for necessary work actually performed on cases can only lead to disputes and increased frictional costs from litigation which could have been avoided with an adequate fee schedule. Proponents of fair compensation for work performed will have substantial legal precedent to argue in these cases. Based on the CWCI study cited above, the DWC should be focusing on improving QME access. They should also be focusing on improving quality QME reporting which has been identified as a significant problem. Cutting payments to evaluating physicians with the revisions to this fee schedule is an extremely misplaced priority, especially in light of the unprecedented cost savings to carriers in the last 5 years from the passage of SB 863.

Lastly, and essential to this public dialogue, RAND presented at the May 25, 2017 meeting of the California Health and Safety Workers' Compensation Commission("CHSWC") on their preliminary findings on the Medical Legal Fee Schedule and reports required in the workers' compensation system. This study was done at the request of the DIR with a Request for Proposal ("RFP") approved by CHSWC in 2014 as part of broader research on the evaluation of SB 863 Medical Reforms. Over a three-year period leading up to this 2017 presentation, RAND conducted stakeholder interviews and consulted with a technical advisory group. RAND also regularly reported at CHSWC meetings on the progress of this study. The study was to be released in Spring 2016 but after additional delay RAND reported at the May 2017 CHSWC meeting that the draft study was in the final stages of "peer review" and would be posted soon for public comment. At this meeting, the CHSWC Commissioners approved the "Posting of DRAFT report titled "Evaluation of SB 863 Medical Care Reforms," by Andrew Mulcahy and Barbara Wynn at RAND, for feedback and comment after it is available, with final posting after 30 days". (See Minutes of Hearing from May 25, 2017 CHSWC Meeting.) One year later the RAND study including recommendations on the medical legal fee schedule has never been posted for public comment. At a minimum, the posting of these proposed medical legal fee schedule regulations on the DWC Forum is premature until the RAND study is released for public comment. More importantly, this action should be considered an attempt by the DWC to circumvent the role of CHSWC and the public meeting laws to which it is bound with regard to a study contracted through the DIR and CHSWC with recommendations on changes to the medical legal fee schedule that the public has never seen. Based on the foregoing, the current rulemaking process on proposed changes to the medical legal fee schedule should go no further until valuable feedback from the RAND study, the public, and the CHSWC commissioners is completed.

The following are our specific comments by regulation section.
§ 9795(c)
ML101, ML 104 and ML 106 No more than 3 hours may be billed for report preparation

This comment applies wherever there is a proposal to cap report preparation at 3 hours in these regulations. There needs to be clarification on what is included in the 3 hours of report preparation time. It should not include the medical records summary, face to face time, etc. Is it contemplated that a doctor should dictate and proof a report on even the most complex claims in three hours or less? Many follow up medical legal evaluations involve a significant amount of medical records to review. What about the firefighter with a cumulative trauma claim to 10 body parts encompassing a 25 year career and with 15 specific injuries where the records come in after the initial evaluation? What about the Psychiatric injury claim where the doctor is requested to review twenty years of records? A 3 hour cap simply does not work for complex cases particularly those with multiple organ systems involved. Does the doctor stop after three hours? Work for free after three hours? Forget about providing a report that is substantial medical evidence? If the doctor stops after 3 hours, do the parties then request a supplemental report to continue the medical legal analysis?? Simply put, there should be no hourly cap on report preparation.

ML 103 (3) - The requirement that medical research used in the preceding 12 months can't be billed for seems unfair. It will likely be used as the new QME licensing 'gotcha' to deny re-certification. How is a physician to remember if they used research from 11 months ago when they have performed 100 QME evaluations since then? Additionally, the facts of each case are different.

How are carriers going to enforce this without increasing their time and costs in investigating whether the research was previously used in the last year by the physician. This will increase frictional costs in the system.
Also, if physicians are required to attach their research this will increase report preparation time and costs.

ML 103 (6) - The requirement of agreement of the parties for the physician to address causation will cause gamesmanship and prevent valid medical-legal evaluations on disputed issues. If one party refuses to agree, then additional litigation is inevitable since that will be the only recourse to resolve the standoff.

Also, this appears to be contrary to Regulation 10909 mandating the carrier to do a good faith investigation of all issues on the case. The issue of causation is often outside the expertise of the parties and must be addressed by the medical experts. It is in many cases the essence of a medical legal analysis.

ML 103(7)(A) and ML 104- As written this section does not consider the complexity of psychiatric claims. An individual's entire life experience, prior psyche history, non- industrial personal issues, effects of non -industrial medical problems, whether apportionment of an orthopedic impairment passes through to a psychiatric apportionment, Benson, *Kite,* and now LC4660. l, in post 1/ 1/ 13 cases must be considered. According to the current proposed apportionment complexity factor definition, such an analysis is not considered a complexity factor!

ML 103 (7)(B) - This will cause delays and add to frictional costs. Often the parties need an apportionment analysis before an MMI determination is reached, whether to assist the parties in an early settlement evaluation or to assist in the assessment of liability between employers and other carriers.
ML 104 (1) & (2) - Again, a definition of what is included in report preparation would be helpful but we continue to assert that there should be no hourly cap on report preparation time.

ML 104 (3) - What does "start of the evaluation" mean? Is it when the physician first reads the cover letters from the parties before the exam of the injured worker? Does it start with the review of the medical records? This needs to be clarified.

ML 106
See comment under ML 103(3) above.
Also for complex cases, two hours of research time may simply not be enough to provide substantial medical evidence when issuing a supplemental report particularly when the parties have raised new medical issues or additional medical records have been provided.

In conclusion, when the totality of the proposed revisions to the fee schedule are considered, CAAA believes this is a misguided attempt which will result in the degradation of the quality of medical evidence. Further, it will drive more doctors out of the QME practice, thereby harming the very injured workers the system is supposed to protect.

Gabor Vari, MD, Chief Executive Officer May 16, 2018
California Medical Evaluators

California Medical Evaluators ("CME") is a leading QME practice management company headquartered in Los Angeles. Our network of over 100 QME physicians performs over 4,500 QME, AME and IME evaluations annually. As a DWC-accredited QME continuing education provider, CME has a special focus on QME training and mentorship in order 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. The exodus of QMEs has been accelerating in recent years. Injured workers are having difficulty obtaining QME evaluations in a timely manner.

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 supply and demand has never been greater.
3. Inadequate reimbursement is one of the main drivers of QMEs leaving the system. QME fees have not been increased since the fee schedule was introduced in 2006.
4. QME report quality is consistently raised as a problem throughout the system.
5. The proposed change to the fee schedule would slash QME reimbursement. This couldn't come at a worse time. Reducing QME compensation would likely accelerate the already alarming rate of QMEs leaving the system and worsen report quality. With the system already understaffed, these changes would jeopardize the stability of the QME program.

Timing

Before addressing the specific proposed changes, we would like to comment first on the timing of these changes. The lawsuit which challenged the DWC's prior enforcement of underground regulations, *Howard v. Baker*, settled in mid-April. In that settlement, the 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 had soured its relationship with much of the QME community after denying reappointment to hundreds of QMEs on the basis of underground regulations. Many within the community felt that the settlement was a sign of hope and signaled that the DWC was prepared to act in good faith with QMEs going forward. Instead, the DWC has elected to scramble and quickly change the fee schedule in order to slash QME reimbursement. **These proposed changes seek to codify several of the underground regulations that the DWC just agreed to stop enforcing.**

Besides violating the spirit of the settlement that was achieved, there are more reasons why the timing of the DWC's rush to slash QME reimbursement is suspect. The DWC hired the RAND corporation several years ago to study the QME fee schedule. This study remains active and results still have not been published. We understand that RAND intends to present their findings on the QME fee schedule later this year to the Committee on Health and Safety and Worker's Compensation ("CHSWC"). In the past, policy changes such as this have only been made once study results were released and CHSWC has had time to digest and analyze the results. Rather than taking a more measured and thoughtful approach as in the past, the DWC appears to be making a frenzied end run around CHSWC, the RAND study, and several stakeholder groups in order to hastily cut QME pay.

Proposed Changes

In order to understand the proposed changes and their effects, it is important to first understand the fee schedule as it stands today. QME reports are generally broken down into 1 of 3 codes: ML 102, ML 103, and ML 104. The fee schedule contains complexity factors. The way to determine which ML code is appropriate for a report depends on how many complexity factors the report meets.

Table 1: QME Codes, Rates and Requirements

ML Code	Rate	Requirement
ML102	$625 (flat)	None/default
ML103	$937.50 (flat)	3 complexity factors met
ML104	$250 (per hour)	4 or more complexity factors met

The underground regulations as well as the current controversy over the proposed changes has to do with the complexity factors. If complexity factors are easier to meet, the highest rate of ML104 is easier to achieve. If complexity factors are more difficult to meet, ML 104 is harder to achieve. **The DWC's prior underground regulations and current proposed changes share a common theme: they both make complexity factors much more difficult if not improbable to achieve.** This results in **lower reimbursement for QMEs.**

The following is our general analysis of the proposed changes:

1. The proposed changes are overwhelmingly negative for QMEs. If the regulations are enacted as written, it would make it much more difficult for QMEs to achieve the ML104 billing level ($250/hour). The DWC is trying to steer more reports towards the capped ML103 ($937.50) or ML102 ($625) levels. Report preparation time would also be capped at 3 hours (currently uncapped) for most ML104s.

2. The proposed changes give much more control to insurance carriers to limit or reduce reimbursement to QMEs. The changes to the causation complexity factor, in particular, would give insurance companies a "veto power" to ML104.

3. The QME has to jump through several hoops and obtain written authorization from both parties on various issues in order to achieve certain complexity factors, thereby making ML104 much more difficult, if not impossible, to achieve. Meanwhile the parties are under no obligation to respond to such requests from the QME. In our experience, they do not respond.

4. Arbitrary anti-provider provisions are included such as capping report preparation at 3 hours per report and restricting physicians use of medical research by only allowing them to use a given research article once per 12 months.

The following is our specific analysis of the proposed changes:

1. 9795(b): 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.

We oppose this change. As discussed in more detail below, the proposed changes make it likely that the QME will be unable to meet the ML 104 hourly rate and must bill under a flat fee ML 102 or ML 103 rate. QME evaluations can take a very long time to prepare due to the voluminous amounts of medical records the QME must review and the complex report that needs to be written. It is not uncommon for the entire report to take over 20 hours to produce from beginning to end. This sets up a scenario in which the QME is working 20 hours and is being forced to bill at a flat rate (e.g. $625 for ML102). **This scenario yields an hourly reimbursement of $31 per hour for the QME.**

The new sentence introduced above makes it clear that a QME who is not willing to work for $31 per hour must still perform the report. The QME cannot decline to do the report because of this new addition. So, QMEs will either a) quit the system altogether to avoid being forced to work at an unacceptable rate or b) do the work so rapidly that the hourly rate makes sense.

Whereas a proper report would take 20 hours to produce in this hypothetical example, the QME may rush through it in only 2 hours in order to make a more acceptable $310 hourly rate. The resulting report will be so barebones that it will either a) be thrown out of court as inadmissible because it does not constitute substantial medical evidence, requiring a replacement QME **resulting in more costs for the carrier** or b) will require the parties to depose the physician or request a supplemental report **resulting in more costs for the carrier**.

2. ML101, ML104, ML106: "No more than 3 hours may be billed for report preparation."

We oppose this change. Many reports, especially mental health reports, cannot be properly written within 3 hours. It is unclear where the number 3 came from. Was this based on data? Were actual QMEs consulted on whether this is a realistic number? The unintended consequence of this is that QMEs will essentially stop writing their reports once they hit the 3 hour mark. That will generate incomplete reports which will further slow the system down. This will increase the number of supplemental reports and depositions **resulting in more costs for the carrier**.

3. Complexity factor (3)

> (3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;

We oppose these changes. Restricting QMEs from citing the same sources within a 12 month period is impractical. Medical research is a vital tool for helping QMEs author more comprehensive reports that will withstand legal scrutiny. Discouraging research will result in reports of lower quality which are more open to attack. This will increase the number of supplemental reports and depositions **resulting in more costs for the carrier**.

4. Complexity factor (5)

> (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;

We oppose these changes. This addition requires the QME to perform at least some medical research, record review and face-to-face time in order to qualify for this complexity factor. This requirement is in direct conflict with the change discussed above. On the one hand, the medical research complexity factor is restricted by disallowing the same research in 12 months and on the other hand, the QME must perform research in order to meet this complexity factor. **It is unclear why the DWC would seek to simultaneously restrict research and require it** in order for QMEs to meet this complexity factor.

In its current proposed format, this complexity factor does not make practical sense. Consider the following two scenarios:

Scenario A: QME received 15,000 pages of medical records which requires 60 hours of record review time. The QME performs 3 hours of face-to-face evaluation. The QME does not believe that research is necessary and performs 0 hours of research. In this scenario, the QME would not qualify for the three complexity factors he or she could earn under complexity factor 5 despite spending 63 hours on the combination of face-to-face time and record review. This is a barrier to the QME being able to charge at the hourly ML104 rate.

Scenario B: QME performs 3 hours of record review, 2.75 hours of face-to-face time and 15 minutes of medical research. In this scenario, the QME would qualify for three complexity factors under complexity factor 5 for spending a total of 6 hours on the combination of face-to-face time, record review, and medical research. Achieving these 3 complexity factors would make it easier for the QME to charge at the hourly ML104 rate.

It does not make sense that the QME in scenario A would not qualify for 3 complexity factors under complexity factor 5 whereas the QME in scenario B would be awarded 3 complexity factors under complexity factor 5.

We propose simplifying this complexity factor by allowing for complexity factor 5 whenever a QME spends six or more hours on **any** combination of complexity factors 1 - 3 without requiring that some time be spent on each of medical research, record review and face-to-face time.

5. Complexity factor (6)

(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

We oppose these changes. The current version of this complexity factor has two requirements:

1. The QME address the issue of medical causation
2. The QME receive a written request from at least one party requesting that the QME address causation

The proposed new complexity factor has four requirements:

1. The QME address *and analyze* (query: definition?) the issue of medical causation ***AND***
2. The physician and the parties agree prior to the evaluation medical causation is a disputed medical fact ***AND***
3. Determination of medical causation is essential to the adjudication of the claim for benefits ***AND***
4. The parties agree that the physician may use causation as a complexity factor for billing purposes

Particularly problematic is requirement #4. First, the carriers probably won't authorize the QMEs to use causation as a complexity factor. The carriers could request a) that the QME address causation and be paid for it or b) that the QME address causation and not be paid for it.

Why would the carriers ever choose to pay the QME to do work when they could require the QME to do it for free?

Second, what will happen on denied claims? The natural path for defendants would be to disincentivize the QME from spending any time on assessing the causation of a denied claim. Defendants will simply not agree to allow the QME to use causation as a complexity factor. This means that QMEs will not be paid to address causation on denied claims. Unless the QME chooses to work for free, injured workers claims will remain denied.

Third, the parties are under no obligation to respond to the QMEs request for agreement pursuant to this or any other complexity factor. Currently, we reach out to insurance carriers for pre-authorization when such pre-authorization is currently required. Such requests are mostly ignored. Several carriers send us blanket denials indicating that their policies forbid pre-authorization for medical legal reports. We have had defense attorneys send us threatening letters in response to such pre-authorization requests. **The practical effect of adopting this new complexity factor is elimination of this complexity factor as defendants will either a) ignore requests for pre-authorization or b) deny them.**

6. ML104(3):

(3) 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. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. When billing under this subdivision of the code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

We oppose these changes. As discussed above regarding the causation complexity factor, pre-authorization is not a practical reality for QMEs. Additionally, the QME may not be aware of extraordinary circumstances until after the evaluation. For example, a large volume of records may arrive after the evaluation. Or the QME may only discover complex issues requiring a lengthy face-to-face evaluation of the injured worker during the evaluation itself. In such cases, requiring pre-authorization does not make sense. QMEs should be able to request authorization for extraordinary circumstances at any point prior to the issuance of their report.

Conclusion

We oppose several of the proposed changes to the medical legal fee schedule. The proposed changes add more complexity to an already convoluted fee schedule. Further, the effect of these

changes will be to slash reimbursement for QME reports and shift most hourly reports to capped fee reports. The QME system is already woefully understaffed and needs to attract more QMEs in order to remain viable. The proposed change in the fee schedule will cause existing QMEs to leave the system, further degrade the quality of QME reports, and result in significant delays and additional frictional costs for carriers.

The timing of this rush to slash QME reimbursement is suspect as it comes on the heels of a legal settlement in which the DWC agreed to honor the existing version of the fee schedule. We respectfully request that the DWC withdraw this proposal and involve stakeholders such as CME and other practice management companies in future discussions regarding changes to the fee schedule.

Domenic Signorelli, DPM May 16, 2018
Foot and Ankle Surgeon
Reconstructive Trauma Surgeon
Sports Medicine/Biomechanics
Qualified Medical Examiner

There are significant problems with the proposed changes to the Medical-Legal Fee Schedule. This letter attempts to outline those problems.

Most glaringly, although changes are made to further limit the ability of a QME to get paid, the proposed regulations do nothing to recognize that amounts payable remain unchanged since 2006. It is unheard of in any other industry to have no increase for cost of living or otherwise for well over a decade. And here, instead of providing for such an increase, it appears that the DWC is attempting to force QMEs to work for free in significant ways.

Under the proposed amendments, a QME cannot condition performance of an evaluation on receipt of a prior agreement by the parties for any matter for which prior agreement is required. But, if the QME determines, in his or her own independent medical judgment, that such a service is required, then the DWC clearly expects them to perform that service for free or be in violation of the regulations and put their certification on the line.

Likewise, a QME cannot bill more than 3 hours for report preparation. Contrary to what some of the other commentators believe, it appears it is not the intent of the DWC to limit how much time a QME can or must spend preparing a report. In other words, QMEs can (and really, must) spend as much time as necessary to prepare and adequate and comprehensive report, but they have no choice but to do so for free after the first three hours.

The following statement is so vague that a truck can be driven through it:

> "In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performedwhich made these complexity factors applicable to the evaluation."

What does this mean? Complexity factors are not actually and necessarily 'incurred' for the production of a report. They are factors that are either addressed or utilized as part of the evaluation, which results in the preparation of a report. Moreover, how is one supposed to account for surprise circumstance uniquely specific to the actual evaluation being performed (in 3 hours or less mind you) that made the complexity factors applicable. Again, what does that mean?

Like the language quoted above, it is unclear what is meant by "All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code" in factors 2 and 3. In factor 2, presumably the criteria referenced is the one contained in Labor Code 4628(a)(2), except that subsection (a)(2) of that code contains no criteria. Like working for free past the first three hours of report preparation, doing a free causation analysis (discussed below) and other work for free, under the proposed amendments, a QME will now be required to either conduct medical research for free, or guess at what they may have read many months ago about a nuanced medical issue they have not encountered since maybe 50 or 100 reports ago. Since the latter is obviously not an option for any QME, their only option is to do the research again, for free.

Not only will they be required to do the research for free, they will also be required to track (how??) any research they did in any report over the course of the previous 12 months to ensure they don't bill for the same research again less they be caught in the compliance violation net the DWC so famously cast the last several years. Along the same lines, to the extent a QME does conduct research (regardless of whether they will be paid for it), the research must be 'reasonably necessary to reach a conclusion about a disputed medical issue.' Well, what if the QME simply needs a refresher on the impacts of certain types of treatments on certain injuries, or the need for medications that the IW has been taking? What if the research was necessary to actually rule out something? In other words, as written, the amendment only allows a QME to bill for research that resulted in reaching a conclusion, but not research that was necessary to rule something out or to familiarize the practitioner with some nuanced issue.

This brings us to causation. Like so much else, under the proposed amendments, QMEs will be required to make a determination regarding causation for free when there is a disputed medical issue unless all parties and the QME agree, in advance, that causation is a billable factor. Given that information often comes out during a face to face evaluation that a defense attorney or claims adjuster may not be aware of, it is highly unlikely that the defense will ever agree to this complexity factor. Why should they? Under the amended language of the regulation, the defense can just as easily agree that there is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits, but then not agree to authorize the

complexity factor for billing purposes. Considering the limitation on QMEs stated at the onset of this letter, a QME cannot condition performance of an evaluation upon receipt of a prior authorization. Thus, the QME will necessarily have to do a causation assessment for free. Another major issue with the changes as they pertain to causation is that it is an end run around the Settlement that the DWC reached just last month in the *Howard et. al. v. California Dept. of Industrial Relations*. Under that Agreement, the DWC agreed, with respect to causation as a factor, that they would not impose "any additional requirement that the underlying injury claim have been denied or contested by the insurer, not to require that both parties (as opposed to a single party) have requested that the issue of causation be addressed, and not to require that nay written request that causation be addressed include any specific words or phrases." The proposed amendment now requires all of these.

The changes related to apportionment are also inappropriate. Currently, the regulations require that for the apportionment complexity factor to apply, the employee must have been employed by three or more employers, sustained three or more injuries to the same body part, or had two or more injuries involving two or more body systems or body regions. This was already a difficult factor to meet and was usually only applied to some of the most complex cases. The proposed amendments now subtly, yet drastically, change the language to require three or more dates of injury to the same body system or region or two or more dates of injury involving two or more body system (or three or more employers). By changing the language from injuries to dates of injuries, arguably, for apportionment to apply, all prior injuries must be industrial in nature. Moreover, by requiring specific dates of injuries, the IW must recall the exact date of injury for the factor to count. This will effectively negate apportionment as a complexity factor in a clear majority of cases where it would otherwise have applied. Finally, the requirement that physician and the parties agree prior to the start of the evaluation that the evaluation involves extraordinary circumstances is replete with the same pitfalls as the requirement for prior agreement regarding complexity.

For these reasons, the DWC should not amend the Medical Legal Fee Schedule as proposed.

Gregory L. Marusak M.D. May 16, 2018

As a QME in this system in its many iterations for over 20 years I have weathered many DWC changes. This is the first time I have been compelled to express my thoughts publicly and state, without hesitation, that I won't work for free and I refuse to produce poor quality work.

I believe the proposed changes will throw the system into disarray, result in massive exodus of physicians and ultimately harm the injured workers with delays and wholesale dismissals of claims. I'm not going to squabble over the details, tell you that psychiatry deserves more than other specialties or that no changes are needed. The proposed changes are arbitrary, not based on fact or research and punitive in nature. The "Underground" Regs failed to work so this is the next

illogical attempt to achieve the same. Changes are needed and I'm waiting to see the latest Rand study to help understand exactly what is what is needed and why. Thoughtful reform will hopefully ensue but this latest proposal is using a machete when a scalpel is required.

Looking at the intent of this proposal I can see driving down costs, and ejecting the thoughtful physicians that produce thorough and ratable reports that address all the pertinent issues and allow each party to fairly address the injuries the worker incurred is the short–term goal. But they are forgetting, you generally get what you pay for. Pay a doctor less and you won't see the same amount of time, effort or thought going into these reports. The result will be a further decrease in the number of quality QMEs, dismissive, templated, cursory, poor quality reporting and a much greater volume of applicants for the few remaining physicians. The changes conflict with the posted purpose of the DWC Medical Unit that describes "Physicians help resolve medical disputes in the workers' compensation system by issuing medical opinions that can be used as evidence before the Workers' Compensation Appeals Board." Reports generated within the new proposals will not resolve disputes or hold up as substantial medical evidence before the WCAB. Simply put, the intent is to throw the system into chaos.

Why would they want this? Follow the money. These changes would be a huge win for the insurance companies. A wholesale change in the existing system is the goal with decreased costs to carriers by limiting liability and expenses related to these claims. These proposed changes will help these efforts twofold. The first being cutting down the number of physicians willing to do these evaluations at a time when more doctors are actually needed. Backlogs, delays and chaos will make it easier to sell a total revamp of a broken system. Secondly, the few remaining physicians will produce inferior, quantity before quality, reporting that is easily ripped apart by the defense. Washing out the applicant and pointing to the shoddy QME reporting as the culprit will become the new norm. The DWC seems more aligned with the interests of the insurance companies and businesses and less so in the interests of injured workers or the QME physicians. At a time when good studies, careful consideration and thoughtful reform is needed these poorly conceived changes will rapidly lead to the demise of a system that actually works.

Daniel Buch, BS, DC, QME May 16, 2018

I have analyzed the proposed changes to the Medical Legal Fee Schedule (MLFS) and have additional comments and suggestions to this forum.

I believe that the current DWC changes to the MLFS would only serve to;

- Devalue the QME physician's time and contribution to the system.
- Increase the potential for inaccurate and incomplete medical legal reports.
- Increase animosity between the DWC and QME physicians
- Drive QME physicians away from *serving* as QMEs within the system.

- Increase the potential for an unfair medical legal report, upon which the injured workers future is often at stake.

I propose the following amendments to the MLFS. Many of these were suggested in prior comments to this forum. I present them here in a summarized fashion.

I trust that the rule makers involved will take the time to consider the following proposals, side by side, with those proposed by the DWC. The proposed DWC changes to the Medical Legal Fee Schedule dramatically undervalue the QME, and appear to be punitive in nature; treating **ALL** QMEs not as a valued contributor to the Workers' Compensation system, but merely as potential law breakers.

The following proposals represent an actual appreciation for the professional training of the physician, and the complexity and time involved in the performance a Medical Legal Examination and Report. The proposals below reflect a starting point, more realistic than those proposed by the DWC, which are more in line with changes *actually* required to maintain and improve the quality and standards of the QME system.

- PROPOSED AMENDMENTS TO THE MEDICASL LEGAL FEE SCHEDULE -

(b) The fee for each evaluation is calculated by multiplying the relative value by $15.*00* ***(currently $12.50)***, and adding any amount applicable because of the modifiers permitted under subdivision (d).

ML10 0 Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation.

The physician shall be entitled to bill for missed or late cancelled appointment as 8 units at RV-5, or his or her usual and customary fee, whichever is less, for each quarter hour. In addition the physician is entitled to bill in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour for any time spent reading/reviewing/summarizing records prior to written receipt of the cancellation notification.

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ML101 Basic Follow-up Medical-Legal Evaluation.

Limited to a follow-up medical-legal evaluation which occurs within nine months of the date on which the prior medical-legal evaluation was performed, **entails records consisting less than 100 pages, and only records from treatment provided during the interim nine months.** The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than 10 hours may be billed for report preparation under this code.

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ML102 Basic Initial Comprehensive Medical-Legal Evaluation.

Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
Includes evaluations which require less than 1 hour face to face time, involve fewer than 100 pages of records, in which neither party disputes causation, and involves injury to a single body part or region.
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ML103 Comprehensive Initial or Follow-Up Medical-Legal Evaluation.
Includes evaluations which do not meet the requirements to be a ML102 Basic Medical-Legal Evaluation and require three or fewer of the complexity factors set forth below.
In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation.

Complexity Factors:

(1) Two or more hours of face-to-face time by the physician with the injured worker;
(2) Two or more hours of record review by the physician. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2).
All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;
(3) Two or more hours of medical research by the physician, using sources that are not routinely cited by the evaluator on the basis of diagnosis, treatment, or type of report.
An evaluator who specifies this complexity factor must also (A) explain in the incorporate the research into the body of the report to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed.
All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;
(4) Four or more hours spent on **any combination *(as the CURRENT MLFS stipulates)*** of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. Any complexity factor used as a stand-alone may not be used in combination under this subdivision.
(5) Six or more hours spent on **any combination *(as the CURRENT MLFS stipulates)*** of three complexity factors (1)-(3), which shall count as three complexity factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision.
(6) Addressing and providing an analysis of the issue of medical causation**.** Causation is presumed to be in dispute unless all parties agree and stipulate in writing prior the start of the evaluation that medical causation is not in dispute. ***(The parties MUST agree in writing to the QME that Causation is NOT in dispute or causation will be an accepted complexity factor)***
(7) Addressing the issue of apportionment, **when one of the following conditions applies:**
The determination of this issue requires the physician to evaluate and provide an apportionment analysis of:
(i) the claimant's employment by three or more employers.

(ii) three or more dates of injuries, whether industrial or non-industrial, to the same body system or body region as delineated in the chapter headings of the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition).
or (iii) two or more or more dates of injuries, whether industrial or nonindustrial, involving two or more body systems or body regions as delineated in that Table of Contents.
(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
(9) The evaluation is being performed by a Qualified Medical Evaluator or Agreed Medical Evaluator.
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ML104 Complex Comprehensive Initial or Follow-Up Medical-Legal Evaluation
The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for face-to-face time, record review, medical research, and report preparation:

(1) An evaluation which requires four or more of the complexity factors listed under ML 103. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation.
(2) An evaluation involving 1 or more prior injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103.
(3) A comprehensive medical-legal evaluation for which the physician and the parties agree in writing within 5 business days of the date of evaluation or the receipt of the applicable records, involves extraordinary circumstances.

Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. The request by the physician may be served on the parties by facsimile. If a party does not respond to the request by 5:00 PM Pacific Time, on the 5th business day following receipt they are deemed to have agreed that the evaluation involves extraordinary circumstances.
When billing under this subdivision of the code for extraordinary circumstances, the physician shall include attached to his or her report either;
(i) a copy of the signed agreements from the parties; or
(ii) a statement under penalty of perjury that the party or parties failed to respond to the request for agreement that the evaluation required extraordinary circumstances. In either event, the evaluator must also provide verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to- face time with the injured worker, preparing the report and, if applicable, any other activities.
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ML105 Fees for medical-legal testimony.
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 up 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 the minimum fee of one hour at the rate of RV 5, or his or her usual and customary fee, whichever is less prior to the commencement of the deposition.
Prior to closing the deposition record, the doctor can present a written invoice and state for the record an accounting of any applicable preparation time, travel time, and/or time in excess of 60 minutes spent in deposition rounded up to the next quarter hour.
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ML106 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.

David M. Broderick, MD May 16, 2018

I am writing this letter with regard to the proposed changes in the QME fee schedule. The proposed changes will, in my opinion, impact the system negatively as the time required to produce a report would not be compensated in any meaningful way as to be financially viable for the Examiner to continue the program. The constraints placed upon the Examiner regarding time allowed to complete the exam as well as redefined factors of causation and other complexity issues will make it difficult to produce a thoughtful and coherent report which is also ratable as per the AMA Guides in a reasonable amount of time.

Additionally it will be difficult to attract new Examiners to the workers compensation field as well as maintain the Examiners already in the field.

If it is the intent of the DWC to disband the present QME system then they may be successful. What will be left will be computer driver algorithm mills or a perpetual industrial purgatory for the injured worker who will rarely, if ever, have his industrial claim adjudicated.
I do not support the proposed changes.

Ira B. Fishman MD QME May 16, 2018
Internal Medicine

My simple impression is that the currently proposed changes will have many unintended consequences. This is particularly true for complex cases that require extensive record review, report preparation and medical research far beyond what the new regulations propose.

I have no quarrel with an attempt to improve billing procedures for QMEs.

I propose pulling the current proposal and convening a stake holder panel to come up with an improved solution that properly accounts for dealing with complex claims.

The reform of QME billing procedures needs to be different from those completed for one dimensional providers such as interpreters or copy services.

Physician evaluators provide a complex multidimensional series of intellectual services to the system that requires a more nuanced and collaborative approach. Also physicians have many other choices for what kind of work they wish to perform.

However I thank the DWC for bringing up this important issue and starting the process. Hopefully it can be more collaborative but if not the future for QMEs will be interesting.

M. Kreidie, MD, FAAN, QME May 16, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Jeffrey F. Caren, MD, FACC, QME May 16, 2018

I have evaluated injured workers as a QME/AME since 2000.
These are my comments on the proposed changes to the Medical Legal Fee Schedule 8 CCR §§ 9794 – 9795

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

1) The fee basis of $62.50 per quarter hour has never been increased since the original creation of the Medical Legal Fee Schedule. Should there not be consideration for such an increase?

2) With regard to the combination of face to face time, record review and medical research [ML103 (5) and ML104 (1)] requiring that "some portion of time has been devoted to each of the three factors" in order to qualify for three complexity factors; that is not in the spirit of appropriately and equitably compensating QMEs and AMEs for the necessary time spent to analyze the issues of a work injury claim for the purpose of determining and outlining opinions from a reasonably medically probable standpoint.

As a specific example of the inequity resulting from requiring "some portion of time has been devoted to each of the three factors," I offer the following:

In Case A, a QME could bill ML103 by spending 2-1/4 hours face to face with the injured worker, 4 hours in record review, and 15 minutes in medical research – a total of 6-1/2 hours of time (plus uncompensated report preparation time); and if a fourth complexity factor is identified, that QME could bill ML104 and include reimbursement for up to 3 additional hours in report preparation (total compensated time spent of 9-1/2 hours)

Yet, in Case B, another QME might not qualify to bill either ML103 or ML104 upon spending 2-1/4 hours face to face, 16 hours of record review and 3 hours of report preparation (billing ML102 for 21-1/4 hours of total time spent; with 19 hours of time spent being uncompensated). That is entirely inequitable and not in the spirit of appropriately compensating QMEs/AMEs for providing opinions from a reasonably medically probable basis given the preponderance of evidence available.

3) If a QME/AME should be disallowed from utilizing the issue of medical causation as a complexity factor in individual cases, then notice should be made to that QME/AME in such individual cases as follows: "Addressing and providing an analysis of the issue of medical causation shall not be used IF the parties specifically state in an advocacy/cover letter, received by the QME or AME prior the time of the evaluation, that the issue of medical causation is NOT in dispute. In the absence of such notice by the parties, addressing and providing an analysis of the issue of medical causation shall be considered a complexity factor."

4) With regard to causation analysis, particularly in Internal Medicine, but also in other specialties such as Orthopedics; the QME/AME is often asked to provide opinions on the causation of multiple, and frequently unrelated, medical injuries within one report. Each claimed injury requires independent analyses of causation. The initial medical fee schedule regulations, and more egregiously, the proposed changes to the use of Causation as a complexity factor, do not take into consideration causation analysis of multiple claimed injuries as independent complexity factors. In my opinion, this is not in the spirit of appropriately compensating the QME/AME. The need for multiple analyses of causation for multiple and unrelated injuries should be allowed as independent complexity factors when those issues are in dispute.

5) With regard to the proposed change in the use of medical research as a complexity factor; this would predictably cause some, if not most, QMEs/AMEs to not spend sufficient time in preparing written analyses and comments regarding specific medical research required to reach reasonably medically probable opinions in specific workers' compensation cases. This would predictably result in less written substantiation for medical opinions being offered in QME/AME reports; which in turn would negatively impact negotiations and settlements between the parties in individual cases. If the criteria for arriving at and providing medical opinions are to be based on reasonable medical probability given the preponderance of evidence available, and if the QME/AME reports are to represent substantial evidence; QMEs and AMEs must be adequately compensated for providing adequate written support within their reports for their medical opinions. Therefore, there should be no changes in the criteria for using medical research as a complexity factor.

Paul M. Goodman MD May 16, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Denise D. Williamson, MD May 16, 2018

I have recently reviewed "Changes in the QME Population and Med-Legal Trends in CA Work Comp" and a study by Frank Neuhauser.

While they addressed trends affecting QMEs, there seemed to be no attention to trends regarding injured workers.

I would be very interested to see if there is any correlation between the number of body parts claimed as injured as a trend over time and as it relates to the increase in fees charged by QMEs.

I think it is very important to look at whether QMEs are charging more over time for the same amount of work done or for having to evaluate increasing numbers of body parts claimed as injured, especially i southern CA.

It is my sincere hope and suggestion that any caps on report prep time are linked to caps on numbers of body parts claimed.

From an orthopedic standpoint, addressing up to 4 body parts is rather routine. I usually take about 4 hours, but will cut back on detail in my report to make it in 3. Any further detail will have to be addressed in a supplemental (but only 3 hours worth of detail - which eliminates pages and pages of attorney questions).

But for greater than 4 body parts, and I routinely get greater than 10 body parts claimed, (even though there are only 10 spaces for compilations on my questionnaire!), there need to be an allowance for the amount of time it takes to address these body parts - to measure the range of motion of each finger or toe (3 joints each!) that clearly is decreased.

Perhaps come up with a sliding scale that allows for the number of body parts being addressed. Or simply, if report prep time is limited, then LIMIT the number of body parts to 4 or less!

And don't allow the usual tricks of claiming "spine" "upper extremity" or "lower extremity." Each one of those broad labels represent 3 body parts.

But first, I think it would be useful to study the claims of the number of body parts (and BTW, my understanding is that it is quite different between northern and southern CA, so don't just average them all together please) to see if there has been an increase over time.

David Pingitore, Ph.D., ABPP
Board Certified Clinical Psychologist
American Board Of Professional Psychology

May 16, 2018

The proposed amendments to the Medical-Legal Fee Schedule will cause irreparable harm to injured workers in California and to a key component of the workers' compensation insurance system that exists to protect them. DWC is charged with continuing to look for ways to wring avoidable costs from the workers' compensation system, but without inflicting more harm on

injured workers. DWC's proposed amendments fail on both elements of its charge and are inconsistent with the enabling statute, Labor Code section 5307.6. A brief overview of the arbitrary, unreasonable, and unnecessary proposed amendments and their inevitable consequences:

- The three-hour cap on report writing will result in inadequate reports and parties waiting even longer to resolve their disputes. The proposed limit will leave QME physicians with three options: (1) rush through the report writing process and produce inadequate reports, which will inevitably result in costly supplemental reports, depositions, and litigation; (2) exceed the three hour limit knowing they will not be compensated for the additional time and effort (highly unlikely); or (3) leave the system and seek more lucrative opportunities elsewhere.
- The stringent requirements on the medical research QME physicians may perform will only deter QME physicians from citing authoritative sources in their reports. The prohibition on QME physicians reviewing sources cited in reports in the preceding 12 months is particularly bewildering: setting aside the impracticality of QME physicians (let alone DWC) tracking which sources were previously cited and when, it discourages physicians from consulting, reviewing, and citing persuasive sources that further the cause of aiding the treatment and recovery of injured workers. The result will be QME reports that are largely devoid of references to relevant medical research.
- The proposed amendments unreasonably burden QME physicians with yet another responsibility: seeking and obtaining the written agreement of both parties—*before the actual evaluation*—that medical causation is a disputed medical fact. Even in the unlikely event QME physicians find a way to actually undertake and administer this responsibility, experience confirms that parties will not even respond to those efforts let alone provide the necessary consent in disputed cases. Asking QME physicians to act as arbiters of disputes over threshold legal and factual issues is well outside the bounds of what should be asked of physicians. In effect, this aspect of the proposed regulation is granting employers and carriers a de facto veto power of whether an applicant may use a QME to further dispute resolution.

As acknowledged in the research studies relied upon by DWC in developing the proposed regulations, QME physicians have been leaving the convoluted system, even with prior changes actually increasing financial incentives to stay. The proposed amendments—which further complicate the process and create a disincentive for the remaining QME physicians—will only hasten the ongoing attrition.

The existing regulatory regime for QME physicians is sound. QME physicians are already subject to competency examinations and renewal requirements, a labyrinthine fee schedule, scrutiny from bill reviewers, and the administrative oversight of DWC. The proposed amendments all but guarantee QME physicians—on which the workers' compensation system depends—will leave the system en masse. Those that remain and adhere to the changes effected with the proposed amendments will produce inadequate reports, and any hypothetical savings

will be lost to the need for subsequent supplemental reports and depositions, and the costs that will result from the inevitable delays in resolving disputed claims.

Clayton Patchett, MD May 16, 2018

I oppose the new or proposed QME fee schedule.

Right now there are too few QME s and the system has gotten too difficult to navigate.

Gary Watson May 16, 2018

I strongly object to the proposed changes to the Med-Legal fee Schedule.

The workers compensation law in California states that the law is to be liberally interpreted in favor of the injured worker. Instead, the proposed changes to the Med-Legal Fee Schedule liberally interpret the law in favor of the insurance companies and to the detriment of the injured workers, the doctors and other care givers, the QME/AME examiners, and the applicant attorneys who are trying to help the injured workers and get the cases resolved.

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Almost every changed or added word in the proposed fee schedule appears to have been designed to create another hurdle for the QME or AME examiner, so that some excuse can be

found to deny billing at the appropriate level as intended by the legislature, and at a level consistent with the work performed and the time required.

It appears that those proposing these changes are unaware of the time, effort and documentation required to prepare a medical-legal report that constitutes substantial evidence, and that will stand up to the scrutiny of the triers of fact if the case goes to court. It also appears that they do not realize how much more complicated California workers compensation cases have become over the years since the present fee schedule was imposed. It is now not uncommon to have several thousand pages of records to review. It is also not uncommon to have 15 to 20 questions from both the applicant and defense attorneys that must be answered, even in a case in which there are no applicable complexity factors, even under the present rules.

It also appears that those proposing these unworkable and poorly thought out changes have forgotten the history of the QME system and particularly the history of the fee schedule. When I first became a QME evaluator at the time the QME system began, the reimbursement for a basic QME evaluation was about $1,100 for the examination, records review and report preparation. Transcription expenses were separately billable. Then the fee was cut to $500 and transcription costs were not separately reimbursable. At that time many QME examiners simply stopped performing QME examinations. I was one of them. It was no longer economically feasible to continue.

As a result of the loss of QME examiners, the legislature recognized that some medical-legal examinations required increased reimbursement. The laws were revised and the present complex fee schedule was developed. The person tasked with writing the billing rules reflecting the revised laws was Ms. Sue Honor-Vangerov, Esq. She had the advantage of being able to talk with the legislators who passed the laws to ensure that the rules complied with the intent of the legislators who passed the laws. She recently testified that the unwritten rules being enforced by the DWC were inconsistent with the intent of the legislature when the laws were changed over 12 years ago. A judge recently ruled that those rules were incorrect, based on the laws.

The proposed rules would officially impose the previous unwritten interpretations of the billing rules that the judge ruled were inconsistent with the laws. In fact, the proposed rules are even more draconian. The intent is obviously to make it essentially impossible to bill for an ML 104 examination, and extremely difficult to even bill for an ML 103 examination.

The DWC has recently been, and still is, on a campaign not to pay for any research. They fail to realize the value of having research in a report. Including research in a report can often make the examiner’s opinions much more credible to the trier of fact and help get the case resolved. Placing arbitrary limits on the time that can be billed for records review and report preparation is unreasonable and inconsistent with the time that is actually required for many reports.

If the DWC actually studied the work and time required to perform a QME or AME evaluation and prepare a high quality report today, and if they were attempting to be fair to everyone

involved, I believe that they would be recommending a huge increase in payments, rather than a decrease.

Ronald Protnoff May 16, 2018

The proposed new billing factors will cut reimbursements to the level which no longer will encourage QME participation.

Why do you seek to punish the physicians that make the system work and who help control the systemic fraud now prevalent in the WC system?

Michele Ginsburg, Administrator May 16, 2018
Office of Mitchel U. Silverman, M.D.

Dr. Silverman and I have read your proposed changes for reimbursement to the Medical/ Legal providers which we find incredibly unrealistic, especially for QME's and AME's dealing with "CT" claims, multiple dates of injury and parts of the body.

If it is your intention to eliminate the use of credible physicians to evaluate injured workers, then you are certainly on the right track.

You propose a physician not spend more than 3 hours for report preparation, yet now you want to demand more of their time just explaining "why this is necessary and why that is necessary" instead of allowing them to author reports that answer all of the questions they receive from the parties involved, i.e. insurance carrier, defense and claimant counsels and even the WCAB Judges.

You fail to take into account the cartons of extensive medical records received daily for the physicians' review, especially those that are not received early enough for the physician to review before an evaluation, (see attached photo). This problem is ongoing and has been a problem for years.

You should be aware that law offices and insurance carriers have now taken to scanning medical records onto DVD's resulting in our having to hire additional employees just to download the material and put it into chronological order.

You simply ignore or fail to understand that this practice results in the physician producing a supplemental report which you are also demanding they spend less than 3 hours preparing, no matter how long it takes to actually review the material.

Staff is required to set appointments 30 days in advance for QME's by secretaries asking for the appointment and receptionists who schedule the exams when neither have been given enough information as to dates of injury, parts of body and amount of records. The parties too often are unable to even get the records to our office in time for these exams.

You require physicians to get prior approval for certain levels of service, but that cannot possibly be determined until the physician receives the required cover letter, reviewed the medical records, and evaluates the claimant.

It is clear from the proposals the Department of Industrial Relations' makes simply exposes their desire to throw our system into chaos, and eventually find a way to make it obsolete.

Your obvious goal is to discourage the few physicians who remain working in this industry producing credible and quality reporting despite the ridiculous hours they have to devote to the requirements you continually demand of them.

You are simply turning the highly trained and dedicated physician into the "mad hatter clerical worker", while handing the carrier a welcome windfall.

What ever happened to your desire for excellent and accurate reporting by credible and honest evaluators?? Be careful what you wish for!

[Note: Provided pictures of boxes full of medical files.]

Saul Rosenberg, PhD, QME May 16, 2018

The DWC should adhere to the same standards expected of QMEs: provide evidence that an opinion -- or a policy -- is justified. There is no evidence -- and no justification -- for placing arbitrary restrictions on reimbursement for reports. Restrictions will result in reports being written that contain less evidence and which will serve neither injured workers, employers or the insurance industry.

Jeffrey A. Hirsch, MD May 16, 2018

I am writing to express my concern about the byzantine nature of the new proposed regulations.

As it stands now, I engage in complex tasks and triple-checking to ensure compliance with the existing regulations. As I have tried to read through these new proposed regulations, those challenges will greatly intensify. For those of us who focus a substantial part of our medical practices on providing well-written and evidence-based reports (as QME and AME) these regulations will block those efforts. In fact I may well need to hire a new part-time employee just to track compliance with these interwoven, outrageously complex regulations.

Adherence to the regulations will become more complex than most of the medical issues analyzed in my reports.

Looking at the big picture, after 18 years of practicing in the Workers' Compensation arena, caring for probably more than 5,000 people, I have experienced sequential difficulty, year-by-year, in providing medical care for injured workers (and writing medical-legal reports about their injuries). These new regulations are true to that spirit, serving as yet another hurdle over which injured people must climb in order to get the benefits they are justly due.

Please try to greatly simplify any necessary amendments. And rather than punishing all of us with onerous regulations. focus on a way to punish the small number of providers who are grossly abusing the system.

Norman Panting, MD, FACP, FACC, QME May 16, 2018

This note is to register my deep concern about proposed changes to the QME reimbursement process.

I have been doing QME evils since 1995. Currently I see a fair number of QME exams for the CIF Fund. These patients have lengthy histories and many pre-existing conditions and each needs to be evaluated and given a rating for their pre-existing non-industrial conditions. This process requires reviewing six and thirty-six inches of medical records and writing lengthy reports. For example a recent patient I saw had twenty-one (21) different conditions to evaluate.

If a three-hour report time were to be adopted, I would probably to stop my QME practice.

Erik J. Marquis, President May 16, 2018
E-Billing Solutions, LLC

I run a healthcare revenue consulting firm and I represent several QMEs. I reviewed the proposed changes to the Med-Legal fee structure and i have a couple comments.

Limiting the preparation of a report to 3 hours is going to result in incomplete reports. This will require more follow-up reports and delay the entire process. A better way to mitigate abuse is to provide transparency to attorneys regarding how much time QMEs average in the preparation of their reports. We don't want to sacrifice quality of the reports and delay the care of an injured worker.

The best way to cut waste in the QME process is to reimburse QMEs to outsource Record Review. Reimbursing providers $250/hour to sort and collate records is not a good use of funds. Additionally, if providers were to outsource Record Review, they do so at their own expense. They are not incentivized to save the system money. If the fee schedule reimbursed third parties $50/hour to review records, the DIR would save $200/ hour.

James C. Strazzeri, MD May 16, 2018

Please make payment for no shows mandatory as it is fairly common and wastes a lot of time that could be used for something else.

Also, the amount of uncertainty and prep for a deposition or court should more equitable reflect medical legal norms.

Don Williams, MD May 16, 2018

Is medical causation discussing the "date that an incident happened" or does medical causation include the date and the accepted body parts included in that date. Please clarify in the proposed text changes. See below.

Regarding the proposed changes on causation: As worded, it does not work for the following reasons

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We often get two letters, and one letter says to discuss causation of one body part while the other body part is accepted, but the other letter is stated both body parts are included.

An applicant or applicant attorney can state that a cumulative trauma case applies to all body parts. The adjuster would disagree. But since both parties do not agree, the CT claim for all body parts would be accepted. The QME would then have to evaluate all body parts. But causation could not be used as a factor since both sides do not agree.

An adjuster can ask for an AOE/COE case: But an Applicant can disagree. Even though "causation" is the primary question, it could not be used as a factor in this case. An adjuster

would have to get an agreement in writing that causation is an issue, otherwise she could not request the analysis.

Proposed Text:
(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

Is medical causation discussing the "date that an incident happened" or does medical causation include the date and the accepted body parts included in that date. Please clarify in the proposed text changes.

Michael A. Sommer MD May 16, 2018

I'm an orthopaedic surgeon who's been performing medlegal evals in one way or another since entering practice in 1973, and a "QME" since that program's inception which is think was in the '80's. And currently most of my work is in the capacity of AME. I believe I'm regarded as offering fair opinions at reasonable billings.

Given the studies which show declining numbers of physicians to do QME reports, and increasing demand for them, I'm confused by these proposed draconian changes in how reimbursement will be calculated. I conclude that the 'powers that be' are either (1) trying to destroy the system (as others have suggested) or (2) painting us all with the same brush as they attempt to rein in some really egregious abusers of the present billing system.

The most onerous proposal is elimination of causation as a factor unless it meets all the conditions described. This is totally unworkable imho. So often issues are discovered in the process of evaluation itself. And what about 'accepted case' but 'nature and extent' in dispute, etc. Some body parts accepted, some not. And to think parties are going to be able to coordinate a causation agreement between them prior to the evaluation date is wishful thinking. Please re-think this one!!!

Another big problem is about research as a factor---to say it must be included, in some settings is just as stupid as to say we have to keep track of what we've read about for the last twelve months! This is totally ridiculous.

If this crap is accepted and published as the new rules, I'm hanging it up (and I bet there are many others who will bail from the system as well). So if that's the intent of DWC, they will have done well.

Antoine Roberts, MD, QME May 16, 2018

I agree with Steve Ounjian of California Medical Legal Specialists, who gave following opinions: a simplified fee schedule would serve all who are involved and at the same time would save money in administrative and billing costs.

It will attract QMEs to the system. The solutions should appeal to all parties.

Therefore keep it simple and objective:

Going forward QME bills shall have a two part component-

1. One flat fee per report. Example $1,000 (the basic fee allowed by DWC back in the late 1980s)

Plus

2. A set fee for each page of record submitted to the QME. 100 pages = $250

Each page of medical record submitted is worth a set dollar amount. This maintains objectivity.

The QME would charge the flat fee plus any allowed record review time by page received. This maintains transparency and eliminates any unreasonable up-coding but at the same time protects the QME from heavy discounts of his or her time. Fairness is built in for all parties.

This new system could eliminate the following:

1. Carriers could save time and money by not having to rely on bill review. Ultimately saving on spending countless hours arguing over the proper level of bills.

2. QMEs could save time and money by not needing an army of collectors to argue the usage of factors. Nor would they need staff to obtain pre-authorizations on large files. They would be paid without a cut to their bill. Confusion and concern would be eliminated.

3. DWC would not need to spend as much time and resources enforcing vague and confusing regulations around QME billing. This would free up resources for the DWC to monitor the quality of the reports produced.

Additionally the following should be considered:

1. Medical Research and preparation time on face to face evaluations eliminated. QMEs could elect to add research but it would not be an add on for time.

2. Interpreter modifier stays the same.

3. Supplemental pricing would be based on time as it currently stands.

4. Psychiatry would need a separate higher flat fee to adjust for added complexity.

5. No Show or Late Cancel fee (under 6 days from DOS) would pay the standard flat fee mentioned above to the QME. This brings a definitive fee to the ML100 code. This is fair as the QME could not cancel the appointment and is required to show. Therefore the QME should be compensated for the lost opportunity to serve the system.

6. Depositions need to be prepaid at the time of SETTING the depositions. Often the deposition gets canceled at the last minute and the parties refuse to pay a late cancel fee.

In closing, let's move to a QME system where the carriers, QMEs and DWC are aligned through a foundation of objective and fair flat fee plus (+) compensation per page reviewed model. This will serve all parties. and allows each to focus on highest quality service to injured worker's.

This to me sounds like the best solution for a positive change.

Justin Frieders, DC, QME May 16, 2018

With regards to the proposed changes in the Medical-Legal Fee structure, it is yet another sad day and (potential) nail in the proverbial coffin in the already miserable lives of injured workers' in California.

As a chiropractor I believe strongly in the benefits of chiropractic care which (outside of the workers' compensation paradigm) allows for many individuals to continue working without the use of pharmaceuticals, however with the past hard cap on both chiropractic care and physical therapy injured workers are now limited to a life of drugs and in many times unable to return to their previous form of employment. I continue to find it odd, that in an attempt to reduce costs to the carriers & employers, chiropractors and our low level of reimbursement through the OMFS are cut off after 24-visits, but PM&R offices which can and do bill astronomical amounts every month without fail, continue to be able to provide limitless "care". But that's not what is currently on the table for discussion. That ship already sailed.

I have had discussions with many QME-patients about the workers' compensation process in California. From my purpose as a QME, limitations on TTD, permanent & stationary status, etc. Amazingly enough, this could be done while in conjunction with taking an accurate history

and performing a complete physical exam and still clock in at around 60-minutes. I am aware that there are individuals in the QME program who no matter how straight forward the claim is still are unable to complete their evaluation duties in under 2-hours. Psychological evaluations not withstanding. That is a problem.

Recently a dark cloud has been present over many in the QME community about how to apply the complexity factors with regards to billing. I particularly find it aggravating when changes are made CCR 9795, which leads to discussions of "oh no, that's how the code used to read, but now its different". The required content for a QME report to be considered admissible has not. Causation, apportionment and all other factors need to be included. If a claim or portion of a claim is denied due to causation, by default it clearly is a point which needs to be addressed even if the parties do not put in their correspondence "Please address causation."

It is also sad that some in the QME program have been accused of literally copying and pasting the same research sources into the body of numerous reports just to obtain another complexity factor for billing. I personally haven't, but by all outward appearances, lets let the transgressions of the few affect the rest of us vs. better screening.

The dour vibe you're likely getting from my email should be palpable by now as it is clearly my intent to convey this feeling.

The main issue I personally will face is how can I honestly provide the parties with an accurate report which addresses all the necessary issues when my preparation time is being capped? Try cooking a Thanksgiving turkey in an hour. As I eluded to above, some claims are straightforward and can be handled with minimal efforts on the part of the QME. However, there are a number of claims and individuals with significant factors which do require more time to develop.

If the intent of these proposed changes are to save the insurance carriers from paying QME medical-legal fees in California, leaving the proposed changes will do that.

If the intent of these proposed changes are to further degrade the workers' compensation system in California by reducing the quality of the QME reporting, leaving the proposed changes will do that.

Given the past direction the workers' compensation program in California has gone I'm not surprised that the medical-legal area is now also being pulled down. The transparency of these proposed changes are evident and serve no benefit to a system which is already stacked against the injured worker.

Rather than stay silent on these proposed changes, the above are my two-cents. In the end there is no "right and wrong" about these proposed changes. To believe there is a "right and wrong" in the California workers' system is nothing more than a daydream. All that exists in the California

workers' system is "big and small". Injured workers are small. Treating doctors are small. QME doctors are also now small.

Who does that leave? Why those that pay the bills.

George McCan, QME May 16, 2018

As a QME for 10 years, my comment regarding the re-imbursement proposal is my doubt that the DWC can retain sufficient numbers of Orthopedic Surgeons.

The fee schedule has not changed from $250 per hour in the last 10 years. Orthopedic Surgeons performing examinations, surgery, or personal injury consultations charge $500, $750 and upward per hour.

During my 10 years of QME work, I have known of many Orthopedic Surgeons who have left the workers comp field, rather than take the associated time commitment, hassle and abuse.

The DWC should adopt a more liberal compensation system, to retain quality doctors, if it wishes injured workers and employers to respect the system for its fairness and quality of medical judgment.

Gerald Besses May 15, 2018

The rules proposal seems to me to be directed only at one purpose, that is to reduce fees paid for QME evaluations. As such, it is a broad brush for a single purpose.

As an Internist, who has worked in the system since 2002, I see some very complicated cases, with very long medical charts. The proposed changes will not compensate me adequately to perform these cases, which may require 10 to 20 hours of record review and prolonged medical literature search. If I, along with the similarly experienced QMEs, refuse to work for a decrease in pay, then cases will go to less experienced evaluators who may deliver less satisfactory reports. And, I will refuse to work for a discount.

Complex cases demand complex reports, which should be compensated adequately. If the goals of the DWC include getting the injured worker back to work, these proposed rules will frustrate that goal by reducing the resources needed to properly evaluate the injured worker.

Please think through the consequences of what is being proposed, as the proposal, as it stands is destructive to our system.

Nicholas DiSabatino DC QME May 15, 2018

I would like to add that the DWC should take action to remove the management companies from The QME process. There could be a requirement that doctors bill directly without management company involvement. Surely any increase in cost is related to 3rd part management involvement and these companies add no value to the system. I read this idea in another post, and it's brilliant. "QME Management companies" are parasites in the system.

Elizabeth Diamante, Medical Billing Specialist May 15, 2018
Nicholas A. DiSabatino, DC

What the DWC is doing here is an absolute stain on our state benefits system. You can measure a society by how it treats its injured workers. And in this case, the DWC Medical Unit has declared open season against the PQME doctor pool, which will in turn dramatically hurt injured workers by denying them the ability to receive thorough PQME exams. First, the insurance company sponsored DWC Medical unit tried unsuccessfully to undermine the PQME process through its agenda of underground regulations. When this failed, the DWC Medical Unit has merely declared war against the PQME doctor pool by proposing to change the fee schedule in a manner inconsistent with supply and demand; that is, destroy the supply by taking away any semblance of reasonable fees, and the PQME process will disintegrate. That is what this is. There is no fairness in this system here, it is completely one-sided attempt to punish doctors working in the system and this, in turn, will hurt the injured workers who rely on the PQME process for independent evaluations in an otherwise contentious /adversarial system that an injured worker must navigate through.

It is truly staggering to realize that the DWC Medical unit is so aligned with the insurance industry and as profits in the industry rise, the Medical Unit works for carrier interest to destroy the independent exam process that injured workers rely on by ensuring that doctors cannot be properly reimbursed for their work. Great Job DWC! "Here is one for the Gipper!"

Mike Post May 15, 2018
RehabOne Medical Group

Historical Perspective

Prior to the establishment of the medical legal fee schedule (MLFS), there was no standardized billing model for medical expert evaluation and testimony in the California Workers' Compensation System. The MLFS, which has been utilized for decades, has served as the guide for commensurate medical legal billing for services rendered. Unfortunately, since 2005, the legal complexity of industrial cases has burgeoned due to major changes in the way permanent disability is determined. These changes have resulted in contentious disputes related to medical care, causation of injury, and apportionment. During the last MLFS revision, the Division of Workers' Compensation (DWC) acknowledged these challenges, along with concerns about the then steadily declining numbers of qualified medical evaluators (QMEs), and proposed a draft MLFS version that purportedly was intended to increase reimbursement to adequately compensate physicians for the additional workload involved with performing these evaluations. However, after a very careful analysis, the California Society of Industrial Medicine & Surgery (CSIMS) determined that the initial draft version would have had the complete opposite effect. At that time, CSIMS worked collaboratively with the DWC to revamp the MLFS to achieve the intended result of providing a modest increase in QME reimbursement, while preserving injured workers access to quality medical legal evaluations.

Over the past several years, case laws have attempted to address ambiguities in the poorly drafted legislation derived from SB 899 and SB 863. Unfortunately, these case laws, such as *Almaraz-Guzman*, *Kite*, *Benson*, *Hikida*, and *Rice* have expanded the scope and complexity of medical legal evaluations. In addition to addressing the standard questions, medical legal evaluators are now routinely being directed to address these very complex issues.

Another major game-changer in the time required to complete these types of evaluations is the industry conversion from simple one-page progress reports (PR-2s) to multipage, electronic health record generated, narrative PR-2s, with attached work status reports, requests for authorizations, prescriptions, and lengthy templated utilization review decisions. Additionally, as a result of the contentious disputes related to causation and apportionment, extensive and voluminous records are subpoenaed by the Defendants in an attempt to create a case against industrial causation of injury, and/or to bolster their support of non-industrial apportionment. Furthermore, to support their fact-finding mission, Defendants routinely depose injured workers, and these depositions have become quite detailed and lengthy, and are included in the medical records sent for review. Furthermore, it is now extremely common that medical records are sent in duplicate or triplicate, unsorted, and in both paper and disc formats. This practice creates another major time sink in completing these reports. Injured workers are also increasingly the subject of surveillance, and lengthy sub rosa videos and reports are also sent as evidence and must be considered when providing an expert medical opinion. All these changes have resulted in a much more complex and time-consuming process. The foregoing is true despite regulatory pressures to complete these reports in a timely manner, as failure to do so risks being sanctioned by the DWC and/or not being paid for late reports.

It is also worth noting that with the establishment of Medical Provider Networks, which can unilaterally and for undisclosed reasons restrict new and established physicians access to injured

workers, coupled with the burdensome process of utilization review, as well as diminished reimbursement for specialists, it is no wonder that there are less physicians willing to evaluate and treat injured workers. As such, it is to be expected that the number of potential QMEs will continue to decline. It is in this setting that the DWC decided to re-interpret the MLFS, and has relied on that misinterpretation as a rationale for disciplinary actions and/or not reinstating several QMEs.

Value of the Medical Legal Evaluation and Testimony

It should be underscored that QMEs and AMEs are expert medical witnesses. Aside from the aforementioned changes that have resulted in the need to review extensive medical records, the courts have established that for medical opinions to be admissible, they must constitute "substantial medical evidence." Case law has significantly raised the threshold for what is required for a physician's opinion to be "within reasonable medical probability." It is no longer acceptable to just provide an opinion, or to qualify it with the number of years in practice and experience. To be considered substantial medical evidence, it is necessary that physicians clearly delineate how they derived their opinions and why they are valid. To achieve this threshold requires careful and extensive scrutiny of the medical evidence, at times medical research, and time to summarize, organize, and analyze the information. If these complex medical legal issues are not adequately addressed in the reports, the parties will have to seek clarification through depositions, supplemental reports, or in some cases a replacement QME or AME. These activities will delay case resolution and result in additional costs for employers and insurance carriers, and lead to increased frustration and poorer outcomes for injured workers.

In other legal venues, such as civil cases, expert medical witnesses are paid hourly, at rates that far exceed the current MLFS. The exception is a basic independent medical evaluation that is generally contracted and reimbursed at a flat rate. However, in these cases, the physician is tasked to solely address whether Applicants can return to their usual and customary jobs, or in some cases any type of gainful employment. Those types of cases might be analogous to a straight-forward case in California Workers' Compensation, where an injured worker has one injury to one or two body parts and no or limited prior/subsequent industrial or non-industrial injuries. In those cases, one would expect limited medical records and less time spent on obtaining the history, performing a physical examination, formulating opinions, and finalizing the report. In my experience, these cases are rare, but when they occur, they most certainly should be reimbursed at a flat rate.

Nevertheless, for the aforementioned reasons, most cases that require forensic evaluation are much more complex and time-consuming. Additionally, medical legal evaluators are now burdened with requesting and waiting for authorization for diagnostic studies that are medically necessary to establish diagnoses and/or accurately calculate an AMA Guides determination of impairment for the purposes of describing permanent disability. Furthermore, treatment is often delayed or denied and many injured workers develop compensable consequence injuries and/or subsequent cumulative trauma, and medical legal evaluators must address issues of causation when they are

brought to our attention in advocacy cover letters, discovered during review of medical records, and/or reported by the Applicant during the evaluation.

It is also worth noting that medical legal evaluators are required to complete the Physician's Return-to-Work & Voucher Report, and are not compensated for the time it takes to perform that task. Additionally, although SB 863 created the Independent Medical Review process as the exclusive remedy to address medical disputes, Title 8 CCR Section 35.5 (g) (2) states, "For any evaluation performed on or after July 1, 2013, and regardless of the date of injury, an Agreed Medical Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue, but shall provide an opinion about whether the injured worker will need future medical care to cure or relieve the effects of an industrial injury." Detailed opinions related to potential future medical care needs are routinely requested by all parties for purposes of case settlement or setting reserves.

Intent of the California Workers' Compensation System and Mission of the DWC

At its inception, the premise of the California Workers' Compensation system was based on a compromise between employers and employees, commonly referred to as the "Grand Bargain." This system and the laws that govern it, were designed to protect employers from potentially devastating lawsuits brought by injured employees. In return for relinquishing the right to sue their employers, employees were granted the rights to medical care, vocational rehabilitation, as well as temporary and permanent disability benefits when applicable. According to the DWC's website, "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."** [emphasis added]

In recent years, legislative changes to the Labor Code have markedly limited the rights of injured workers in favor of reducing costs to employers. These changes have included, but are not limited to, restrictive utilization review, arbitrary caps on physical therapy and chiropractic care, assigning the final remedy to determine reasonable medical treatment to a paper review process, a 104-week cap on temporary disability benefits, and major changes to how apportionment of permanent disability is determined. Considering these changes, it is imperative, now more than ever, that the DWC ensures that injured workers retain the ability to receive thorough and objective forensic evaluations that can significantly impact their remaining benefits.

The DWC's recent misinterpretation of the MLFS criteria, that resulted in disciplinary action and/or non-reinstatement of several QMEs, in addition to the current proposed revision, is counter to the spirit of minimizing the adverse impact of work-related injuries on California employees or employers. For example, the proposed arbitrary limit of three (3) hours for report preparation does not support the production of **quality** reports that provide injured workers the rights they are entitled to and protect employers from having to provide benefits that they are not

responsible for. This time limit will undoubtedly lead to substandard reports that will ultimately result in additional costs as referenced above.

It should be underscored that under the provisions of California Labor Code Section 139.3, physicians declare under penalty of perjury that the bill for their services is true and correct to the best of their knowledge. If the DWC's intent in proposing these regulations is to address excessive billing practices by a few medical legal evaluators, it should be emphasized that there are already several checks in place that address this nefarious behavior. For starters, Defendants and Applicants can attempt to select an AME who is respected by all parties, and who historically provides comprehensive, objective, and valued reports. In cases where such an agreement cannot be reached, both parties can strike one QME from the panel list, if either party considers their reports to be substandard and/or their billing practices excessive. Additionally, in cases where the parties are "stuck" with an "undesirable" QME, and the report is not timely, they can object to the report on that basis and the Defendants are not obligated to pay for it. Finally, if the Defendants disagree with any bill, they can down-code the payment, with a final determination made by independent bill review if disputed by the medical legal evaluator.

Conclusions

Over the past decade, medical legal evaluations have become progressively more complex and time-consuming due to changes in the Labor Code and case law. At a time when there is a dearth of new physicians entering into the workers' compensation system, and when considering the shrinking pool of QMEs, I am bewildered that the DWC has chosen to act as they have with respect to their misinterpretation of the existing MLFS and the proposed revisions that they perhaps believe will achieve the same results. What the proposed changes will accomplish is to further erode an injured worker's right to a fair, impartial, accurate, complete and professionally prepared medical legal evaluation.

I have carefully reviewed the proposed MLFS revisions and have purposely not addressed each specific proposed revision, as my hope is that there will be enough constructive criticism, in addition to an outcry from the medical, legal, employee, and employer community that the DWC continues with the current MLFS for now, in favor of a carefully designed strategy to bring forth meaningful changes that acknowledge the purpose and importance of forensic evaluations.

In my opinion, the only way to truly accomplish something that is a sustainable is through a comprehensive, collaboration involving all the affected stakeholders. I propose that the DWC considers convening a panel of stakeholder experts to thoroughly examine the issues, and draft a carefully considered MLFS revision, rather than rely on the current proposal. In the spirit of the "Grand Bargain," I pray that sounder minds prevail and leads to an effective and desirable solution that preserves the integrity of the California Workers' Compensation system and the rights of injured workers, employers, and insurers alike.

Gordon D. Lewis, MD May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Lazaro Alonso, MD May 15, 2018

1. end of paragraph 1 on first page, assumes the evaluator has already reviewed the medical records prior to seeing the patient to determine the information available in the medical records?. It states that claims administrator is not responsible for costs of duplicative testing if already in the record. How else does the doctor know unless entire medical records are reviewed prior to seeing the patient if an echo was done, or a CT was done if the patient does not provide the history correctly?

2. The 3 hour maximum allowed for ML 101 may be problematic, sometimes follow up medical legal evaluations prove to be more complex than the initial evaluation, particularly if the two evaluations are several years apart and involve apportionment between a prior award and a new opening of a claim for new and further disability. These cases are complex particularly if several internal parts are involved and it is not only a matter of simple editing, to make the report make sense a lot of analysis and thought needs to go into some reports. Granted there are some re-evaluations that are more straight forward, but in my opinion to provide an arbitrary 3 hour maximum is problematic in some cases.

3. For the ML 103 section item 4 the red lined comment …any factor used as a stand alone may not be used in combination under this subdivision… I am not sure I understand this explanation.

4. Again the limitation of 3 hours of report preparation for the ML 104 in my opinion is an arbitrary limitation and limits the ability to provide a clean , clear , well written report in many cases of a complex case.

5. For ML 104 item 3, does this mean that before an examiner starts the evaluation, that he or she, and the parties need to agree to a ML 104? How can this be done? Does the evaluator estimate the number of hours of records review? Estimate the number of hours of face to face? Or if a complex case that legitimately require some research does the evaluator estimate the number of hours needed? I don't see how the parties agree to this without significantly delaying completion of the report.

6. For ML 106 item 5, again the issue comes up with maximum 3 hours billed under report preparation, this is ok for simpler cases, but more complex cases are problematic.

Thank you for allowing my input to the DWC forum

Anonymous QME May 15, 2018

I would like to direct my comment not toward some of the specific details of this poorly conceived proposal to amend the Medical Legal Fee Schedule (MLFS), but toward a greater concern of the very reason of why has such an amendment to the MLFS been drafted.

California is now the 5th largest economy in the world, recently surpassing Great Britain. As an economic force in the world, California rightly takes this position seriously, and is making efforts to maintain growth of industry and employment. With that responsibility comes the responsibility to the millions of workers in California, who are subject to labor laws and Workers' Compensation Laws implemented over 100 years ago in California.

Containment of Workers' Compensation Insurance premium costs on employers is clearly, and justly, one of the priorities of the Division of Industrial Relations (DIR) and its subordinates, the Division of Workers' Compensation (DWC) and the DWC Medical Unit.

One look at figure 23 within the 2017 California Commission on Health and Safety and Workers' Compensation (CHSWC) Annual Report tells us that the DIR is concerned about medical legal expense in the system.

The complete report may be found at:
https://www.dir.ca.gov/chswc/Reports/2017/CHSWC_AnnualReport2017.pdf

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

Medical-legal Evaluation costs are seen as the black bar, third from the top of the graph below. Above it, in the diagonal stripes, second from the top is Medical Cost Containment.

Please note that Medical Cost Containment is shown as decreasing from the years 2012 to the present and medical-legal Evaluation costs increased from 2012.

There is no doubt that medical legal costs increased in response to SB863 which introduced alterations which increased medical legal disputes. The DIR no doubt is not concerned with *why* medical legal costs increased, but rather how to bring these costs down.

The DIR no doubt would like to bring medical legal expenses down to pre 2012 levels and has taken a very damaging path toward achieving such decreases.

What the DIR has forgotten, is that the injured worker is lost in this arithmetic. By first following its own "interpretations" of the MLFS and now proposing that those same interpretations become part of the California Labor Code, the DIR is willing to render the QME system an unfair, unworkable and biased system. A system stacked against the injured worker and heavily skewed toward the insurance provider. The DIR is taking this risk in the hopes of driving Medical–Legal Evaluation costs down. In reality, they are threatening the very QME system which was created to give the injured worker the best possible chance at receiving a fair and unbiased face-to-face physician evaluation to address medical legal disputes which cannot be addressed by non-physicians in the legal realm.

Clearly, this is certainly one of those issues which no one cares about until it happens to him or her. But to the millions of workers in California, this is a very real issue. An injured worker relies upon the QME to deliver an unbiased and *complete* opinion on several very critical and complex areas, including:

- The issue of medical causation. Was the injury caused by the work exposure or accident?
- The issue of Maximal Medical Improvement status. Is the patient as good as he or she will get, with or without further medical care?
- The issue of permanent physical impairment. Is there a permanent impairment or disability and if so, what percentage according to the AMA Guides to the Evaluation of Permanent Impairment.
- Is there a need for Apportionment in this case? Did another previous injury or condition contribute to the current physical impairment, and if so, what percentage?
- Is there a need for additional medical care or future medical care?

If the injured worker is NOT to receive such an unbiased medical legal opinion, then the *entire reason* for the establishment of the DIR and its subordinate offices are called to question. Yes, the DIR has a responsibility to the employers of California. But it also has a responsibility to protect an injured worker from being unfairly treated by a system only concerned about its bottom line. Too often, the injured worker is not fairly dealt with.

Qualified Medical Evaluators perform a very important and complicated task. Imposing the currently proposed MLFS changes will drive many excellent QME's out of the system. Those who remain will be forced to generate reports in less time and under increased pressure. This can only have the effect of decreasing the objectivity and accuracy of the needed medical legal evaluation.

It is important for the parties deciding the fate of these proposed changes to realize that not only will such a dramatic devaluing of the QME Evaluation result in unfairness to the injured worker, it will also no doubt *increase* medical legal costs. These increases will be created by the influx of incomplete and inaccurate medical legal reports created by physicians under time constraints imposed by the Labor Code. This will lead to the need for additional Supplemental medical legal reports and QME depositions.

In total, the proposed changes to the MLFS are a *sure* recipe for increasing bias and unfairness into the system. A system which at its very heart is intended to protect and care for injured California workers.

Anonymous May 15, 2018

With the proposed QME fee schedule reductions, it will be very difficult for an examiner to apply the much needed time and due diligence each case deserves, and still afford to do QMEs in an affordable capacity.

Steven W. Meier, MD May 15, 2018
Diplomate of the American Board of Orthopedic Surgery
Meier Orthopedic Sports Medicine

The recently proposed changes to the California medical legal fee schedule are very concerning to me. As a QME in orthopedic surgery for the past 10 years, I fear that the proposed changes will lead to a decline in report quality, drive up costs within the workers compensation system and limit injured workers' access to evaluations. With all the time and resources necessary in a medical practice to take extensive medical histories, perform extensive and comprehensive physical examinations, sort through and analyze reams of medical records and thoughtfully formulate accurate opinions to produce high quality reports that constitute substantial medical evidence, the proposed restrictions on billing will make doing this work cost prohibitive. As a physician in private practice, I fear that this may push me and many of my colleagues out of performing these evaluations that are vital to the workers compensation system.

The proposed requirement that causation may only be addressed upon prior agreement by the physician and all the parties is not reasonable or realistic. There is nothing to compel busy attorneys to respond to these inquires as the impending date of each evaluation approaches. Anyone who has attempted to obtain these prior agreements knows that this exercise requires considerable time and effort on the part of the medical office and is almost never successful. Yet causation analysis is a fundamental part of the medical legal evaluation and these restrictions inhibit the physician's ability to produce reports that constitute substantial medical evidence.

The proposed requirement that report preparation time be limited to only 3 hours is also not reasonable or realistic. This timeframe may suffice for simple reports, but as an evaluator who performs good number of complex AMEs, I don't believe that restricting report preparation time would be a sustainable practice when dealing with cases with extensive medical records, multiple dates of injuries, multiple body systems, past injury claims, multiple employers and/or multiple insurers. To provide a high-quality report, the physician must put in the required amount of time to do the job well. And the time required is not the same for every report. Having an arbitrary cutoff for report preparation just doesn't make sense.

Another problem with the current medical legal fee schedule is that it doesn't consistently account for cases with extensive medical records. I've performed a number of evaluations where, due to the particular complexity factors of the case, I was restricted to billing only a ML102 or ML103 flat fee in spite of voluminous records that took many hours to process and review. As long as changes are being proposed for the fee schedule, I would suggest that a certain minimum record review time such as over 3 hours be added as a complexity factor that would allow hourly billing as an ML104.

Another modification that would help make the fee schedule more fair and equitable would be to remove the current restriction that "fees will not be allowed for supplemental reports following the physician's review of the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation". Oftentimes, these supplemental reports also involve a disability determination, permanent impairment rating, apportionment, permanent work status and a provision for future medical care. There is a good deal of time and work that goes into composing these reports and they are not being compensated for under the current system.

I appreciate having access to this forum and the ability to voice concerns about the proposed fee schedule changes. I enjoy being a QME and performing AMEs and QMEs. It is mentally stimulating and allows me to contribute to the welfare of injured workers in a very complex system that is often bewildering to them. I would regret to lose the opportunity to contribute in this way. The closing message I would like to convey is that these proposed fee schedule changes will harm the workers compensation system. They will likely lead to a deterioration in report quality as physicians no longer have the time to do an adequate job. This will result in fewer reports constituting substantial medical evidence leading to more supplemental report requests and depositions, paradoxically driving up costs within the workers compensation system and bogging down cases. As QMEs decide this work is not sustainable, they will drop out of the system and the access of injured workers to the medical legal process will suffer. I remain

hopeful that a reasonable conclusion will be reached so this doesn't happen. Returning to a simpler and more reasonable hourly rate formula for all reports would be the most fair and equitable and consistent with the way other medical expert work is done.

Larry Richman May 15, 2018

Having reviewed the Reimbursement of Medical Legal Expenses, 8 CCR 9794-9795, it occurs to me there may be unintended consequences as regards the guidelines for meeting the complexity factors proposed for Apportionment. The guidelines for apportionment (A) (iii) mention that 2 dates (or more) of injury are required. There may be multiple " body systems or body regions " one of which is impacted by an injury and another that may be apportioned with respect to permanent disability, to a prior injury or condition in small or large part, or a new condition that occurred following the specific or other industrial injury. By restricting the examiner to address only one date of injury, and given that various conditions in the areas of internal medicine, neurology and psychiatry can be more complex, it appears that the insured for the date of injury claim may not be afforded the ability by an examiner to analyze several components of an injury (unlike orthopedics for example) such as a brain injury associated with impaired cognition (though the claimant may have a history of alcohol or drug abuse, learning disability, etc.) and with that same date of injury, dizziness (thought there may be a longer standing history of ear infections with dizziness, etc.). I would pose the question as to how one proceeds with a copious amount of records to review when there is no allowable application of a complexity factor. By means of example, The AMA Guides states the DRE Method for spine injuries is the preferable method, whereas the range of motion method is highly time consuming and complicated yet on the average yields about 10% WPI higher on any given spine segment injury. Most orthopedists use the DRE approach. I don't speak for myself, rather am providing a constructive observation as to what may evolve regarding different analytical approaches that may be applied by some physicians when multiple body systems or regions are injured. I believe it may be prudent to amend the language of (iii) at least for the medical and psychiatric specialties, such that one date of injury is not a requirement, so as to properly and consistently apply apportionment.

Ali R. Berenji, MD May 15, 2018

Earlier today after reviewing the coming changes based on 10 pages report Re: 9794, and 9795 provided by **California Medical evaluators** I felt my professional interests were in danger. I felt I was obligated to send you an E-mail to describe my feeling about certain items on this two bills.

However, while I was describing certain items of 9795 I was trying to say certain items were harmful to QMEs. In doing so, I used the word" Barbaric". However, after going through dictionary I feel I have used a wrong word, (what I really meant was the items were unfair to PQME), nothing more .

So please accept my apology in this regard.

I also want to recognize and accept the fact that your service is vital to the survival of PQMEs. Actually, we must accept that we are all indebted to DWC work, which seems to be trying to help maintain a functioning working comp system. Otherwise we will not be able to provide any service at all.

Lisa Breuner, DPM May 15, 2018

I have been a QME for 25 years and have concerns about the proposed fee schedule change. Currently, my 2 younger associates have declined to perform QME evaluations, primarily because of the volumes of medical records which I receive and review when performing these evaluations.

In performing QME evaluations, it is not unusual to receive over 500 to 1000 pages of medical records to review. To accurately review this amount of documentation in a 3 hour time frame is not feasible. The proposal to restrict the time allowed for review of records, in addition to changes is the complexity factors addressing causation will only cause existing QME's such as myself to discontinue seeing these patients and will discourage younger physicians from obtaining QME certification.

I urge you to reconsider these changes.

Timothy Brox, MD May 15, 2018
QME, Orthopadic Surgeon, FAOA

I suggest a simplification of the QME fee schedule. This will eliminate the confusion and acrimony currently growing in the system.

Eliminate the entire model of using factors to set billing levels. It isn’t working and adding more language to this billing model could take us further away from solutions that will attract and retain QMEs to the system. I will assume that the retention of existing QMEs is of critical importance to the DWC. The proposed solutions should appeal to all parties.

Therefore keep it simple and objective:

Going forward QME bills shall have a three part component-

1. One flat fee per report/injury evaluated. Example $1,000 (The basic fee allowed for a QME report by DWC back in the late 1980s was actually above $1,000)

2. A supplemental fee for substantial and documented "second or additional" questions.

Plus

3. A set record review fee for each page of medical record submitted to the QME.
Example: 100 pages = 1 hour ($250)

Each page of medical record submitted is worth a set dollar amount. This maintains objectivity. It's fair and ALL parties should agree to the pricing.

The QME would charge the flat fee plus any allowed record review time by medical record page received. This maintains transparency and eliminates any unreasonable up-coding but at the same time protects the QME from heavy discounts of his or her time. Fairness and an up front agreement is built in for all parties.

Not paying fairly for review of what can be extensive records is VERY problematic.

This new system could eliminate the following:

1. Carriers could save time and money by not having to rely on bill review. Ultimately saving on spending countless hours arguing over the proper level of bills.

2. QMEs could save time and money by not needing an army of collectors to argue the usage of factors. Nor would they need staff to obtain pre-authorizations on large files. They would be paid without a cut to their bill. Confusion and concern would be eliminated.

3. DWC would not need to spend as much time and resources enforcing confusing regulations around QME billing. This would free up resources for the DWC to possibly monitor the quality of the reports produced.

Assuming the above suggested fee schedule was implemented the following should also be considered:

1. Medical Research and preparation time on face to face evaluations are entirely eliminated. QMEs could elect to add research but it would not be an add on for time or increase charges.

2. Interpreter modifier stays the same.

3. Supplemental pricing would be based on time as it currently stands. No time restrictions on prep time. Record review would follow same model as outlined above.

4. Psychiatry would need a separate higher flat fee to adjust for added complexity.

The following should be updated regardless of the fee schedule model used:

1. No Show or Late Cancel fee (under 6 days from DOS) would pay the standard flat fee mentioned above to the QME. This brings a definitive fee to the ML100 code. This is fair as the QME could not cancel the appointment and is required to show. Therefore the QME should be compensated for the reserved time and lost opportunity to serve the system.

2. Depositions should be required to be prepaid at the time of SETTING the depositions. Often the deposition gets canceled at the last minute and the parties refuse to pay a late cancel fee. Deposition fees should be set higher than what the current fee schedule allows.

It is critical that the new language being considered and implemented protect ALL participants contributing to the work comp system. This includes the QME too. QMEs have to feel that the fee schedule is fair to them. They should be looked upon as a highly valued participant supporting the system not as just a line item frictional cost. This is critical and they shouldn't be trivialized or ignored on this matter.

In closing, let's immediately move to a QME system where the carriers, QMEs and DWC are aligned through a foundation of objective and fair flat fee with supplemental for additional issues plus (+) compensation per page reviewed model. This will serve all parties and allow each to focus more fully on their highest and best use in the system.

Andrew Stoner, J.D., Ph.D. May 15, 2018
Psychologist

I have had the great opportunity to work as a QME since 2012. I have serious concerns about the proposed Med-Legal Fee Schedule. These proposed changes to the Fee Schedule billing are unrealistic and unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to return to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report

preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction. The three hour cap would certainly result in low quality reports without much usefulness to the interested parties.

In addition, the proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Ali R. Berenji, MD May 15, 2018

My name is Dr. Ali R. Berenji. I have been in the practice of orthopedic surgery since 1987. My main motivations have been to update myself and provide descent, not as harmful practice involving care for treating W/C patients, Medicare Patients as well functioning as PQME.

Large % of my reports have been accepted by the courts in helping the injured worker to get sufficient care as well as settling their cases ASAP to reduce costs to the system.

I feel new changes described in 10 pages (8 CCR 9794-9795) has certain negative effect in keeping good practitioners in the service of W/C system with the following reasons:

In the section of 9794:

1. It is said payment will be paid within 60 days, **we know better.**
2. The contesting time is **adding additional burden.**
3. Review process **not favoring M.D.**
4. The 2nd review is **unfair to M.D. as well.**
5. **Partial pay is unfair.**
6. Written objection **time limit is unfair.**

In the section of 9795:

1. Relative value described is unfair.
2. Forcing the Dr. to evaluate a case on which parties do not agree is barbaric.
3. Missed appointment not to be paid is barbaric.
4. F/U examination time limit is barbaric.
5. Complexity factors not correctly accounted for.
6. Research not correctly accounted for.
7. Apportionment not correctly accounted for.

8. Causation not correctly accounted for.

Final comments:
I am afraid these changes not remedy the problems we are having but to worsen them.

Juan Realyvasquez May 15, 2018

I am new to QME evaluations. I was a teacher in orthopedics for 35 years. I have read your proposed guidelines for reimbursement and I am surprised, They appear to be one-sided. To have a claims administrator judge how much an evaluation is worth, is like asking a judge to prejudge cases before they are presented. It also allows claims administrators to reduce pay if he dose not like or agree with the report. The DWC was made to aid the employees in getting good medical care. This section removes it.

Another comment on liimiting research time to 2 hours. Good research requires assimilate of multiple facts and is not limited in time. Many articles are online on PUB MED, but to view complete articles, we must pay for them. Every case is different in many factors and a good report should include good research material. I agree that evaluators that keep using the same articles are probably not doing research.

The need for preauthorization of level of examination again limits the quality of evaluation.

I agree that costs for workman's compensation are high. I worked for a short time at several WC medical offices. What I saw there were decisions made to get the employee get to work regardless of his injury. Procedures and treatment were delayed because of review An example: Patient with acute or recurrent lumbar pain respond better to aggressive treatment. Acute PT or Chiropractic manipulation will result in less loss of work days than having him wait for 6 weeks before it gets started.

Many of these workers do not understand their rights. It is the job of the DWC to protect those rights. The current changes reduce their rights to INDEPENDENT QJUALFIED MEDICAL EVALUATIONS.before

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Peter Dell May 15, 2018

I am a psychiatrist and QME, and also trained and board certified as a Forensic Psychiatrist. I echo the comments of many other providers that these regulations are unworkable and restrictive. It seems that the DWC wants to have expert opinions from highly trained individuals, yet they are unwilling to pay for it. Specifically, by limiting the proposed report preparation time is significant. The type and level of complexity of these reports is very high in many cases. Writing reports that are sometimes multiple hundreds of pages and then expecting to only be paid for 3 hours for writing the report is outlandish. You cannot have it both ways: expecting excellence but being unable to pay for it.

Due to the clear direction of the DWC to try to reduce compensation for evaluations as shown by these new guidelines, I am retiring from doing workers' compensation evaluations. I have attempted to provide excellent reports to the parties in these cases, but this latest series of efforts to undercut the compensation of these reports is a bridge too far. I believe that other providers will follow suit. There was already a limited number of QMEs. All parties in this system, from the applicants to the attorneys to the insurance companies, will suffer if these changes become official. These changes harm the system. I hope you can see past the short term reduction in bills to see the long term harm you are causing to the system.

Roy Curry May 15, 2018

In a psychiatric history there can be a discovery which can influence causation whether accepted claim or not. Even if accepted the discovery could result in reconsideration or substantial apportionment. The medical record review is often vital in reaching both causation and apportionment and usually cannot be done in 3 hours. Thirdly, in preparation of report to produce substantial medical evidence and explain reasoning for conclusions it is necessary to collate and synthesize data from various sources the history, clinical exam, medical records often personnel records and depositions. Rarely can this be done in 3 hours often 6 sometimes more is necessary. At DWC conferences it is repeatedly emphasized to EXPLAIN and SUPPORT the conclusions to provide Judges a reasonable basis for their opinions.

Howard Rome May 15, 2018

The new expense regulations are unworkable for psychology and psychiatry and will cause me to resign after doing QMEs for some 15 years.

Dr. Dean Leav, Psychology QME May 15, 2018

In response to the proposed change of “no more than 3 hours may be billed for report preparation” under codes ML101, ML106, and in certain circumstances under ML104, I surveyed as many QMEs in psychology and psychiatry as possible in the short period allowed before all comments have to be submitted to the DWC.

These were active PSYCH QMEs in good standing (i.e., not currently subjected to investigation or disciplinary actions by the DWC).

The survey asked the QMEs to provide their report preparation time for the last 10 evaluations in the categories of ML104, ML101, and ML106. Report preparation time was defined as time spent on preparing the report apart from face-to-face interview, record review, medical research, and psychological testing.

The average report preparation times for ML104, ML101, and ML106 were calculated, and they were 12 hours, 10 hours, and 5 hours, respectively. The averages were rounded to the nearest whole number.

Based upon the results of the survey, I would like to propose the following, which I believe is reasonable and based upon the realistic demands of a PSYCH medical-legal evaluation:

> **For PSYCH ML104, the limit for billable report preparation time is to be 12 hours.**
> **For PSYCH ML101, the limit for billable report preparation time is to be 10 hours.**
> **For PSYCH ML106, the limit for billable report preparation time is to be 5 hours.**

Furthermore, there are often evaluations that involve "extraordinary circumstances" and that exceed the limits I am proposing. The DWC's proposed ML104 (3) takes this possibility into consideration. However, it requires the physician to attain agreement from the "parties" that the evaluation involves extraordinary circumstances prior to the start of the evaluation. This requirement is unrealistic for the following reasons:

1. It is often impossible to determine whether a case involves "extraordinary circumstances" prior to the start of the evaluation because the physician is generally not able to gather sufficient details of the case at that point of the process. The cover letters from the attorneys and the medical records are often received just a few days before the evaluation. Occasionally, they are received after the day of the evaluation. Moreover, relevant details of the case that only the applicant can provide are not available until the day of the evaluation.

2. It is quite challenging to receive timely responses from the "parties" (i.e., attorneys and claim adjusters) prior to the start of the evaluation. It would be unreasonable to expect a written agreement or disagreement from the parties prior to the start.

3.

Consequently, I would like to propose the following, which would apply to the categories of ML104, ML101, and ML106:

> **The physician can request from the parties that the limit for billable report preparation time be lifted. The physician has up to 30 days following the date of evaluation to submit such a request. The parties may deny or approve of the request. After receiving a response from the parties, the physician has 30 days to submit the report under the prescribed limit for billable report preparation time.**

The aforementioned proposals, if accepted, would help ensure that PSYCH QMEs are able to produce medical-legal reports that represent "substantial medical evidence." It would not be possible otherwise.

Darryl Klawitter, DC, QME ` May 15, 2018

I am opposed to the burden placed on the QME to put time/effort in contacting opposing parties in the hope of getting the parties "written authorization" for the QME to use "causation" as a complexity factor. Securing a TIMELY "written authorization" from opposing parties is doomed to failure and will be the wasted QME time. Why not hold the parties responsible for accurate content in their cover letters, and allow the QME to respond to the cover letters as received?

In addition, the 6 or more hours on any combination of three complexity factor is not congruent with the amount of time that the QME spends. Face-to-face time (interview and physically examine the patient) often exceeds 6 or more hours; however, there may be no need for medical research (Example: injured worker who has claimed multiple body region injuries, has other health issues (i.e. metabolic condition),and large box of medical records is submitted for review. I am opposed to requiring a QME to offer medical research in order to qualify for the complexity factor.

Then the proposed cap to 3 hours preparation time, if imposed, will result in considerably less detailed explanation in how the QME arrived at a conclusion because explaining the bridge of information gathered (mechanism of injury, complaints, exam findings, diagnostic evidence, clinical course) to a meaningful conclusion takes time. This is also true for QME discussions regarding: Permanent Impairment, Almarez/Guzman consideration; and Apportionment. A cap as proposed will result in cursory reports lacking detail parties are accustomed to, result in requests for more QME depositions, and result in an infusion of QME liens.

Miriam Shipp, MD, MPH May 15, 2018
Occupational Medicine
Preventative and Public Health
Qualitied Medical Examiner
Alumni, University of California, San Francisco, Medical School

I am writing to voice my opposition to the proposed medical-legal fee schedule. I believe they will harm injured workers, whom the DWC is charged to protect.

These proposed changes will result in a significant increase in unresolved claims, and an extended time before the injured worker is able to get back to work. This is to the detriment of workers, employers, and the DWC.

The proposed changes put a cap on report preparation and the use of research, which will substantially reduce the quality of our reports, and/or cause many of us to leave the QME process. Our reports are used to discover facts that are important and useful for everyone involved, most importantly the injured worker. The proposed regulations also require prior written agreement to address causation of an injury, before the evaluator has seen the applicant, which is untenable in most cases.

The proposed changes appear to be an attempt to cut corners. The DWC should pull back the proposed regulator ions, and conduct a stakeholder process, rather than pushing through regulations that will cause considerable harm.

We strongly request that you pull back these proposed changes and conduct a fair and impartial stakeholder process for regulation reform.

Dr. Wayne Inman May 15, 2018
(CAPT, Ret, USN)

I will add my overall disappointment in the proposed changes which seem arbitrary and not in the best interest of the workers and medical providers. My biggest concern is the "cap" of 3 hours for report preparation. I recognize there have been abuses in report preparation, like paying for "research", but there are many times when there are obviously voluminous records to be reviewed, and complex multiple injuries that indeed add real time to report preparation. Many of the "records" are not really medical, so maybe someone can filter them before the QME evaluation? My thoughts regarding the cap is that I should "cap" my review to 3 hours, and then review the additional in a supplemental report. Further, by imposing this cap, and then requiring a QME to accept a case which obviously will exceed that cap, this becomes a sort of "forced labor". I highly suggest re-review with inclusion of the major stakeholders (like COA).

Baziak & Steevans, APC May 15, 2018

We are opposed to the proposed billing changes for QME's as they will only further discourage physicians from getting involved in evaluating workers' compensation cases. We need good doctors in the system, and they deserve to be paid a fair wage for their expertise.

Don Eisner, Ph.D., J.D. May 15, 2018

Hello, I am wondering with the rationale is for limiting the time on reports.
I am wondering what is the rationale for having QME's being responsible for getting feedback from the attorneys/insurance company.

I am wondering what the rationale is for limiting research to one article per year.

Teo Ernst, Psy.D., ABPP May 15, 2018

I am extremely concerned about the proposed changes to medical-legal billing. Of particular note, as a psychologist, it is simply not feasible to write a thorough report, typically answering 10 or more referral questions, which meets the criteria for substantial medical evidence, within a three hour limit. I am concerned that if this proposal is formally put in place, not only will the majority of high quality QME's be forced to work elsewhere, but the remaining psychological and psychiatric medical-legal reports will become pre-templated (as a time saving measure) to the extent that they become meaningless and fail to serve an actual legal function. Ultimately, injured workers will be less served. I sincerely hope that these proposed changes are seriously re-worked.

Daniel E. Bruzzone, PsyD May 15, 2018
Clinical, Forensic and Police Psychology

As a fairly new QME in Psychology, I have read with interest the postings regarding the proposed changes to the Med-Legal reimbursement regulations. I doubt that my words could rise to the level of some of my colleagues in describing their concerns with these regulations, so I defer to them; however, I wholeheartedly wish to add my voice.

My observation with the process thus far is that the “rules of thumb” we all use for billing the actual work done are woefully out of touch with reality. In order to provide a good, fair product I invest a great deal of time in each phase of the QME process; yet, it is not uncommon for me to bill half or a third of the hours actually worked so as to fit with the norms. Therefore, any change that would reduce my ability to bill further will do nothing more than to get me to question seriously the need for me to continue with this part of my career.

One of the worst parts of the proposal involves changes to the rules that would put me in a position to negotiate fees through complexity factors ahead of the assessment and without the ability to back out of the deal. Were that to be the case, it would be tantamount to an illegal taking of my right as a businessman to conduct my business in the best way I see fit. "Negotiating" with a metaphorical gun to one's head is not equitable.

In my opinion, that is apparently shared by many, is that the DWC should concern itself with going after those who abuse the system and in creating equity in the system so that all parties arrive at an excellent end point as efficiently as possible; however, efficiency does not equate to cheapness, and should not involve nickel and diming QMEs into submission. As some have proposed, doing away with the mountains of miscopied and duplicated records is a good way to start, and one that should be directed at those providing the records rather than dumping it on the QME. A follow on to that would be to create a system that would allow the use of professional records reviewers that could be contracted by the QME for a reduced and equitable fee. It would still fall on the QME to review all records, but these professionals could save the QME process a lot of time by accurately collating and highlighting salient information. This too would provide efficiencies without undue pressures on the already strained QME following the extant Med-Legal process.

The Med-Legal system should serve all parties equitably and not be allowed to so blatantly serve the needs of defendants. Yes, it serves society to have a system whereby employers can engage in a good-faith effort to make injured workers whole; but that should not be a goal at the expense of those who suffered and those who are investigating and quantifying the facts and resulting deficits.

Dr. David Polushkin, DDS, QME May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other

stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process. If the above changes are approved, in all likelihood I will not be renewing my certification.

Don Houts, MD May 15, 2018
Associate Clinical Professor, Department of Psychiatry
UCSD School of Medicine

Please note that I've limited my workers' compensation practice to psychiatric AME examinations and reports.

It is quite common for the issues that come to me to be significantly complex. Often years have passed since the original injury, and as a result, documents are often voluminous. Frequently, I've spent a day or two just reading documents. In order to report the medical and legal documents that have been considered, as well as to described the history of injury and relevant personal issues, the report writing alone often requires 8-10 hours, sometimes more. The notion of limiting report writing to only three hours is unrealistic with the sorts of cases that are routinely referred to my office. No limit is appropriate in this regard. I'm actually quite grateful when the cases are simple and straightforward and I wish that would happen more often - but then the expertise of an AME probably would not be necessary.

I'm also concerned about the proposed requirement that the referral letters must request that the issue of causation be addressed. Referral letters are often poorly and incompletely written. Furthermore, especially in AME matters, just because causation has been accepted by the insurance carrier does not mean such acceptance was always correct. Causation is critical to every case that comes to me and I should be free to address that issue whether or not the referring parties have requested that I do so.

If it is the goal of the proposed changes to drive more doctors out of the workers' compensation system, then such changes will certainly have that impact on me.

Myron L. Nathan, MD May 15, 2018

I am responding to your request as a psychiatrist who has been working in the Worker's Compensation field for over 25 years. I have evaluated over 20,000 applicants. Currently I only perform AMEs and Panel QMEs and an occasional QME.

Due to my specialty the face-to-face exam or re-exam requires a minimum of 2 hours, although most exams are between 3 and 4.5 hours. I have no problem satisfying the complexity factors.

If causation as a factor is eliminated and there are no or minimal medical records, here is what would occur: An exam lasting 3.75 hours with no records or 3.5 hours with .25 hours of record review will have to be billed as ML-103, as the preparation and dictation of the report does not count.

Keep in mind the most important aspect of any report upon first reading is the impressions and recommendations section. Psychiatric reports (initial and reevaluations) which include the battery of psychological test results usually are a minimum of 28 pages and a maximum of 40, without including a summary of the medical records. The dictation of the report takes an average a minimum of 2.25 hours to a maximum on average of 3.25 hours, plus one full hour to review or edit. Therefore, the range is 3.25 - 4.25 hours for the first report, and to be paid at ML-103.

We have no control over how many pages we are asked to review in preparing an initial or a supplemental report - the more pages the more time the report takes to complete. Also, in a supplemental report it is necessary to review one's prior report or reports. Given voluminous medical records, the report does often require more than 3 hours of preparation time. I don't always know how long a file box of medical records will take to review or how long it will take to prepare a supplemental report. Therefore a request for preauthorization will be necessary, even if it turns out not to be necessary. If report preparation is going to be capped at 3 hours, then the number of pages sent to do a supplemental report or reevaluation should be capped, which would also include depositions.

In my specialty, I hardly ever do research and would use this point as a compromise.

Cindy Pajak, Injured Worker May 15, 2018

I was injured on the job while I was working as a pet groomer. My employer and the Workman's Comp Insurance company did everything they could to restrict my treatment choices. I had an evaluation by a three doctor panel and it really help my case. They took the time to sit down with me and spent time explaining my medical condition to me. The QME doctor helped me to resolve my Workman's Comp case and I was able to get back to work after getting the treatment I needed.

My understanding is that the Division of Workman's Compensation is trying to lower and restrict fees for Qualified Medical Examiners and that these doctors have not had a pay increase for

twelve years. The DWC appears to me to consistently side with the insurance companies. Have the insurance companies raised their fees? I still work in the same industry thanks to my examining doctors. What will happen to me if my doctor leaves the system? People like me will have even more problems getting the help we need to get better and having our cases closed in a satisfactory and timely manner.

I urge the DWC to listen to the doctor's comments in this public forum and preserve, not destroy, access to evaluating doctors

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Gennady Musher, MD, Ph.D. May 15, 2018

The purpose of the QME is to offer expert substantiated medical legal opinion to the parties and to the trier-of-fact.

It is clear that under the present proposal that the time spent by such expert plays no meaningful role in the compensation, that ML104 would be essentially impossible to use, leaving mostly ML102 and ML103. In the case of psychiatry, this will leave the expert spending a minimum of 8 hours, in my experience, and on average closer to 16-20 hours for a fee varying between $600 and $900, covering the time INCLUDING administrative and other office expenses.

Let's compare: clinical work of the same duration would be compensated by Medicare (the lowest payer on the market) taking into account BOTH complexity AND time spent at approximately $1800 for the 8 hour version of the services. Let's compare: I get daily emails from recruiters offering psychiatrist $230+/hour in California Penal institutions and county clinics WITHOUT OVERHEAD EXPENSES AT ALL. Needless to say, private practice pays more than either one of the above payers.

So could we envision the logic for a psychiatrist to seek or maintain QME certification? 1. The love of medical legal work above all other activities in the field. 2. Overwhelming desire to serve the attorneys and the trier of fact caused by unresolved conflict in the childhood relationships with father and with siblings. 3. Obtaining a non-profit status for the practice, which would allow collection of tax free contributions from the public. 4. Can anyone think of any others?

If the DWCMU is aware of this state of affairs, why not frankly eliminate the QME as a category and let the PTP or the attorneys or the Trier-of-fact make the determinations of medical legal issues, since the value of time spent by the expert is nil.

Alfred Roven May 15, 2018

I would loosen the rigidity, increase the reimbursement, and assign a person to person contact for each case.

Dr. Martins, DC, QME May 15, 2018

I am writing to address the proposed changes to the QME fee schedule. I am truly disappointed with these changes. As an active QME I strive to provide the best work possible.

I read, for example, that the proposed fee changes will cap research payments at 2 hours. When I'm required to provide research in my reports I do my best to find the qualified research that pertains to the case.

Sometimes I am required to provide several references. Often times this takes more than 2 hours. I carve time out of my busy schedule as a business owner and parent to provide quality service and I am unable to work for free.

I take this position with a great deal of honor. I will say, however, that with these proposed changes in fees that I will no longer be able to justify providing my services. I predict that many QME providers will no longer be able to provide there services which are essential to the med-legal process. I predict a shortage of providers and those that stay will provide inferior service. I ask that you consider these points and keep the fee schedule as is.

Michael Carlish, Ph.D. May 15, 2018

I'm writing to give my opinion about the proposed fee schedule changes: three hours per report is unreasonable and unrealistic. There is a steep learning curve associated with doing these types of evaluations, and it takes time to get them right. Unfortunately, if this change comes to pass, I don't anticipate that continuing to do Worker's Comp. evaluations would be worth my time.

Robert B. Gerber (DDS) May 15, 2018
COL (CA) CSMR
State Dental Officer
Deputy Commander
Clinical Associate Professor, Ostriw School of Dentistry of USC

I am writing to object to the new proposed regulation changes. These changes will limit the ability of QME professionals to provide substantial evidence needed to determine causation, impairment and apportionment. Ultimately this will cause reduction of critical benefits to the injured worker. This violates both the spirit and the intent of the State of California's obligation to injured workers.

James Deck, Ph.D., QME May 15, 2018
Psychologist

I have been performing psychological evaluations in the Worker's Compensation system since 1988. I am writing with my concerns regarding the proposed changes to the medical-legal fee schedule, which are unrealistic and will lead to a lower standard of care for QME/AME evaluations.

Typically, there is a dispute regarding liability in such cases, with AOE/COE being the predominant issues. To limit report preparation to three hours is arbitrary and unrealistic. By definition, a psychological evaluation only occurs if the nature of the injury is "extraordinary" or complex. Often there are other factors that require thoughtful analysis in order to arrive at accurate opinions regarding diagnosis, disability, causation, recommendations, and especially apportionment. No doubt, if the proposed changes are adopted, there will be fewer QMEs to perform such complex evaluations. This will result in reports with opinions of less quality and accuracy, because there will be less time to investigate research aspects particular to the case, contemplate, and prepare the reports.

It is my opinion that adoption of these arbitrary regulations is not in the best interest of the employer, injured worker, and/or evaluating and treating doctors, but of the insurance companies.

Grant Hutchinson, Ph.D. May 15, 2018

The proposed regulations will dramatically inhibit adequate reporting in complex medical-legal cases, particularly those with voluminous medical records and attorney cover letters that require addressing multiple injuries and injury dates. This problem will be further exacerbated by the limit of three hours report preparation time. In particular, psychiatric/psychological and neuropsychological reports and complex internal medicine reports demand a thorough analysis which often requires more than three hours of intense report preparation. Limiting report writing to three hours will encourage cursory analyses that will subsequently require supplemental reports and depositions, extending the time/cost factors in reaching substantial medical evidence

that will far exceed the cost of more than three hours of report writing. I cannot imagine writing an adequate and medically substantial neuropsychological report—for example—in three hours.

Having seen many cases for multiple re-evaluations, often spaced months or years apart, allowing no time to review past records to refresh my memory and integrate new records (often requiring chronological re-sequencing) is unreasonable. Further, like limiting report writing to three hours, disallowing review of older records requires that QMEs remember old data accurately and any subsequent errors will virtually guarantee extending the time/cost factors in reaching substantial medical evidence such that supplementals and/or depositions will be required.

The proposed language for ML-103 seems unclear and difficult to understand such that, being open to multiple interpretations, QMEs may be in jeopardy of violation—not because of any ill intent on the part of the QMEs but due to poorly thought out and written regulations.

I have heard that some Southern California QMEs are billing excessively for record review and report preparation, although I have seen almost none of this in Northern California. Targeting all QMEs in order to prevent such excesses by a small group decreases every QME's ability to prepare clear and medically substantial reports. Rather than throwing the baby out with the bath water, I suggest periodic audits of QMEs who appear to be overbilling as a far more effective solution. If some QMEs bill for more hours than is conceivable in one month, those QMEs could be subjected to discipline while allowing QMEs who bill normally to continue to provide quality services.

Overall, and ignoring my own interest in the system as a QME, the proposed regulations will likely encourage many current QMEs to leave the system and discourage new QMEs from entering the system. Fewer QMEs providing services to injured workers will only hurt injured workers by making it difficult to obtain a quality report that allows rapid treatment and settlement of claims. I agree with other QMEs to whom I have spoken that the results of the new regulations will be catastrophic for injured workers.

Shahin S. Rad, MD May 15, 2018
Board Certified Orthopaedic Surgeon

I would like to express my opposition to the proposed changes to the Med-Legal Fee Schedule. By trying to limit the report preparation to only three-hours will make it difficult to perform a thorough evaluation. Although some evaluations are straightforward and are billed as

an ML102, many are more complex. I often receive voluminous records in excess of 10 inches, or many cases with multiple dates of injuries. This requires a great deal of time reviewing medical records. By limiting the hours, there is less incentive to perform these complex evaluations, which will result in a substantial increase in unresolved claims and a significantly extended time frame before an injured worker is able to get back to work. As it stands, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. I strongly believe that the proposed changes of the medical-legal fee schedule will result in many QMEs to leave the worker's compensation system. I hope that you will reconsider the proposed changes.

Anonymous May 15, 2018

The DWC does not appear to have taken the following into consideration:

1. Many QME's have satellite offices to help cover remote or underserved areas of the state. As we know, there has been significant attrition of QMEs in recent years. Now with the further reduction in pay, we know that injured workers in minority and remote areas will not be able to adequately find QMEs within the regulatory distance because QME doctors will not be able to afford offices in these areas. This is because there is a significant amount of overhead to maintain offices in these areas and participate in deposition in these areas. The DWC should see if their policy is consistent with the state government's goals to increase access to injured workers. Injured workers in big cities will be able to access QMEs, if there are any after these proposed regulations, that choose to work for little money. Before writing any new regulations, the DWC needs to study how decreased physician reimbursement will impact vulnerable populations and see if this goes against state policies regarding access to physicians.

2. As we know, to participate in Workers' Compensation treatment, it takes a significant amount of medical legal expertise to write reports, supplemental reports, PR-2s, etc. The DWC worked on cutting payments to providers and we know that many left. This left injured workers without adequate access to care. Some have to travel extremely long distances to access a provider. Some will go without care when they cannot find a provider. We know that many QMEs also do treatment in the Work Comp system. As QMEs leave the system, they will more likely not want to accept treating patients due to the significant uncompensated time involved. This will again lead to decreased access to care for injured workers. This will also worsen access to care especially in areas where medical providers are scarce.

3. With the new proposed regulation regarding Causation, if the QME cannot refuse to do the evaluation, there is a real chance that QMEs will suffer a financial loss by doing an evaluation. For example, if a QME has to travel, there is a significant amount of overhead to see an injured

worker and produce a report. After taxes, the revenue received will not be able to cover the possible cost of performing the evaluation and developing reports. Again, this will lead QMEs to practice less in rural regions and regions where there are significant poor and minority populations. We know that some of these populations do not read, write, or have access to adequate transportation. We have all encountered evaluees who report they do not have enough resources to travel to their QME appointments.

Here are proposed reimbursement regulations:

1. If a QME has reasonable belief that they cannot afford to do an evaluation or that the evaluation will be compensated at a level that they cannot produced a report that constitutes substantial medical evidence, they can refuse to do the evaluation without any consequence by the DWC. The QME will be allowed to talk to one or both parties, for the sake of efficiency and time, and without being considered ex-parte communication, to ascertain what records are involved in the case and a preliminary history of the evaluee.

2. QMEs who are deposed will be entitled to be paid 250 dollars an hour for whatever preparation time they put into preparing for a deposition. This is necessary because QMEs give a significant amount of uncompensated time preparing for depositions. This will also help to compensate for manipulation of the legal process by parties who use deposition as leverage to gain favor for their case but then may cancel depositions at the last minute without compensating the doctor.

3. QMEs should be able to peform their deposition at their local offices rather than where the workers at satellite offices were seen. Lawyers already request to call into depositions. This will save QMEs the overhead money of traveling to a deposition and potentially losing money and a day of being able to do other work.

4. If a worker does not show up for an evaluation and there was not at least a two-week advanced notice, the QME shall be compensated 8 hours of time at 250 dollars an hour. Additionally, the QME will be paid for any record review time prior to the evaluation. The insurance companies have a history of stating that they don't have to compensate for this or providing for minor amounts of money. The DWC has also worked with the insurance companies to respond that per the DWC, doctors can do other work. Well, if you are in a satellite office, what other work do you have to do? What other worker will compensate for the lost revenue for reserving, in advance, an office? If you are at your home office, what other work are you expected to do, on such short notice, to compensate for lost revenue? QME's have to often reserve hours to a full day for an injured workers. This will help reduced the risk that the parties abuse QME uncompensated time and will help to ensure QME's get paid for actual work done and actual work lost.

We know that that allegedly the DWC engaged in underground regulations and settled without acknowledging any responsibility. These proposed regulations will help to ensure that the DWC will never engage in underground regulations in the future:

1. Any DWC employee who has been accused of engaging in underground regulations must immediately recuse themselves in any regulator work including but not limited to enforcement and creation of regulations.

2. The DWC shall obtain approval of 75% of QMEs before any new regulation governing QMEs is passed. This will help to ensure that QMEs are being governed with their consent. The DWC allegedly has a history of telling QMEs they do not have due process rights and that the DWC serves as the judge, jury and executioner. We know that government's legitimacy and moral right to use state power is only justified and lawful when consented to by the people or society over which that political power is exercised.

3. DWC employees are banned from working for insurance companies for a period of 10 years after termination of their employment from the DWC. This will help prevent the DWC from being unduly influenced by the insurance companies when making reimbursement regulations.

4. The DWC shall establish an anonymous hotline with the appropriate agency such that any alleged underground regulations can be reported and investigated without fear of retaliation.

5. If the proposed regulations by the DWC come into existence, prior to issuing a panel of physicians for QMEs, the DWC will obtain from the parties written notice of whether causation is an issue and whether an evaluation requires extraordinary circumstances. This will shift the cost and burden of obtaining this information from QMEs to the parties where is rightly belongs. This will also prevent the DWC from going after physicians by using underground regulation. Once the panel is issued, the parties will seek consent by the doctor regarding whether the doctor is willing to participate. If the physician is not willing to participate because of financial reimbursement issues, the parties can choose to fully reimburse doctors for report preparation time or request another panel. If the doctor on the next panel refuses to do the evaluation due to financial reasons, the parties must fully reimburse the doctor for report preparation time as no further panel will be issued.

6. Any DWC official now or in the past who has been engaged in enforcing underground regulations shall have their name placed on the same list as disciplined physicians as DWC officials are expected to maintain an extremely high standard, arguably just as high as doctors.

The insurance companies need additional regulation. We know how they inappropriately delay or deny QME billing. Given the terrible proposals by the DWC, the following are necessary to stop significant payment abuse by insurance companies:

1. Insurance companies are required to fully reimburse the QME as per the reimbursement regulations. Insurance companies who claim that reports are lost, that evaluations are unauthorized, use the official medical fee schedule instead of the medical legal fee schedule, or any other excuse that is not valid, will be found to be in violation of the reimbursement regulations. The responsibility will fall directly on the adjuster.

2. Adjusters will answer calls from QME offices regarding billing. If no call is returned within 2 business days by the adjuster or office of the adjuster regarding following up of an unpaid QME bill, the adjuster will be found in violation of the reimbursement regulations.

3. Insurance adjusters will be required to take a 12 hour course in medical legal billing sponsored by the DWC. Once that course is completed, they will be certified by the DWC. Once certified, if their insurance company is found in violation of the reimbursement regulations, the adjuster shall be disciplined as per the labor code. Because adjusters are being held to a high standard of integrity regarding physician reimbursement, if they violate the reimbursement regulations, they can be suspended from practicing as certified adjuster with the DWC and their name will go onto the same list as disciplined physicians and DWC officials.

4. The DWC will establish an anonymous line for the reporting of any adjuster, bill reviewer, or insurance company engaged in the inappropriate denial or delay in paying QME fees.

These proposals will help to balance the reimbursement code.

S. Gary McClure, Ph.D., ABMP May 15, 2018

Capping the time frames for a medical-legal QME evaluation will substantially change the way I approach a QME report. Currently, my QME reports can be quite extensive and time intensive. However, the medical/legal product (QME report) is intended to address specific issues related to the case and therefore, if done comprehensively, the QME report should reduce costs by decreasing litigation time and by aiding the Court and the parties involved (applicant & defense) in resolving the case.

The time limits proposed for the med-legal fee schedule changes will result in substandard QME reports that will likely prolong the contested QME cases and the litigation expenses.

The new proposed changes seem similar to a "capitated" or "flat rate" plan (like the ML-102 and ML-103) where the QME is required to accept a case and complete the report regardless of complexity of the case. This model is not compatible with the expectations of a comprehensive QME evaluation, particularly regarding psychiatric QME evaluations.

If there are abuses occurring in the QME billing, they should be addressed on a case by case basis.

William Hale, MD May 15, 2018

These payment levels are not sufficient to cover costs. Everyone will quit.

William Hale, MD May 15, 2018

These payment changes are too extreme. No one can practice at these low rates. There will be a mass exodus of QMEs. The lawyers, employers and insurers will insist on a governance change at DWC when the case log backs up for years.

Niveen Gorgy, DC QME May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Kara Winter, Ph.D. May 15, 2018

The proposed changes are devastating to the injured workers with whom I have dedicated my career. It is one more hit to the people who have worked hard all their life to support their families. Why???

Dr. Phu Q. La May 15, 2018

The proposed Med-Legal Fee Schedule change if implemented, it will be detrimental to the QME community as a whole, evaluators will not able be effectively deliver quality report due to cap. It will certainly escalate and cost much frustrations process for evaluator to render a thorough med-legal report. Again, I think it's a bad idea if proposed changes pass.

Ashraf Helmy, MD May 15, 2018

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. My strongest objection has to do with the proposed three-hour cap on report preparation. In my opinion, if this 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 will take more (often much more) than three hours.

If this three-hour cap on report preparation is implemented, the QME would be obliged to produce hastily written, substandard reports, or work for many hours without compensation. Allowing only three hours for report preparation would encourage templated, prefabricated reports devoid of the necessary careful analysis of the relevant data; it would be impossible for any evaluator to adequately address the many complexities involved in a psychological/psychiatric evaluation in three hours. 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 this rule would undoubtedly force competent, ethical evaluators out of the system.

It may cost more upfront to obtain an admissible report, but in the long run, the inefficiencies introduced by the three-hour report preparation cap would negate any cost savings by necessitating more supplemental reports and depositions to address deficiencies in hastily-prepared reports. This would undermine the entire purpose of the QME evaluation, which is to assist the parties in resolving contested claims in a timely manner.

The requirements for medical research that are being proposed are, I assume, designed to put a stop to those who simply insert the same template of material into each report without regard to its relevance to the case. I appreciate that there are some who do this, but the proposed solution imposes undue burdens on all QMEs, including those who do not abuse the billing regulations. Will the QME be expected to keep track of sources that were cited in previous reports, to ensure that they not be used again for a year? If so, this will be another area where the evaluator is expected to work without compensation. If one is working on a case that addresses the same or a

similar issue that was addressed in a previous case, it would not make sense to be prohibited from citing authoritative, relevant research simply because it was cited in an earlier report.

Overall, it appears that the proposed changes have been suggested by someone who has an incomplete understanding of the time and effort that it takes to perform an adequate QME evaluation and write a decent report that can be relied upon by the parties to help resolve a claim. In my opinion, the DWC should go after those who are abusing the billing regulations, rather than imposing unworkable "solutions" on all of us.

Victoria Kuhl, Ph.D., QME May 15, 2018

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Overall, it appears that the proposed changes have been suggested by someone who has an incomplete understanding of the time and effort that it takes to perform an adequate QME evaluation and write a decent report that can be relied upon by the parties to help resolve a claim. In my opinion, the DWC should go after those who are abusing the billing regulations, rather than imposing unworkable "solutions" on all of us.

Paul Nottingham, MD May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are not good. While I understand that people to do not want to have a fee schedule that can be used to over-pay QMEs, a fee schedule that under pays doctors will hurt the injured workers . With under payment, quality evaluators will leave the system. Poor evaluations result in mis-diagnoses, improper ratings, ill-conceived work recommendation (that not infrequently lead to further injuries and costs) and incorrect medical care recommendations.

As a Board Certified Orthopedic Surgeon who did a great deal of spine surgery across a broad spectrum of ailment for 25 years, I find that my experience has helped me enormously in providing reasonable and accurate reports. With the " shadow" re-imbursement rules in place I was preparing to stop my QME work as I could otherwise make more money performing other work including fairly menial tasks.

It is my understanding that the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal puts a cap on report preparation (perhaps the most critical element in creating a reasonable and accurate report) and the use of research (which often brings clarity to the diagnosis, prognosis and medical care to be recommended). Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. Limit the report preparation to only three-hours on complex cases does not square with the reality of good report writing. Approximately 50% of the cases could not meet that time restriction even as many of them are billed out at the ML-102 and ML-103 levels.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder.

DWC should pull back the proposed regulations and gather the expertise of the various parties involved to design regulations that can lend to a best practice approach.

Dennis Gardner, Ph.D., QME May 15, 2018
Forensic Psychologist

I have been doing these types of evaluations for 20 + years. The proposed cap of 3 hours prep time is not tenable. We write quality AME/QME reports for the Attorneys, Courts, Employer and Injured Worker. These reports are arduous and by necessity have to be thorough and of the highest quality standard of best practices. This requires a lot of digging into the details and history and past medical records and putting that all together. The reduction of prep time will lead to poor quality of reports with lack of necessary details for the attorneys, courts, employer, and employee. My concern is that this legislation would lead to poor quality, non-satisfactory reports with poorly substantiated opinions that may not qualify as meeting reasonable medical probability etc. This could lead to boiler-plate reports and no one will benefit from that. Many QMEs would choose to not to do poor quality reports and would discontinue doing QME\AME evaluations. I would be one of them. This proposed legislation will contribute to the dysfunction of the QME process, which even with all the present complexities and obstacles does seem to be working in a fair and reasonable manner for all the parties involved. The process, in my opinion, could be improved but this proposed legislation will not be beneficial.

Keyvan Yousefi, MD May 15, 2018

The proposed amendments to the Medical-Legal Fee Schedule will cause irreparable harm to injured workers in California and to a key component of the workers' compensation insurance system that exists to protect them. DWC is charged with continuing to look for ways to wring avoidable costs from the workers' compensation system, but without inflicting more harm on injured workers. DWC's proposed amendments fail on both elements of its charge and are inconsistent with the enabling statute, Labor Code section 5307.6. A brief overview of the arbitrary, unreasonable, and unnecessary proposed amendments and their inevitable consequences:

The three-hour cap on report writing will result in inadequate reports and parties waiting even longer to resolve their disputes. The proposed limit will leave QME physicians with three

options: (1) rush through the report writing process and produce inadequate reports, which will inevitably result in costly supplemental reports, depositions, and litigation; (2) exceed the three hour limit knowing they will not be compensated for the additional time and effort (highly unlikely); or (3) leave the system and seek more lucrative opportunities elsewhere.

The stringent requirements on the medical research QME physicians may perform will only deter QME physicians from citing authoritative sources in their reports. The prohibition on QME physicians reviewing sources cited in reports in the preceding 12 months is particularly bewildering: setting aside the impracticality of QME physicians (let alone DWC) tracking which sources were previously cited and when, it discourages physicians from consulting, reviewing, and citing persuasive sources that further the cause of aiding the treatment and recovery of injured workers. The result will be QME reports that are largely devoid of references to relevant medical research.

The proposed amendments all but guarantee QME physicians—on which the workers' compensation system depends—will leave the system en masse. Those that remain and adhere to the changes effected with the proposed amendments will produce inadequate reports, and any hypothetical savings will be lost to the need for subsequent supplemental reports and depositions, and the costs that will result from the inevitable delays in resolving disputed claims.

John Sedgh, MD May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Martin R. Taubman, D.P.M., M.B.A. May 15, 2018

I wish to comment on the proposed legislative Medical-Legal Expenses Regulations.

Just who do think you might be serving with these regulations? The injured workers? I don't believe so as the new proposed regulations will prolong and complicate reporting. The doctors doing the reviews? No, again. The restrictions are unfair and will result in poorer reports because of time and payment constraints. The State of CA Department of Industrial Relations? No, you will just get bad press and feedback from the injured workers and doctors. The judges? Hell, they are so overworked now it will probably make no difference for them. Just like almost every bureaucratic decision I have ever witnessed the decisions made are often short-sighted and cause more problems than they solve! Let me ask you one more question. Would you work harder for less?

Alan Berkowitz, MD May 15, 2018

The proposed amendments to the Medical-Legal Fee Schedule will cause irreparable harm to injured workers in California and to a key component of the workers' compensation insurance system that exists to protect them. DWC is charged with continuing to look for ways to wring avoidable costs from the workers' compensation system, but without inflicting more harm on injured workers. DWC's proposed amendments fail on both elements of its charge and are inconsistent with the enabling statute, Labor Code section 5307.6. A brief overview of the arbitrary, unreasonable, and unnecessary proposed amendments and their inevitable consequences:

* The three-hour cap on report writing will result in inadequate reports and parties waiting even longer to resolve their disputes. The proposed limit will leave QME physicians with three options: (1) rush through the report writing process and produce inadequate reports, which will inevitably result in costly supplemental reports, depositions, and litigation; (2) exceed the three hour limit knowing they will not be compensated for the additional time and effort (highly unlikely); or (3) leave the system and seek more lucrative opportunities elsewhere.

* The stringent requirements on the medical research QME physicians may perform will only deter QME physicians from citing authoritative sources in their reports. The prohibition on QME physicians reviewing sources cited in reports in the preceding 12 months is particularly bewildering: setting aside the impracticality of QME physicians (let alone DWC) tracking which sources were previously cited and when, it discourages physicians from consulting, reviewing, and citing persuasive sources that further the cause of aiding the treatment and recovery of injured workers. The result will be QME reports that are largely devoid of references to relevant medical research.

* The proposed amendments unreasonably burden QME physicians with yet another responsibility: seeking and obtaining the written agreement of both parties—before the actual evaluation—that medical causation is a disputed medical fact. Even in the unlikely event QME physicians find a way to actually undertake and administer this responsibility, experience confirms that parties will not even respond to those efforts let alone provide the necessary consent in disputed cases. Asking QME physicians to act as arbiters of disputes over threshold legal and factual issues is well outside the bounds of what should be asked of physicians. In effect, this aspect of the proposed regulation is granting employers and carriers a de facto veto power of whether an applicant may use a QME to further dispute resolution.

As acknowledged in the research studies relied upon by DWC in developing the proposed regulations, QME physicians have been leaving the convoluted system, even with prior changes actually increasing financial incentives to stay. The proposed amendments—which further complicate the process and create a disincentive for the remaining QME physicians—will only hasten the ongoing attrition.

The existing regulatory regime for QME physicians is sound. QME physicians are already subject to competency examinations and renewal requirements, a labyrinthine fee schedule, scrutiny from bill reviewers, and the administrative oversight of DWC. The proposed amendments all but guarantee QME physicians—on which the workers' compensation system depends—will leave the system en masse. Those that remain and adhere to the changes effected with the proposed amendments will produce inadequate reports, and any hypothetical savings will be lost to the need for subsequent supplemental reports and depositions, and the costs that will result from the inevitable delays in resolving disputed claims

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Brian Park, MD May 15, 2018

The proposed changes in CR Section 9794 and 9795 are troubling. It appears the goal of the changes is to simply reduce payments to QME evaluators with no other considerations.

Regarding the arbitrary time limit of 3 hours- Unless you also arbitrarily cap the amount of medical records that may be submitted, how can you ensure the evaluating doctor will be paid at all? I have had multiple cases in my career where over 10,000 pages of medical records were submitted. Can I pick and choose which panel assigned cases I accept? Or am I being asked to work for free/pay myself for the privilege of performing the evaluation? For a great many cases medical record review ALONE would exceed 3 hours.

Other doctors on this forum have indicated that they feel someone has "just made up an imaginary number" for the time "it should take to prepare a medical-legal report," and I must agree with them.

As the QME why should I be asked to get written agreement from both parties on whether causation is a disputed medical fact before the evaluation happens? What do I do if one or another party fails to respond to me in a timely fashion? If both parties don't agree what would I do? I am not a legal arbitrator.

I think an injured worker under these guidelines will find very few doctors willing to work as a QME evaluator and therefore unless he/she has a very simple and straightforward claim it will be very hard to receive due process. They have the burden of proof.

I can see how insurance companies would benefit from these proposed changes, but I do not see how this would improve the function of the worker's compensation system. I think it will be very hard for injured workers to get a fair evaluation of their claims, and it is likely that most QME doctors would stop doing evaluations. As it is compensation for these reports has been stagnant for over a decade while costs continue to rise.

Michael Newman, D.C. May 15, 2018

I have reviewed and analyzed the proposed changes to CCR Section 9794 and CCR Section 9795 that DIR employee **[REDACTED]** has set forth.

I have prepared my response with my thinking that the DIR does want input from the medical-legal evaluators as well as from the applicant and defense attorneys, such that the problem of inappropriate billing of medical-legal reports can be solved.

I find the proposed changes go far beyond being not well thought out and irrational. I find specific sections of the proposed changes to be internally inconsistent. Those sections are criteria 4 and criteria 5, cited below. I will discuss this internal inconsistency later in this response.

These proposed change go to what appears to be a denial of due process for the injured worker.

I begin this response by noting that I have 38 years of experience as a medical-legal evaluator and I am well versed on the correct billing procedures for medical-legal reports as set forth under CCR Sections 9795.

I appreciate that my responses to the proposed changes of CCR Section 9795 should be as brief and to the point as possible but the proposed changes are so arduous that my responses have to be more expansive.

Think of my responses as more akin to an ML-104 billing code than an ML-102 billing code.

I am not one to mince words and I am not one who tries to be politically correct.

The issue at had is the abuse of the ML-104 billing code by AME and QME medical-legal evaluators and **[REDACTED]** responses to this problem.

This billing code is comprised of 10 billing criteria very clearly set forth under CCR Section 9795.

I will go over the ML-103 and ML-104 billing criteria and comment on what I have observed in my rebuttal comprehensive medical-legal evaluations.

Criteria 1. Two hours of more face to face time.

Criteria 2. Two hours or more on records review.

Criteria 3. Two or more hours spent on medical research.

Criteria 4. Four or more hours spent in <u>any combination of two</u> complexity factors. This counts as two complexity factors.

I have set forth Criteria 4 due to proposed changes to CCR Section 9795 that are frankly non-sensical and irrational and are discussed later in this report.

Criteria 5. Six of more hours spent on any combination of three complexity factors.
This counts as three complexity factors.

I have also set forth Criteria 5 due to proposed changes to CCR Section 9795 that are equally non-sensical and irrational and are discussed later in this report.

Criteria 6. Addressing the issue of medical causation upon written request of the party of parties requesting the report, <u>or if a bona fide issue of medical causation is discovered in the evaluation.</u>

This last sentence, <u>or if a bona fide issue of medical causation is discovered in the evaluation</u>, is a major issue BECAUSE the face to face encounter is a fluid interaction between the IW and the evaluator and many causation issues are discovered during this fluid face to face encounter.

Criteria 7. Addressing the issue of apportionment. This is a complexity factor if the physician must evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region, or two or more injuries involving two or more body systems of body regions.

This criteria is very specific and exact.

Most of the QME and AME medical-legal reports that I rebut fail to meet the specific apportionment criteria but still cite apportionment as a complexity factor.

The primary issue that has spurred **[REDACTED]** in his quest to address medical-legal billing irregularities is the medical-legal evaluator's failure to meet all of the above CCR Section 9795 billing criteria required to justify the ML-104 bill code but still billing the evaluation under the ML-104 billing code.

If the above criteria is not met, it falls to bill review to deny the submitted bill or process the submitted medical-legal bill under the ML-103 or ML-102 codes.

Bill review can require documentation as to the time spent on review of medical records.

Bill review can require documentation as to the time spent on research.

The medical-legal evaluator can object to the reduction of the bill and proceed with independent bill review.

The medical-legal evaluator can then file a lien or a petition for costs and go before the WCAB and resolve the dispute.

The medical-legal evaluator can try to explain to the WCJ why he or she did research and for what purpose and can explain why it took 2+ hours to review a half-inch of medical records.

My point is that IF CCR Section 9795 billing criteria are followed by Bill Review, most of the problems with the inappropriate use of the ML-104 billing code will go away.

I doubt most of the abusers of the ML-104 billing codes want their day in trial to explain to the WCJ how they billed their medical-legal report.

Now on to the issue of the proposed changes to CCR Sections proposed by **[REDACTED]**:

The DIR recently settled with Howard et al. The issue was the underground regulations that **[REDACTED]** had applied to what he perceives makes up the CCR 9795 billing criteria.

[REDACTED] chose to interpret CCR Section 9795 NOT as it is written.

It was NOT his job to interpret the California Code of Regulations.

[REDACTED] has now been assigned to make changes to CCR Section 9795 and bring his personal interpretation of how the CCR Section 9795 should be written into how he wants it to be written.

I have reviewed his proposed changes on a line by line basis and this is my analysis:

CCR Section 9794. Subsection 3. **[REDACTED]** writes "No other charges shall be billed under the Office Medical Fee Schedule in connection with a medical-legal evaluation or report".

Comment: Medical-legal reports are NOT BILLED under the Official Medical Fee Schedule. They are billed under the Official Medical-Legal Fee Schedule.

CCR Section 9795. Subsection (d). **[REDACTED]** last sentence reads: "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".

Comment: This is a meaningless sentence.

ML101. Last sentence. **[REDACTED]** has added the sentence " No more than 3 hours may be billed for report preparation under this code.

Comment: A follow up re-evaluation often includes review of medical records. There is no limit to the quantity of medical records that the evaluator may be asked to review. An evaluator simply cannot discuss and review a large quantity of medical records, or a small quantity of complex medical records and address all the issues of causation, apportionment, periods of temporary total disability, period of temporary partial disability and how all regions of injury are most accurately rated with an imposed arbitrary time limit of 3 hours to prepare, edit, proof read and review a medical-legal report.

[REDACTED] has just made up an imaginary number for the time he thinks it should take to prepare a medical-legal report, unrelated to the complexity of medical-legal report preparation.

Each medical-legal evaluation is a unique case and the complexity of each case can vary greatly. The time spent to review whatever quantity of medical records that are provided, summarize those records, prepare the report, and review, edit and proof-read the report will rarely come to 3 hours.

Is it reasonable to expect the evaluator to review large volumes of medical records and summarize those records and spend all the time it takes to formulate and delineate a well-reasoned opinion in 3 hours?

The IW with a complex case will be unable to obtain a comprehensive medical-legal evaluation because the physician will soon learn they cannot work for free.

ML-103. **[REDACTED]** has inserted the sentence that the physician shall clearly and concisely specific which of the following complexity factors were "actually and necessarily incurred for the production of the medical-legal report and were require for evaluation, and circumstances uniquely specific to the actual evaluation being performed" which made these complexity factors applicable.

Comment: This language to vague. It is unknown by any evaluator what **[REDACTED]** means by "circumstances uniquely specific to the actual evaluation being performed"

Subsection 2. [REDACTED] writes: "An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed".

Comment: Labor Code 4828 (a) (2) already requires a review and summary of prior medical records but dose NOT require that the summary be placed within the body of this report.

The task of summary of prior medical records has no limit on the quantity of medical records reviewed. At times medical records can be 5,000 pages, 10,000 pages or more.

It takes many hours to review large volumes of medical report and it takes many hour to write up the summary of the review of medical records.

[REDACTED] has proposed a cap of three hours total time on preparation of a medical-legal report inclusive of review of any quantity of medical records.

The IW is tasked to prove his/her claim of industrial injury and residual impairment.

The evaluator will not be able to provide a report that addresses complex issues and requires significant time to review and summarize large volumes of medical records and provide a well-reasoned opinion within the allotted 3 hours that **[REDACTED]** has proposed.

Is it really conceivable that a medical-legal evaluator will spend 5, 10, 15 hours to review thousands of pages of medical records and summarize that review - yet be unable to bill for the time to provide a cogent summary of those medical records?

This goes to the issue of the IW being denied due process to prove his/her claim.

Subsection (3). Research. **[REDACTED]** states that the evaluator "explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue".

Comment: [REDACTED] has now raised the issue of a disputed medical issue as a basis for doing research. Research can be used to address the issue of need for future care. It can be used to address rating by analogy. **[REDACTED]** has now limited research as a complexity factor only to a disputed medical issue wherein research can and often is necessary to address other issues.

Subsection (4). [REDACTED] has stated that any complexity factor used as a stand-alone may not be used in combination under this subdivision.

Comment: This is a perplexing sentence. As this sentence stands a face to face encounter at two and a half hours is a stand-alone factor. Review of records at one and three quarter hours is not a

stand-alone factor. The time 2.5 hours and 1.75 hours comes to 4.25 hours but since the 2.5 hours is a stand-alone factor there can be no two complexity factors.

Subsection 4 allows combining only two factors. If either complexity factors is 2 hours or more it counts as a stand-alone complexity factor and cannot be used.

If two complexity factors are each less than two hours they do not count as a stand-alone complexity factor BUT also cannot add up to the threshold of 4 hours or more.

Get It? You cannot add less than 2 and less than 2 and get 4 hours or more.

I will state this again so the point cannot be missed. If face to face time is two hours or more and review of records is less than two hours, or research is less than two hours there would be only one complexity code.

Subsection (5). This section allows for three complexity factors for any combination of face to face time, research or review of records, BUT notes than any complexity factor that is used as a stand alone factor cannot be used in combination in this section.

Comment: This means that if face to face time or review of records time or research is two hours or more, then three complex factors cannot be used.

The same math applies. Research at 1 hour and 59 minutes is not a stand-alone complexity factor and review of records at 1 hour and 59 minutes is not a complexity factors BUT if face to face time is 2 hours and 2 minutes, which makes for 6 hours total, the face to face time cannot be used because it is a stand-alone complex factor. Face to face time would have to be less than two hours to NOT be a stand-alone complexity factor.

Same as the above section: Less than 2 hours and less than 2 hours and less than 2 hours is less than 6 hours.

Based on this language there are no combinations of face to face time and/or review of records, or research that will come to six hours or more, and count as a 3 complexity factors, since any of the factors at two hours or more is excluded. This simply means that there cannot be any combination of these factors that comes to 3 complexity factors.

Section (6). Addressing medical causation, **[REDACTED]** proposes that the physician and the parties agree prior to the start of the evaluation that the issue of medication causation is a disputed medical factor.

Comment: As noted earlier in this response, the issue of medical causation is often discovered during the medical-legal evaluation. The applicant attorney or the defense attorney may raise this issue in a cover letter to the QME or AME. As this language now stands no carrier will ever

agree to the issue of addressing causation as a complexity factor. This again goes to the issue of denial of the IW due process to prove his/her claim.

Section (7). Apportionment. **[REDACTED]** has taken the current language of three of more injuries to the same body system or body region and changed it to three or more dates of injury to the same body system or body region.

Comment: This means that for the IW that cannot recall the date of any prior injury, this complexity factor cannot be used.

[REDACTED] has also taken the current language of two or more injuries to two or more body regions or systems and changed it to two or more dates of injury to the same body system or body region.

Comment: Again, this means that for the IW that cannot recall the date of any prior injury, this complexity factor cannot be used.

Based on this change in language any IW that has suboptimal recollection of any prior dates of injury limits the evaluator from billing for this complexity factor.

Section (7) (B). **[REDACTED]** now limits apportionment as a complexity factor if the IW is not at the maximum medical improvement.

Comment: Apportionment is likely the most complex issue in a medical legal report. The current CCR 9795 criteria does not require that the IW be at the MMI in order to address apportionment.

Cases are often settled after the applicant has seen the QME or the AME, and prior to a determination that the applicant is at the MMI.

Apportionment is a major issue for all the parties and can certainly be addressed as an issue before application of specific percentages of impairment are applied.

The only issue of apportionment for which the applicant must first be at the MMI is the determination of the exact percentages and an explanation of how those percentages were determined.

ML-104. The changes to this section include all the changes to the ML-103 complexity factors and adds that no more than three hours can be billed for report preparation.

Comment: This means that for a complex case with around 1,000 to 5,000+ pages of medical records and medical-legal issue to address, to include a summary of those 1,000 to 5,000 pages of medical records, and likely 10-15 hours of report preparation, that the evaluator is limited to billing only for 3 hours for report preparation.

ML-106. This changes to this section adds that for a requested supplemental report, that no more than three hours can be billed for report preparation. This also includes complex cases with around 1,000 to 5,000+ pages of medical records and medical-legal issue to address, to include a summary of those 1,000 to 5,000 pages of medical records, and likely 10-15 hours of report preparation, that the evaluator is limited to billing only 3 hours for report preparation.

Comment: This means that for a complex case wherein the IW is not seen but with around 1,000 to 5,000+ pages of medical reports and medical-legal issues to address, to includes a summary of those 1,000 to 5,000+ pages of medical records, and likely 10-15 hours to report preparation, that the evaluator is limited to 3 hours for report preparation.

[REDACTED] has provided his opinion how the CCR Section 9795 regulations should be re-written.

Causation is out as a complexity factor.

Apportionment is out as a complexity factors unless the applicant is at the MMI.

Combination of two complexity factors that together come to 4 hours or more is out.

Combination of three complexity factor that together come to 6 hour or more is out.

Review of medical records and the time to summarize all those records, regardless of the amount of the records reviewed is now capped at 3 hours, and those three hours must include addressing all the other issues that comprise a medical-legal report.

Given **[REDACTED]** proposal that any complexity factory that is a stand-alone may not be used in combination under sections (4) and (5), and with causation and apportionment no longer billable complexity factors, this literally ends the use of the ML-103 and ML-104 billing codes.

The IW with anything more than a simple case can no longer obtain a comprehensive medical-legal evaluation to prove his/her claim and thus loses his/her right to due process.

These proposed changes effectively render almost all medical-legal evaluations billable only as ML-102.

This will likely collapse the system as the evaluators discover they are now working for free for most of the time they put into the evaluation of the injured worker.

If the goal is to end all medical-legal evaluations payable over the ML-102 rate, drive the applicant attorneys out of business, drive the defense attorneys out of business, drive out most of the workers' compensation judges from their jobs and deny the IW a fair and equitable evaluation of their claims, this is a perfect final solution.

I am aware that there is a problem with medical-legal evaluators not following the billing criteria under CCR Section 9795.

I do not think these proposed changes are the answer.

The proposed changes will result in much greater problems for our workers' compensation system than the problem of physicians overcharging for their medical-legal reports.

I think the answer lies in CCR Section 9795.

Causation should always be a complexity factor and there should be no need for any party to request it be addressed.

Face to face time needs to be documented with start and stop times, signed under penalty of perjury.

Review of records also needs to be documented, also with start and stop times, signed under penalty of perjury.

The same goes for research BUT the physician needs to explain the purpose of each cited research document and discuss each document that is researched and how it applies to the issues the evaluator is addressing.

Apportionment needs to be a complexity factor but I see no need for it to include three employers.

The issue is the region of injury and if it was injured in the past or re-injured after the industrial injury. Hence the criteria of three or more injuries to the same region or body system needs to be changed to two or more injuries to the same body region or body systems.

If the IW never suffered any prior injuries to the same body region or system and never suffered any subsequent injuries to the same body region or system, then apportionment is out as a complexity factor.

Stopping the abusive use of research and stopping the abuse use of apportionment as complexity factors will address most of the current billing problems.

The solution lies in bill review demanding the physician documents the work performed.

Any physician that feels bill review is wrong to cut his/her bill should be required to file a petition for costs and face a workers' compensation judge. No lien representative. The Doctor should appear and tell the WCJ why it took him/her over two hours to review a handful of

documents and why he/she spent 2 + hours on research that had nothing to do with his/her opinions and conclusions.

This stops the problem.

Nancy M. Molina, DC, QME, JD May 15, 2018

I am writing to express my concern with the DWC's newly proposed amendments concerning the medical-legal fee schedule.

In my opinion, these proposed amendments (particularly as they relate to "causation", "apportionment") with respect to imposing limiting times in report preparation etc., poses a significant threat to the feasibility regarding the efficiency of the unimpeded operations of the Workers' Compensation system and to the potential civil imposition this would place upon an injured worker and their employer i.e., fairness doctrine and the opportunity to be heard.

It also places an undue burden upon the Court and its Appeals system of having to judge the competence of a report (*once limited by time to prepare*) and assure that said reporting QME has met the requirements proffered upon them; **to write a substantial medical-legal evidence report.**

It must be reiterated that the commonality reasons for a QME request is whether there exists: a compensability dispute (multiple issues must be resolved: is there a new or further injury? i.e., compensability consequence?), temporary disability, future medical treatment, permanent and stationary status and/or apportionment? Moreover, our democratic system encourages government agencies to follow agreed upon industry standards. As to a doctor in the medical industry; this requires a cognitively demanding skill with mastery of healthcare provisions, delivery, various subspecialties, keeping abreast of current peer-review literature, specialized medical terminology, years of practical training as well as knowledge of and adherence to a medical standard.

I am also quite concerned about the great disservice that will be thrust upon our QME's as a result. Interestingly, I do not find that the fraud issue is closely correlated to these proposals. While the DWC has made an effort to eliminate from the WC system providers accused or convicted of fraudulent activity (suspension) according to Neuhauser 2017, this represents a small minority of all QME's (< 2%). Thus, these current proposed amendments if to curtail fraud would indicate they are not quality driven. Also regarding strict *preclusion in sources cited in reports in the preceding 12 months*- arguably attempts to exclude **relevant** medical research.

In addition, when proposals are made in this manner it would lead to the QME being driven out of the field, causing further prejudice to the injured worker. On its face the number of QME

participants has already been steadfastly decreasing over the last decade, however, the demand for QME has increased. I must urge you to place yourself in the shoes of an injured worker and the employer facing litigation. The Court must make certain that factual evidence being reported to support or not support the claim is coupled by substantial reasoning for which to support the QME opinion; it cannot fairly adjudicate if the QME is restricted in their ability to perform.

I urge the DWC to carefully weigh the risks indicated by the amendment proposals. Bearing in mind, that a dispute resolution process reform must be meant to improve the delivery of the medical-legal evaluations expeditiously and equitably for both parties.

Gary DeVoss Ph.D. May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction. The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Sharon Goldstein, Ph.D., QME May 15, 2018
Clinical Psychologist

I have been performing psychological evaluations in the Worker's Compensation system since 1990. I am writing with my concerns regarding the proposed changes to the medical-legal fee schedule, which are unrealistic and will lead to a lower standard of care for QME/AME evaluations. Typically, there is a dispute regarding liability in such cases, with AOE/COE being the predominant question. To limit report preparation to three hours is arbitrary and unworkable.

By definition, a psychological evaluation only occurs if the nature of the injury is "extraordinary" or complex. Often there are other factors that require thoughtful analysis in order

to arrive at accurate opinions regarding diagnosis, disability, causation, recommendations, and especially apportionment.

No doubt, if the proposed changes are adopted, there will be fewer QMEs to perform such complex evaluations. This will result in reports with opinions of less quality and accuracy, because there will be less time to investigate, research aspects particular to the case, contemplate, and prepare the reports.

It is my opinion that adoption of these arbitrary regulations is not in the best interest of the employer, injured worker, and/or evaluating and treating doctors, but of the insurance companies.

Edward D. Jennings, DC, DABCN, DAAPM, QME May 15, 2018

I am a California licensed chiropractic neurologist actively treating the general adult population and with a significant Worker's Compensation evaluation practice as well (QME, AME, SIBTF). I am writing in regards to the proposed QME Medical Legal Fee Schedule Changes.

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only 3 hours, DWC must not have the data necessary to make an informed judgment because the majority of the cases could not meet that time restriction.

There are often times when I receive records in excess of 2000 pages. In some cases, records measure 5-6 inches in height. To propose that I am to review these records and record their information and still discuss the other components of the report in 3 hours is ridiculous.

The stringent requirements on the medical research QME physicians may perform will only deter QME physicians from citing authoritative sources in their reports. The prohibition on QME physicians reviewing sources cited in reports in the preceding 12 months is particularly bewildering: setting aside the impracticality of QME physicians tracking which sources were previously cited and when, it discourages physicians from consulting, reviewing, citing persuasive sources that further the cause of aiding the treatment and recovery of injured workers. The result will be QME reports that are largely devoid of references to relevant medical research.

The requirements governing the use of the causation complexity factor are ambiguous and unworkable, seemingly designed to ensure the practical impossibility of employing this factor. The need for a causation evaluation is in place and in the denial by the insurance or defense party of any claim or part thereof. The award of any permanent impairment (total or partial) requires causation of injury and/or disability to be present: thus, it is essential to the adjudication of the claim for benefits. To ask that the parties agree that the physician may use causation as a complexity factor for billing purposes, suffers from the same weakness as the "extraordinary circumstances "requirement.

The current fee schedule as it stands today is woefully inadequate. The upper limit that I can earn to serve as a QME is $250 per hour, depending on the report. I understand that this has not changed since the fee schedule was introduced in 2006. I can think of no other industry in which a professional's fees are not adjusted over the course of 12 years to account for inflation. During the past 12 years doctor's costs have risen but reimbursement has not. While the top amount QME's can earn of $250 per hour has nominally remained constant, the reality is that the real dollars earned per hour has been eroded away due to inflation. This has meant a reduction in real dollars earned by the physician. In the 12 years from 2006 to 2018, there has been a total inflation of 26%. That means that QME should be reimbursed at least $315 per hour now in order to be compensated the same amount as $250 in 2006.

Jeffrey Miller May 15, 2018

The new rules are far too difficult for QME's and unfair.

Brian Boni, MD, MPH May 15, 2018

I have been a QME (qualified medical evaluator) for injured workers for over 20 years. This position supposedly is important in assuring that claimants receive the benefits to which they are entitled—neither more nor less. A certain amount of anxiety goes with this territory, since one must resolve "disputes," and there are strict timelines regarding scheduling exams, filing reports, and much paperwork, and a complicated system of billing involving various "complexity factors."

With regard to the proposed rule changes around Medical-Legal (QME) billing, I have the following comments.

With regard to new requirements for using "causation" as a complexity billing factor:

It is unlikely that a QME can get the "parties" to agree that "causation" is at issue and that the QME can use it as a billing factor PRIOR to the evaluation, considering logistical and behavioral issues including:

--can a QME conveniently communicate with several parties simultaneously prior to the evaluation;
--if not simultaneous, one risks "ex-parte communication;"
--my experience is that claims adjustors do not respond to me in a timely fashion;
--recently, a SCIF adjustor refused to a agree that a certain report qualified for 104 (3), since she "could not speak for the state of California;"
--if the applicant is unrepresented, he/she is a "party" but would have little understanding about "causation" or "complexity factors;"
--finally, why would the applicant or defense have any interest or motivation in helping with my billing issues?

With regard to imposing "caps" on billable hours for factors such as record review and report preparation, this would not be fair or equitable to a QME who spends a long time on record review, formulation of opinions and report writing, when these hours are indicated and necessary in order to produce a substantial report which properly addresses the issues at hand.

Stefanie Stolinsky, Ph.D., QME May 15, 2018

There are plenty of comments here. For one thing, NOT TO USE THE RESEARCH WE found not more than once in 12 months? Is someone crazy? What if that is the seminal report for brain dysfunction? What if that is the proof of research on a particular topic? Who is making these designations? Doctors, lawyers, laymen? I personally cannot do a QME in 3 hours. It is physically impossible. I do a complete history, a clinical interview, I use at least four tests and then must score them and finally I type the entire report including a medical review which often takes 5 hours in itself. Those are my remarks. Let me know how I can assist further in a fair evaluation of those needing workers' compensation.

Ronald Wolfson, MD May 15, 2018
Orthopaedic Surgeon

1. The new proposal will further complicate a very complicated and confusing system.

2. The new proposal does not aide the parties resolve complicated medical disputes.

3. The new proposals for changing complexity factors make it impossible to bill for time spent, almost impossible to qualify for a ML 104.

4. The hourly rate will be so low that no one will work.

5. Causation is more than AOE/COE. What about accepted claims that should be subsequently denied with new information?

6. Causation is an ongoing evolving process throughout the claim, many times evolving into cumulative injury. What about causation of permanent disability?

7. The proposed new causation requires written agreement from all of the parties. In most cases this will be impossible to obtain.

8. The parties have no incentive and no urgency to provide the QME/AME with a written agreement that causation is a disputed fact.

9. Much more work, more delays, less pay. It will not work.

10. Please let the evaluator respond to the cover letters as written.

11. Does the DWC really expect complex discussions of diagnostic studies, permanent impairment, substantial medical evidence, A/G II, strict impairment vs alternative impairment ratings without adequate reimbursement?

12. We will not work harder for less pay.

13. In order for the system to work, it should be simple and time based.

14. If the evaluators are paid less, the reports will be poor, and the good doctors will not participate.

15. Please stop the nonsense with the apportionment factor, and please stop trying to prevent us from billing ML 104.

16. These reports are expensive and time consuming to produce. These new proposals should be an embarrassment to whomever wrote them, and are only an attempt to justify their prior illegal underground regulations.

Joseph Mann MD May 15, 2018

I have reviewed the bulk of the comments submitted to this Forum. I am particularly impressed with and taken by the comments of Michael Newman D.C. He has addressed the proposed Regulations point by point, commenting on each and offering reasonable alternatives. I urge the DWC to take Dr. Newman's remarks to heart.

The thrust of these proposed changes is to carefully eliminate all billing Codes except ML-102 and a maximum 3 hour ML 101 and ML106. These are deeply cynical and even, in my opinion, mean-spirited proposals.

They imply a deep skepticism of Physicians integrity and professionalism. There are certainly (and will always be) a small percentage of QMEs who will behave unethically. These proposals, however, imply that such behavior is the norm for QMEs. To believe this is to do a profound disservice to physicians and ultimately to injured workers. The vast majority of QMEs operate within firm ethical boundaries and truly wish to accurately and thoroughly represent the medical facts in work injuries. We also strive to understand and apply the pertinent legal parameters. Doing this requires considerable experience, time, compassion, judgement and thoroughness. I believe most of us take considerable pride in our reports. In light of this, to be met by the DWC with such a cynical approach to payment is both troubling and infuriating. When such a tone is set by the DWC, how can the system expect quality work from qualified physicians? Are we to "finesse" having to do complex reports, continue to do good work "out of the goodness of our hearts"(i.e. free) or leave the system? Lousy alternatives all.

I urge the DWC to reconsider it's approach. Moral among QMEs (whose numbers are dwindling) is low. A fair and reasonable reimbursement system would go a long way to improve moral and with it produce good reports, increase the rol1 (number) of QMEs, increase the efficiency of the system, create an incentive to go "above and beyond" and, most importantly, allow the system to function the way it's creators envisioned.

Philip Edington May 15, 2018

I have been a QME for 20 years. I want to comment that the new rules regarding causation are misguided. Causation is an issue in every case unless specifically stated otherwise. It should count as a complexity factor unless specifically excluded.

Regarding research, similar cases will require similar research. The rule allowing literature quotes only to be used once per year is unfairly discriminatory

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Thomas Troung May 15, 2018

It look like the CA government especially the department of worker compensation trying to work favorably toward insurance company which contradict the democratic philosophy and failed to protect the interest of minority. In the past year, insurance companies have made billions of dollars while failed to properly provide medical treatment to workers who contribute majority of the CA economy. Because of this, workers seek independence medical evaluation by utilizing the process of QME evaluation to protect their interest. The department of worker's compensation trying to eliminate the QME doctors by using underground legal procedure but they failed. Now they try to discourage the doctors from performing the QME evaluation by cutting the fees. I think they should change their name to department of insurance compensation instead of the department of worker compensation.

Bruce P. Hector MD
Former Medical Director
Parthenia Medical Group

May 15, 2018

This letter is to provide comment on proposed regulatory changes to the QME fee schedule. As former Medical Director of Parthenia Medical Group from 1990 to 2012 and Exam Works West from 2013 – 2016, I have followed the many reform efforts. I even consulted with the Governor's office concerning adoption of the AMA Guides in 2006, served on the CMA WC Committee in the 1990's that proposed the ML 101 – 105 schedule and have testified before the legislative committees on WC issues.

On more than one occasion I have been struck by persistent DWC efforts to reduce payment for QME exams despite CWCI consistently noting that the entire QME system only accounts for 3-4% of the WC cost. Further, in contrast to efforts to reduce fees, regulators have repeatedly required greater demand for "substantial evidence" to be cited in report. Since these are legal reports, read by lay persons, physicians are also required to present written evidence in a manner that can be understood sufficient for decision making by lay persons, a special skill not used in medical practice nor received in training. Thus, it should be realized by administrators that the task asked of us is neither usual and customary to physicians nor is it acquired in training.

From this physician's perspective, you provide no logical rationale for the proposed changes except as a means to diminish reimbursement to the evaluator without altering demands and in some cases increasing them. If your goal is to motivate evaluators to cease performing these examinations, delay claims processing to frustrate injured workers to give up on their claims, promote animosity between evaluators and regulators and convince evaluators the compensation is not worth the effort, your proposed rule changes will hit the mark. I would sincerely hope my government workers are not so malicious or nefarious. If so, it becomes easy to understand the average citizen's loss of confidence in government personnel.

Your motives seem more oriented toward saving money for insurance carriers than serving injured workers. Is there any evidence insurance carriers need economic relief? Are carriers fleeing the market? Is the State becoming the insurer of last resort? If this is not the motive for the changes, what is? What problem do you seek to solve?

Specifically, what evidence does DWC have that fees for report preparation are excessive or inaccurate? Has anyone been cited for violation of this element? I am aware of a recent QME evaluators' initiated suit that challenged QME rule interpretation by Mr. West when he was director. My understanding is the plaintiffs prevailed. Is this action seeking retribution on all QME's?

Concerning medical research, you expect evaluators to be experts in their field. To do so requires both seeing similar cases repeatedly and being familiar with the literature both old and new including classic studies that repeatedly are cited as basic to sound medical explanation for legal system use. Every report should provide substantial evidence alone, adequate for the decision maker to rely upon without need for further explanation from others unless specified by the respective parties. To do so, requires a medical explanation of the claimant's conditions starting from a common level of understanding. Explanation using "foundational" references repeatedly is critical for adequate understanding by the non-physician decision makers. This occurs frequently when textbooks are cited. However, before citing the reference most physicians review the text and consider its applicability. That they are cited repeatedly makes them more valuable from the physician user's perspective as well as necessary to include. DWC appears to have decided to prejudicially preclude payment for this research. Why should this effort be discounted? While I appreciate the DWC's right to be arbitrary and capricious, such behavior would seem inconsistent with its stated role of helping injured workers. Your request that the evaluator with his research submit excerpts, explain contribution to report of research and "provide a list of citations to the sources reviewed" requires a greater level of report documentation thereby increasing report length (and attendant expenses) and report preparation time. In the next stroke you recommend setting a ceiling to report preparation time to three hours. One gets the feeling that DWC feels obligated to repeatedly increase work demand from evaluators while reducing allowable billing. Does this not serve to reduce rather than increase the WC system effectiveness?

You reduce reimbursement but deny evaluator the option to decline an appointment even if reimbursement does not meet the needed effort. As medical professionals, we will comply for that case but then leave the QME system. I suspect if you got paid lees than you deemed the service worth, at best you too would do the requested work once but then cease. If reimbursement is inadequate for the demands made, you should expect the same from QMEs.

The requirement for explanation of each factor of complexity with specific unique reason for each case adds additional time to report preparation encroaching upon the three-hour limit after which service must be provided free. This compels the examiner to spend less time on the substance of the report in favor providing justification for billing. Again, who does this serve? Only the payer of the bill. It does not help the injured worker. One wonders whom you really serve.

Often when evaluations are performed, an injured worker identifies affected body parts that have not previously evaluated. If both parties must agree that that body part is a "disputed fact", the likelihood of reaching both parties the same day is low and hence all the examiner can do is mention the claimant's allegation of additional injury, adding more time and evaluations to the process when it could have easily been addressed in that report. The only apparent motive is so the DWC can prevent the evaluator from billing for addressing causation. Again, you subject the injured worker to unnecessary time and aggravation to avoid carrier expense. Who is it you are trying to serve?

The machinations devised in Section 7 on apportionment in 9795 seem equally designed to minimize payment obligations. By definition, apportionment is applicable when there is prior or subsequent impairment to a body part as well as the specific industrial injury. Requiring three or more employers, body parts or systems to justify addressing apportionment is rhetoric without logic, seemingly designed to justify subsequent payment denial at whim by either the carrier or DWC. You have succeeded in making medical professionals with integrity feel they are treated like thieves and your job is to protect the till of the carriers. I ask again, who do you serve?

In summary, you now appear to be implementing rules to allow the same behavior that Director **[REDACTED]** inappropriately limited. I have written this document not because I expect anything more than a cursory reading or any sympathy but rather because as one involved with the Ca. WC system as long as most of your employees, I feel a responsibility to speak out when the system fails the injured worker. Your behavior toward medical professionals and the intent of these regulations will hurt them and that in turn will hurt the injured worker as well as the entire WC system. In over 35 years of association with the CA. WC, the level of disrespect, animosity and malicious behavior to medical professionals appears only to have increased. If your goal is alienation, congratulations on your success.

Mark S. Casha DC QME May 15, 2018

I am writing to present my opposition to the "no more than 3 hours of report preparation" in the proposed changes.

On multiple occasions, I have far exceeded the number of actual hours in preparation than what I have billed for the preparation of a report.

On my last ML-104 case, I billed for 12 hours of report formulation but had actually spent 18-20+ hours.

On a complicated case, I will do my best to cover all points of concern and this will far exceed the 3 hours proposed.

I'm not a report mill and these constraints would cause me to do an incomplete evaluation only to be deposed for something that was missed in the report.

Douglas Drucker, Ph.D. QME May 15, 2018

I object to the recommended fee changes on many grounds, essentially the changes will not reimburse me correctly for my time and expertise. The changes will undermine my ability to

provide good and accurate evaluations for the State of California. I request the changes be dropped and a more reasonable proposal be put forward.

Kent Karras May 15, 2018

I believe that any attempt to force QMEs to writing reports against their will is morally wrong. I further believe that forcing QMEs to go to insurance carriers for approval of complexity factors compromises their independence. I also believe that QMEs are substantially underpaid for their efforts and insurance carriers desired to reduce these costs is an affront. I also feel that any attempt to reduce report preparation and research times will reduce the quality of reports and allow abuse by insurance carriers. Many time insurance carriers have not provided medical records and other relevant patient information on a timely basis. This has forced me to do the bulk of my report as a supplemental or wait until re-exam. This would become commonplace and severely penalize the QME and reward the insurance carriers who would easily abuse this.

John M. Warrington, Ph.D., QME May 15, 2018
Licensed Psychologist

I was distressed to read the proposed revisions for the Medical-Legal Expenses and believe that many of the changes are unwarranted and discouraging to QME who serve the Workers' Comp community.

I do not agree with capping at billing three hours for report preparation time. As a psychologist I spend a lot of time preparing my reports and have taken pride in doing a good job. Caps make that difficult to continue.

The new proposed version for Causation Complexity Factor has four requirements making it very much more difficult to reach the ML104 level, even for a psych evaluation.

While I agree that QMEs are should be forbidden from citing the same research article more than once in the course of 12 months. Research should not capped at two hours for supplemental reports. QMEs should get paid for the work they produce.

QMEs should not be forbidden from refusing to perform an evaluation on the basis that they did not receive authorization to use the causation complexity factor or to bill under ML104(3).

James R. Cole, Ph.D., ABN May 15, 2018
Clinical/Neuropsychology

As a QME for over 25 years and the majority of my evaluations as AME, typically neuropsychological evaluation per traumatic brain injury, the proposed changes are problematic both in regard to quality report that sufficiently addresses the issues at hand and providing adequate report that serves the injured worker. With my experience and quality reporting throughout the years, the cases referred are usually more complex and at times request to address both the cognitive and psychiatric issues with a case. Thus, three hours of allotted report writing is not sufficient and I have significant concern will contribute to "minimal" reports that do not meet the standard of substantial medical evidence. In my mind, the issue is balance of quality evaluation and report with reimbursement so that seasoned and respected evaluators are motivated to remain within the system. I encourage that such be achieved for the benefit of all.

Elizabeth Preston Cisneros, Ph.D. May 15, 2018
QME – Psychology/Neuropsychology

I am writing to express my grave concern regarding some of the proposed changes to the QME med-legal fee schedule.

While three hours may seem sufficient for a report for some disciplines, I routinely prepare reports which cover the interpretation of numerous lengthy and complicated test batteries, which have implications on a host of psychological issues which have to be discussed in the report. The discussion of issues related to psychological disorders, their origins, and their implications require far more than three hours of report preparation. Being capped at 3 hours would mean that I would have to either choose to use simple tests that do not have sufficient validity and reliability to employ (which is related to the complexity of their interpretation), do a shoddy and superficial job of interpreting test results, or doing an inadequate job of thoroughly describing the implications of the test findings as they relate to questions of AOE/COE, causation, apportionment, and disability as well as future medical treatment. I have found that since I first began being involved in worker's compensation cases as a student, the complexity of issues that are now involved in these cases have increased dramatically. Advocacy letters from the attorneys involved routinely have pages of questions to be addressed. This requires sometimes an incredibly lengthy amount of time to prepare reports.

Another proposed change is that the QMEs will not be allowed to cite the same research article more than once in a 12 month period and research will be capped at two hours for supplemental reports. Both of these proposed changes hamper QMEs from doing the very best job they can for these clients. Despite the fact that I may rely on a particular research article for more than one case, I will often have to apply that research in a very different way for different cases.

For example, I routinely rely on research related to a particular test as it relates to different populations. I may use a given research article as it relates to a pain patient in one evaluation and the same research article as it relates to depression in another patient. Both will require me to read the research article and analyze it with respect to each patient's data. Arbitrarily not allowing me to rely on the same research article would mean I would need to choose to spend more time to find another research article or to go on memory about what I have read in the past. The choice would be either wasteful or unethical. Oftentimes, research for supplemental evaluations may actually be more time consuming. Often, at the time of an initial evaluation, if a patient has not yet met MMI status, issues of apportionment and long-term future medical treatment have not yet come into play. At the time I see them for a re-evaluation at which time I issue a supplemental report, I may be addressing those more complex issues, which may take significantly more research in order to address them effectively.

Finally, the proposed rule forbidding a QME from performing an evaluation on the basis that they do not receive authorization to use the causation complexity factor or bill under ML 104 will mean that QMEs have to take a leap of faith that they will get paid or may delay the evaluation from taking place while such an agreement can be made amongst the parties. I find that often, parties may not be aware of issues related to causation until they have read my report and its history, so requiring agreement on these issues in advance requires something of a crystal ball.

In summary, these proposed changes to the QME med-legal fee schedule prioritize the cost savings of insurers over the ethical and thorough evaluation of injured workers. As a result, if these proposed changes go through, you are likely to see a withdrawal of your most conscientious QMEs from the panel.

Anonymous May 15, 2018

I am against the proposed changes.

Dane Jay, Office Manager & Hearing Rep. May 15, 2018
For Prakash Jay, MD, QME

As the Court of Appeal recognized over 20 years ago, "It is of more than theoretical importance in the workers' compensation system that medical providers be paid promptly and *treated fairly, for without them the entire benefit system would fail*." (*American Psychometric Consultants, Inc. v. Workers' Comp. Appeals Bd.* (1995) 36 Cal.App.4th 1626, 1640 [60 Cal.Comp.Cases 559, 569], italics added.)

I share the frustration and outrage expressed by the majority of the QMEs who have commented thus far. I understand the goal of preventing fraud and abuse of the system by medical providers, but this proposed fee schedule goes far beyond that and hurts *all* QMEs and in turn will hurt the entire system including injured workers, the WCJs, and WCAB. These proposed changes will drive out most of the experienced and competent QMEs. With the absence of many experienced and competent QMEs combined with the proposed time restrictions, the frequency that QME reports will not constitute substantial evidence will significantly increase thereby causing unnecessary delay and litigation and thereby squandering the WCAB's limited resources.

Notwithstanding the language in the current MLFS, Labor Code section 5307.6(a) does not actually require that complexity be the *controlling* factor of the fee schedule, only that it be a factor. The current fee schedule is arguably already complicated, and the proposed changes would make it far more so. In my opinion, this opportunity should be used to simply the fee schedule, not further complicating it and discouraging providers from being QMEs. Furthermore, simplifying the MLFS would reduce billing disputes which would benefit both claims administrators and medical providers.

My employer specializes in Internal Medicine and Toxicology, and his evaluations typically involve a plethora of records he must review. It is not at all uncommon for him to have to spend 10 or more hours reviewing them, and it is *completely unreasonable* to require him to spend so much time and only be able to bill as an ML103 (which would equate to less than $100/hour) simply because he did not need to do any medical research. There have even been evaluations for which he has had to spend 40 or more hours reviewing records, and in such circumstances, he would only be reimbursed at about $25/hour which, let's be honest, is simply ridiculous. Therefore, I suggest that in complexity number (5), the "Six or more hours" may be spent on <u>any</u> combination of complexity factors (1)-(3), instead of all three.

Lastly, I would like to suggest that "death cases" be added to the MLFS. Currently there is no fee schedule for cases involving a deceased worker as a QME cannot perform a physical examination in such cases. And even if the current or proposed MLFS were applied to such cases, it would be virtually impossible to meet the complexity factors required for an ML103, let alone an ML104, because by the very nature of such cases, face-to-face and apportionment are out the window. Therefore, I suggest that cases involving a deceased worker be automatically deemed an ML104 as these kinds of cases generally involve a tremendous amount of records and are often very complex, and the nature of the reports are most similar to supplemental reports which are billed at the same rate as ML104.

Kent Karras May 15, 2018

I have read the proposed changes to QME for supplements reports. I find the requirements onerous and unfair. First report preparation time of 3 hours is not adequate. Many reports are

complex and take many hours to write. Also by limiting preparation time it allows insurance abuse as medical records could be withheld from the initial evaluation and then provided them for the Supplemental report.

Forcing QME to have to insurance carriers to get permission for fees, rates and inclusion of complexity factors comprises the neutrality of the examiner. No, he is at the mercy of the insurance company and this can skew his freedom of decision making. Also QMEs are small individuals providers forcing them to take time and fill out forms and get approval is time consuming and expensive. Insurance carriers have huge resources that QMEs lack and therefore this is unfair.

With concerns to research, this should be allowed at the QMEs discretion. Many cases have multiple body parts of unusual symptoms. How can a QME be expected to make educated demand rulings regarding a case without being able to research? Also rereading a quoting highly informative and related articles should be allowed to support the QMEs decision. Making sound decisions and using good judgement is the foundation of the QME system. Allowing Insurance carriers to gut this system will only add costs and increase time of cases within the WC system. I completely disagree with any of these proposals and the DWC should without hesitation come forward and support QMEs and protect us from the undue influence that large insurance carriers are placing on us.

Mechel Henry May 15, 2018

I'd like to post a comment but do it as:

QME opposed to changes.

Do I just send the comments to you to do this?

Tom Harpley, Ph.D May 15, 2018
Psychologist & QME

The proposed changes to QME evaluations are unworkable & add unnecessary burdens. To proffer a substantive psyche med-legal evaluation, including those w/ Rolda issues, in 3 hrs or less is unlikely. And now you're asking us to get specific permission to address causation?! Insurers & defense are difficult enough to get responses from without asking us to pursue more. These proposed changes only make the med-legal evaluative process more cumbersome.

Konrad Ng, MD, QME May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Jay Foley MD May 15, 2018

As a CA Orthopedic QME, I urge that no changes be made to any of the fee schedules. The proposals for change really do not make any sense. The work that we put in in prep time, research and report writing should not be changed. Please stop having lawyers tell QME Doctors what is important and relevant. Compensate us appropriately for the work we do. Many of these cases are extremely complex and multifactorial. They will never be cleared to the system unless proper compensation is given for the time commitment expended.

Adam Sverdlin, DC, QME May 15, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and

the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Mark Ganjianpour May 15, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records. QME are often faced with the daunting task of reviewing thousands of pages of medical records that are submitted without being reimbursed for their time to do these reviews. Taking away the causation complexity factor is only going to exacerbate this problem and the QMEs have no choice but to either not take cases with large medical records or do record reviews and not be paid for the tremendous amount of time it takes to review them.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation. As such, the QME will not be able to review the records thoroughly and will issue reports that not only do not resolve issues, but also will generate many more interrogatories which will add significant cost to the system. Causation will not be addressed in these reports if it will not be considered a complexity factor.

- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases and again medical records will not be reviewed thoroughly.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified while maintaining the integrity of hundreds of good QMEs who are trying to provide fair and comprehensive report and discern factual information form the medical records. There are less QMEs now than ever before and it is becoming harder to find good QME who are willing to put in the time to provide reports with substantial medical evidence. This proposed changes in its current form will only drive these honest QMEs out of the system.

David L. Friedman, MD Ph.D May 15, 2018

Please consider this as an addendum to my previous comments as detailed in a letter dated 5/10/18.

I see that the compensation for time spent in report preparation for ML 101, 104 and 106 has been capped at 3 hours.

This should not cause major difficulty for ML 106 or ML 101, as the time necessary to create these reports rarely exceeds that number in psychiatry.

ML104, however , is another story. Please recall that an initial comprehensive psychiatric evaluation requires a detailed presentation of an individual's entire life from birth to date of evaluation, including history of injury, past psychiatric and medical history, social , developmental and vocational history, as well as mental status examination, formulation of diagnosis, analyzing causation, disability status and , if the applicant is MMI, apportionment (time spent for psychological testing is separate and billed per the OMFS).

The older the person, the more lengthy and complex the life history. A lot can happen as the years go by, and it takes a long time to describe all of it. If we don't, the report will likely be deficient in analyzing causation and apportionment.

A psychiatric evaluation is considered as a complexity factor due to these considerations.

Digesting that information and creating a document that reflects it accurately takes far longer than 3 hours, even in a relatively young person.

Accordingly, if an outside limit is to be placed, I believe it should be much higher…no less than 7 hours. It would also be reasonable and fair to have this higher ML104 limit be applicable for psychiatric evaluations only, as they are recognized as having this added complexity.

Failure to provide compensation for this time will lead to conclusionary medical legal opinions, more requests for supplemental reporting, depositions, as well as Motions to Strike reports as not constituting substantial evidence, replacement evaluations, etc.

More costs for the payors, more delay for the applicant, more friction in the system. Things we all hope that changes in the Regs will diminish, no to worsen.

Carl Brakensiek May 15, 2018
CSIMS

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.: 2018-35 dated May 3, 2018, indicates that the proposed revisions to the Medical-Legal Fee Schedule (MLFS) attempt to establish the following goals:

- Objective standards for the application of complexity factors in the fee schedule;

- Provisions that align the Medical-Legal Fee Schedule with the statutory scheme for reimbursement of medical-legal expenses;

- Elimination of provisions that refer to medical-legal evaluations no longer being performed;

- Clarification of when billing under the Official Medical Fee Schedule can be accomplished in conjunction with billing under the Medical-Legal Fee Schedule.

- There are no changes to the amount of fee schedule payments. The proposals clarify the use of the complexity factors relating to causation, medical research, record review and apportionment. The factors that indicate the presence of extraordinary circumstances in a medical-legal evaluation are more clearly defined. The language required in a report to define extraordinary circumstances is explained. Realistic limits on certain areas of billing are implemented.

A careful review and analysis of the proposed revisions leads CSIMS to the conclusion that most of the stated goals will not be satisfied. Rather than resolving some alleged "ambiguities" in the current MLFS, the proposed revisions are likely to lead to more confusion, friction, litigation, delayed resolution of complex medical-legal issues, and will reduce the quality and usefulness of medical-legal reports. They may also reduce the supply of physicians willing to provide this vital service.

We recognize that the proposed regulations are, in part, a temporary response to the settlement of litigation in *Howard, et al. v. DIR* concerning underground regulations. We understand that the Division contemplates more extensive revisions to the MLFS sometime after the release of one or more studies by RAND Corporation later this year. As such, the comments herein will focus primarily on the interim proposal rather than the more extensive future revisions. We would be remiss, however, not to recognize the importance of producing high-quality medical-legal reports that constitute substantial medical evidence. Any revisions to the MLFS should aim to enhance, not reduce, the quality of these reports.

Comments on Specific Changes to the MLFS

1. Addition of §9794(a)(3). The proposed subdivision (3), in effect, provides that other than permitted by subdivision (1), "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 (§§31.7 and 32(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 (3) 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).

2. Amendment to §9795(b). The proposed additional language, while petty, is consistent with long-established DWC policy.

3. Several provisions limiting report preparation to three hours. Several sections (ML 101, 104, and 106) propose to place an upper limit of three hours on report preparation. This limitation is ambiguous and is of great concern because the regulation fails to define what the term "report preparation" encompasses. It also fails to recognize that some specialties such as mental health, internal medicine, and neurology require a more extensive discussion and analysis than some other specialties. Furthermore, we know of no empirical evidence, and DWC has presented none, to substantiate any limitation on the time spent on report preparation. As such, the three-hour limit on report preparation appears arbitrary and capricious. At a minimum, the revised fee schedule should clarify that "report preparation" does NOT include any time spent face-to-face with the applicant

or on record review or medical research or the review of diagnostic testing results. Any consideration of a cap on the time required for report preparation needs an analytical understanding of the time that is currently being billed in the various specialties. If the extent and nature of the times currently billed is not well defined, any attempt to limit those times can only be seen as fundamentally without logic or merit. A clear statistical definition of the status quo should be a prerequisite for any effort to impose a cap or limit. We recommend that the DWC start collecting statistics on average time for report preparation, by specialty.

4. Complexity Factors at Beginning of Report. The DWC proposes to amend the first paragraph of ML 103 in §9795 to read: "In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors **were actually and necessarily incurred for the production of the medical-legal report and were** required for the evaluation, and the circumstances **uniquely specific to the actual evaluation being performed** which made these complexity factors applicable to the evaluation." For the most part, the new language is probably non-substantive. For decades, the MLFS has put the burden of proof on the evaluator to specify the complexity factors at the beginning of the report. However, payors are likely to argue that the "new" language imposes a higher standard on evaluators going forward when, in reality, it does not. We fear it will create opportunities for arbitrary and spiteful billing disputes. The "new" language should be deleted.

5. **Limitation on Research**. Proposed §9795 ML 103(3) denies complexity point credit for research of a particular article if the evaluator cited the same article in another report within the past 12 months. This restriction is problematical because many research articles discuss a number of issues and may involve multiple diagnoses and multiple possible outcomes. An evaluator may consult a meta-analysis document for a particular medical condition in one case but need to re-review the same document months later with regard to a similar, but not identical, diagnosis in another case. Stated otherwise, a particular piece of research may serve different purposes in different factual situations. What should an evaluator do in such a situation? Obviously, the evaluator should explain the necessity of doing research in the first place and should cite any research materials relied upon in the preparation of the report.

6. Stand-alone factors may not be combined. Proposed §9795 ML 103(4) and (5) add language providing that "Any complexity factor used as a stand-alone may not be used in combination.... " This clarifies our understanding of the current fee schedule.

7. Mandatory research for use of the three complexity points. Proposed §9795 ML 103(5) requires a report to include face-to-face time, record review, and some research in order to receive "three complexity factors." While this change codifies DWC's recent interpretation of the fee schedule, CSIMS has always taken the position that DWC's interpretation was erroneous. Subdivision (5) of ML 103 was added several years after the addition of subdivision (4) because the Administrative Director realized that in many

cases the volume of medical records is extensive and requires many hours to review but there may not be sufficient complexity factors to reach the ML 104 level. Other cases may require extensive research. As such, subdivision (5) was added to create some flexibility in complicated cases to recognize that differing factual situations may require different combinations of face-to-face time, record review, and/or research. There was never any discussion of mandating all three factors in order to earn three complexity points. An unintended consequence of this proposed amendment is that in close cases, it will encourage evaluators to conduct research that they might not otherwise do. No requirement for the use of all factors was ever contemplated by the Administrative Director and such makes no sense. The proposed regulation narrowly redefines the notion of extraordinary complexity in a fashion that fails to embrace other, and in fact more significant, contributory factors such as the number of injuries and the number of body parts, all of which are reflected in the amount of records and time necessary to review them, irrespective of any need for research.

8. Limitation on Causation as a complexity factor. Proposed §9795 ML 103(6) denies credit for discussing causation unless "the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation." [emp. added] Such a limitation is myopic and unreasonable. Frequently, one party but not both, will request a discussion of causation. If one party believes causation is a disputed issue, they should not be precluded from having it considered, evaluated and discussed. Otherwise, the Division is limiting a party's right to discovery. Furthermore, prior to 2015, the fee schedule also permitted a discussion "if a bona fide issue of causation is discovered in the evaluation." This language should be reinstated because in order to accomplish substantial justice, the evaluator must be permitted to discuss both occupational and non-occupational injuries that have not been recognized by the parties. Finally, even if both parties agree that there is an issue of causation that needs to be evaluated, what if the defense refuses to agree that the evaluator may use causation as a complexity factor? If the evaluator declines to discuss causation, there is a risk the report will not constitute substantial medical evidence. If the evaluator discusses causation, there is a risk that he/she will not receive proper compensation for the effort. Either way, the proposed revision of ML 103(6) is biased, unreasonable and short-sighted.

9. Apportionment. The proposed revision of §9795 ML 103(7) may be non-substantive and may bring some clarity to the interpretation of the subdivision. Others may have different responses to the proposal.

10. The missing carriage return in §9795 ML 104(3). The last sentence of the proposed revision in this subdivision reads, as follows: When billing under this **subdivision of the** code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii)

verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities. As we have pointed out to the Division on numerous occasions, the Division's own rule making file clearly establishes that the foregoing paragraph has always applied to ML 104 in its entirety. The proposed revision would limit the paragraph's application solely to ML 104(3). It makes no sense for it not to apply to the other subdivisions of ML 104. All ML 104 reports, not just those qualified under subdivision (3), should explain their extraordinary circumstances and should be verified under penalty of perjury.

11. Needed adjustment of MLFS Conversion Factor. The revisions to §9795fail to propose an adjustment to the $12.50 conversion factor in subdivision (b) that has been in place since 2006. Inflation, alone, would justify an increase to nearly $16; but considering that numerous court cases since then have significantly increased the standards necessary to produce a report that constitutes substantial medical evidence would just a much higher conversation factor. All medical-legal reports are more comprehensive today than they were 12 years ago.

CSIMS appreciates this opportunity to comment on the proposed revisions to the MLFS and urges the Division to consider seriously the comments made herein.

Samuel I. Miles, MD May 14, 2018

I have reviewed the proposed changes to regulations regarding medical legal expenses. As written, these proposed modifications will likely delay resolution of claims of injured workers in a substantial number of cases. Arbitrary limitations on the amount of time allowed for preparation of reports will lead to many more depositions and requests for supplemental reports as data or reasoning is omitted from the report by the hurried physician. To the extent that the proposed regulations prevent physicians from being fairly compensated from their work, the best physicians will leave the system and fewer evaluators will be available as AME's and QME's.

The Workers Compensation Appeals Board favors production of medical evidence in the form of written reports. An outline of data required in these reports is included in Title 8 California Code of Regulations Section 10606.

Going through the proposed regulation, Section 9795 (b) would prohibits a physician from conditioning performance of an evaluation on receipt of prior agreement of the parties. While it may be reasonable prohibit physicians from always conditioning performance of evaluations on receipt of prior agreement, it is not likely that such agreement would be forthcoming if the physician cannot insist on it in a given case.

Limiting reimbursement for report preparation to 3 hours is unreasonable. For most psychiatric reports more time is needed to provide a readable comprehensive report which provides substantial evidence for the Board.

For ML-103 and ML-104, the verbiage added to the first paragraph of the regulations makes that section more vague and ambiguous. The Mona Lisa is clearly unique. The circumstances which make an evaluation unique is not clear.

While a list of records reviewed has been required in the past, these proposed regulations require a summary of all records as well. It seems more reasonable for pertinent records to be summarized, while others are listed. (Wouldn't it be better for me to summarize 50 pages of psychiatrically relevant records, rather than the entire 5000 pages of records which were reviewed?)

In order to count six or more hours on a combination of complexity factors as three factors, the proposed amendment would require that some portion of the time was devoted to each of the three factors. This is not rational. Why should a physician who spends more than six hours reviewing records and seeing an examinee be treated differently than one who also included two minutes of medical research?

The old language on medical causation as a complexity factor was clear, simple, and adequate. The proposed limitations outlined in the regulations are problematic. Parties frequently cannot even agree to one AME letter. Instead, they send two advocacy letters. An agreement from parties that the issue of medical causation is disputed and essential to adjudication of the claim for benefits is highly unlikely. (Some attorneys might consider such an admission as potential grounds for legal malpractice.)

The second clause in that section indicates that the parties must also agree that the physician may use causation as a complexity factor in billing. In essence, this proposal would allow claims adjusters to unilaterally block physicians from billing for their time.

For psychiatric claims, physicians are often asked to apportion permanent psychiatric disability in relation to prior non industrial psychologically injurious events. The work involved to develop the data necessary for such a determination is similar to, or greater than, the work required to understand apportionment in a case of three dates of injury or three prior employers. Modification of this section is necessary to acknowledge the complexity of this work.

While it is reasonable to prohibit a physician from billing for research for which he or she has already been compensated in another report, limitations on time for research and report preparation in the billing for ML-106 is not.

Overall, the proposed amendments to regulation will do more harm than good. To the extent that DWC's motivation is to reduce abuse, enforcement of Labor Code 4628 (i) would be more appropriate and effective.

Seymour Levine, MD May 14, 2018

There is no good reason to change the Med-Legal fee schedule. Making it more onerous for doctors to do med-legal evals makes no sense and keeps younger doctors from entering the workers comp field. There is a tremendous amount of professional work that goes into a med-legal eval including a detailed history and physical exam, interpretation of diagnostic tests, a comprehensive review of medical records and a detailed med-legal report covering the usual issues in a workers comp case. This requires fair reimbursement with the current schedule being acceptable to most doctors. Incorporating the proposed billing schedule runs the risk of the more experienced and knowledgeable doctors leaving the field. This endangers quality and deters new doctors from participating.

Simon Gamer, D.D.S., QME May 14, 2018
Ceders-Sinai Medical Center

Please reconsider the proposed draconian cuts to QME/AME report preparation time.
Patients deserve a careful and detailed analysis of their medical issues in the report. Often times the documents provided, to write the report, are 400+ pages long. The current system has enough saved cards with complexity factors, to provide fair analyses to the parties.

Putting a cap on report preparation time and research will jeopardize the health of the injured worker.

Barry Weiner, DPM May 14, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly

the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Craig C. Joseph, MD May 14, 2018

After reading your newly proposed regulations, I have many questions, one of which is as follows: why do you want doctors to work for free ???? First, it is obvious that you are attempting to rail-road doctors into ML-102 and ML-103 categories !!!! Now, let us do some simple arithmetic using ML-103.I personally see from zero to five medical –legal patients per month. Each inch of records is approximately 250 pages—on several occasions I have personally counted the pages. Once in awhile I am only provided approximately one inch of records. However, on many occasions there are approximately 1,500 pages to 3,000 pages. Furthermore, on some occasions I am provided with 3,000 pages to 6,000 pages. Indeed, there are times ,rarely,of course,that I am provided with 10,000 pages to 12,000 pages. Finally, on even more rare occasions , I am provided with up to approximately 15,000 pages of records. I started doing my own record reviews in the summer of 1986 (yes,1986). All of my conclusions are based on my record reviews. In general, and there are many exceptions,t he records tell the truth. Before the introduction of electronic health records, interpreting one page sometimes took from 5 to 10 to 20 minutes—using a yellow magic marker and a high power magnifying glass. Now, with the introduction of electronic health records there are new problems—there is cutting and pasting of information that preceded the date of service and cutting and pasting of information that was acquired subsequent to a particular date of service. The point is that each case is different - - - a cookie – cutter approach of forcing reports into ML102 or ML103 will result in many reports being labeled as lacking substantial evidence and then you have another mechanism to harass doctors / non renewal of QME doctors. Now, I will provide some real life scenarios on the basis of your newly proposed regulations. Currently,in the state of California, in 2018, the minimum wage for businesses with 25 or less employees is $ 10.50 / ten dollars and fifty cents - - in 2022 it will be fifteen dollars per hour. Now, if I spend fifty hours on a report and I am forced to bill under ML-103,then I am reimbursed at approximately eighteen dollars and seventy four cents (937/ 50) -- -- do think that is reasonable ? Why should a doctor do medical-legal work, when many employees will be making more money than the doctor-- -- is that your mechanism to eliminate QME and AME doctors ?

Anonymous May 14, 2018

I am opposed to the proposed QME fee rules changes. I have been a QME for over 20 years and feel these changes are unfair.

Craig C. Joseph, MD May 14, 2018

Are you aware that your newly proposed regulations are part of a grand scheme to consolidate health care in California under one roof ? If I remember correctly, Kaiser operated a pilot program to treat industrial and non industrial injuries under one roof without distinctions as to whether medical problems were industrial or non industrial- - this was in the early 1990's in northern California. Are you aware that on September 2, 2009,that Work Comp Central published an article on its website regarding secret negotiations between organized labor and big business interests to eliminate the production of medical –legal reports by AME's and QME's and replacing them with cursory paper evaluations by IMR doctors similar to that seen in group health insurance? Are you aware that in the 1990's and maybe in the early 2000's,a number insurance companies and self insured entities started sending defense doctors, as I was at that time,check off forms which were then submitted to work comp judges in place of reports. I was told that the judges would not accept the check off forms and provided awards to applicants because there was an absence of any defense report to disagree/dispute the applicant report. The workers comp judges are highly intelligent people-- -- do you think they were unaware of the motives of some of the insurance companies and self insured entities? Perhaps, it is time for some people in the workers comp system to read the book , Games People Play, by Eric Berne,M.D.,psychiatrist, published in 1964 ? It is my understanding from talking to people with knowledge of the system,that approximately twenty years ago, there were approximately 4,500 QME,s and now there are approximately 2,200 .Is the goal of your newly proposed regulations to make medical-legal reporting a money-losing business such that QME's and AME's leave the system and then you announce the best alternative is put all medical care under one roof ? Are you aware that Kaiser has instructed its occupational doctors that they are only permitted to discuss work injuries that have been accepted by the employer/ insurance company and are you aware that if a Kaiser doctor violates that policy, the doctor is subject to termination?

Nicholas N. DeSantis, DPM May 13, 2018

I have been a QME since 1995. I have regularly served as a subject matter expert in preparation of the questions for the QME licensing examination for the past 20 years. I have a busy private

practice of Podiatric Medicine. The new proposed changes to the Medical-Legal fee schedule will further damage an already broken worker's compensation system. As it stands today, it is already difficult to find competent physician specialists to accept a worker's compensation patients because of the amount of paperwork as compared to private practice patients. It is also difficult because of the routine denials for treatment authorization, which require more of the physician's time to appeal each denial. Therefore, many specialist physicians will not accept worker's compensation patients.

Now someone has the absurd idea to not fairly compensate the medical-legal evaluators for the amount of time it takes to perform QMEs. I estimate that 50% of the QMEs that I perform involve more than 400 pages of medical records to review. And often, they contain as much as 1000 pages of medical records to review. Reviewing these records does not include the actual patient encounter nor does it include the preparation of the report and the additional medical research required. Ultimately, a single, complex QME involves 15 or more hours of work to complete. However, the new proposed rule changes make it almost impossible to bill for ML103 or ML104, because it proposes to only pay $625 per report.

My nightmare scenario is as follows: My office receives a call to schedule a QME. I schedule the QME for appointment one month later. This is to allow time to receive the medical records and the cover letter explaining the disputed issues. Then, a few weeks after scheduling the QME, I typically receive a box with over 600 pages of medical records, as well as a cover letter without mention of causation. However, upon review of the records there is a bona fide issue of causation. This example QME report takes 8-10 hours just to review the medical records. This does not include face-to-face time with the patient, preparation of the report, and often additional medical research. The total time spent by this evaluator would be approximately 15 hours, yet he or she would only get paid $625. This is ludicrous. This amounts to $40 per hour, well below industry standards for a specialist physician. Because I have a private practice where I spend 80% of my time treating patients, I typically complete QME reports during my off-hours. When I write a QME report, I review the medical records of the patient, as well as medical research and literature applicable to the case. Afterwards, I prepare of the final QME report. All of which I do at home over the weekend.

The new proposed changes will result in most QMEs examiners leaving the system. I will resign rather than bearing the burden of performing a complicated QME for such ridiculous small payment. Fair amount of pay for a fair amount of work. I believe that ML102 is very appropriate for cases involving less than 150 pages of medical records to review. Because then the total time spent for a QME would be 3-4 hours.

Ultimately the new proposed changes will hurt the California workers, the employers, the physicians, both applicant and defense attorneys and some worker's compensation judges will also loose. These proposed changes will destroy the present worker's compensation system. I wonder if that is the goal?

Scott T. Anderson, MD, PhD May 13, 2018

I oppose any limitation of time in the proposed new fee schedule to three hours of preparation. My field is internal medicine, and I often see examinees with a half dozen or more conditions for which injury is claimed. Medical records routinely arrive in boxes, often so voluminous that getting through them is a major challenge. I enjoy the process of developing a differential diagnosis and rendering a well-thought out opinion. I note, however, that it will be very difficult to provide the same level of evaluative expertise if I am limited to just three hours of preparation time. That would be unfortunate for all involved parties, including the injured worker, the applicant and defense counsels, and the insurance companies that are involved.

Peter Alexakis, MD, QME May 13, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Craig C. Joseph, MD May 13, 2018

Assuming that I have correctly read the new proposals, are you aware that there is an absence of addressing substantial evidence in your new proposals? Are you aware that the judges base their decisions on substantial evidence? Are you aware that judges have an absence of basing their decisions on the basis of bills? Are you aware that your constricting proposals will result in many reports being prepared in an abbreviated period of time with a lack of substantial evidence because the doctors are not being reimbursed for reasonable amounts of time required to write a

report. Do you have any constitutional authority to interfere with the judicial adjudication of the system? Are you aware that when reports are stricken from the record for lack of substantial evidence,that this can increase the financial liability to insurance companies/ self insured entities by hundreds of thousands of dollars to millions of dollars ? Are you aware of the adage of the following: one size shoe does not fit all feet? Are you aware of the adage - - one size glove does not fit all size hands? Are you aware of the saying - - people who live in glass houses should not throw stones? In my humble opinion, I think you need to consider alternative mechanisms to reduce the fraud in the workers' compensation system.

Alexander Sparkuhl, MD, QME May 13, 2018

I was dismayed regarding the medical fee schedule changes proposed by the DWC. Not only will injured workers be injured again by a creaky, capricious, and bureaucratic system, but the doctors who provide their services to make the system work realize they are being shown the door. The most egregious examples are the approach to the use of research and report preparation time. Experienced QME's understand how to write a report; to limit that effort will lead to inferior report quality and claim settlement delays because important data will be missing in order to make a well-reasoned decision. Lastly if the proposed changes go into effect there will be fewer QME's available to deal with injured workers' claims.

Unfortunately the rapidity by which DWC leadership has moved to make changes to the fee schedule excludes other important individuals in the system including injured workers, employers, and insurance companies. They all have a stake in the process which should be performed in a thoughtful and orderly manner.

Craig C. Joseph, MD May 13, 2018

Report preparation time has been a prominent and conspicuous piece of terminology in the newly proposed regulations. Please define precisely what entities are covered by the umbrella terminology of report preparation time

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David Scharf, MD May 12, 2018

In 20 plus years of performing AME and QME exams in neurology, rarely am I referred a 'simple' case. WCAB judges have ordered applicants to be evaluated by me. Attorneys from all over the state have requested that I evaluate particularly complex medical legal cases. These often include multiple body parts and the cases often have DOI's that extend back five or more years.

Though I am a Board certified neurologist, many of these cases have significant (and even predominant) psychiatric overlays. Alternately, they may include many medical issues that are hotly debated in the medical community. To properly prepare a report that is truly substantial 'medical evidence' requires a significant time outlay. To write a report that makes sense and is written in clear and concise English requires several edits and re-writes. Many of the reports that I issue read as 'term papers' or mini treatises on a contested subject as it applies to issues of causation and science (and updated literature reviews are indicated). There is no way that I can prepare and write a quality report in 3 or less hours (as is now purposed for ML 101, 103 and 104 reports)!

I do not see myself as remaining a QME with such tight time restrictions to report preparation. Ultimately the parties will get what they pay for: reports that meander, or prove to be difficult to truly utilize. Reports will be simplified cookie cutter type reports. The specialists that you depend on will not accept reduced reimbursements to perform complex and time consuming work.

For the insurance companies, I suspect they will pay out more high cost settlements (why bother to prepare a complex analysis of apportionment in a devastating disease or injury? It would take me several hours to explain the issues appropriately and the reimbursement for my extra time and effort would be zero). For the applicant side, I suspect that many of the derivative injuries will be glossed over. If I pick up on an additional internal medicine or psychiatric diagnosis that was work related, it would take several additional hours of reporting to properly explain it so that it could be considered industrial (and the appointment letter has already capped my time and reimbursement). What about the cases that are referred with multiple diagnoses wherein several of the diagnoses are MMI but one major issue has not reached MMI? The judges and attorneys are bright…will they be happy with sub-par reporting? This is clearly an issue of writing guidelines that are penny-wise but dollar-foolish.

It is amazing to me: No one ever caps an attorney's compensation if they work hard to prepare a tough case (and especially one that carries a large dollar tag). Yet, the system purposes that the doctors on whom you all depend on to determine the key issues may be capped at measly sums. I can foresee cases that take me 12 or more hours of time to examine the applicant and review the records, and prepare an intelligent report, now returning an ML 103 reimbursement of $937.50 (to determine a complex medical issue that is worth more than a million dollars to the interested parties in current and future medical costs)! Your best and brightest QMEs/AMEs will quickly desert the system. I have spoken to several. Why bother to keep offices open, we will retire from the Workers Comp arena.

Several of the additional proposals are also poorly written in that they encourage denial of services for other complexity issues. One however makes excellent sense:
Citations for medical research need to be appropriate. I am also disgusted by some QMEs who cut and paste the same 'research' in every one of their reports and then bill for it each time. This sullies good doctors' work…those who truly address the questions at hand and bill for new research time.

In conclusion, several of the proposals are penny-wise but dollar-foolish. You will lose the best of the QMEs and AMEs the system depends on. A warning: the system will get what it pays for

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Eduardo Lin, M.D. May 12, 2018

This letter intends to respond proposed amendments to the medical legal fee schedule as public comments.

1. Response to 9794 regards to prior testing authorization. It is totally waste of time, efforts and money. As QME /AME supposed to provide opinions based on objective evidence findings. Who has authority to authorize testing? While waiting for approval. Patients might not be working and are collecting disability payments. So sooner QME or AME are done. Sooner the case can moving forward. Not waiting for approval of testing. For impairment rating purpose. Objective testing is recommended. Per AMA impairment rating book 5th edition. For instance for rating of back injury DRE methods. Impairment rating is provided based on objective testing plus clinical examination finding.

2. ML101 … No more than 3 hours may be billed for report preparation.

3. This means if we received large record that requires more than 3 hours. We only allowed up to 3 hours to review the records and not to pass more than 3 hours. This language is not reasonable the above language should be deleted.

Hose Kim, MD May 12, 2018

I am writing this letter with great concern for the proposed changes by the DWC on the current Medical-Legal system.

The proposed changes seek to limit what constitutes "Causation" and "Apportionment" as complexity factors. You are trying to make the issues of Causation and Apportionment more difficult to classify as complexity factors. Basically, the DWC is trying to turn ML-104's into ML-103's and ML-102's. You cannot expect quality reports but not pay for them. We, physicians, spend much time and effort in evaluating and composing good-quality QME reports, many of which take hours to do. Many of the cases also come with large stacks of records, which take many hours in reviewing and summarizing. Currently, we as QME's are getting only paid hundreds of dollars on many complex cases. To do what you are proposing to do would be

totally unfair and unconstitutional. In no other industry other than medicine, such practice of fee cutting takes place.

In the same vein, I am also against the idea of the 3-hour limit on billing for "report preparation" for the codes ML-101, -106, and -104. One never knows ahead of time how much time will have to be spent on any report. So, placing such limit is not only unfair but also ridiculous, not mention no adjustment of the fees for inflation.

Due to the recent DWC practices against the QME's, I have seen a significant drop in the number of good QME physicians (especially orthopedic surgeons), which would obviously translate to decreased access to quality QME physicians and more lengthy and costlier resolution of cases. I am confident that good QME reports written by good QME physicians save money for the workers' compensation system as a whole. This type of proposed changes, in my opinion, is not going to decrease or contain costs, but likely result in increased costs, for the reasons stated above.

It feels as if we physicians are being treated as criminals. What happened to the honor system? The DWC can fairly question/investigate any "non-honorable" QME's on an individual basis rather than wrecking the whole system that has been working.

In short, I am vehemently against the proposed changes as they will have nothing but negative effects on all parties involved including the insurance companies. If these changes were to be implemented, I would have no choice but stop preforming QME evaluations.

Gangaw Zaw, Ph.D. QME May 12, 2018

I am writing this letter in response to the proposed changes regarding billing for Report Preparation for Qualified Medical Examinations, for re-evaluations and supplemental evaluations.

The suggested change to limit report preparation to three hours severely limits my ability to conduct a complex medical evaluation and write a sound, complete report for the attorneys and judges.

I am currently a Psychologist, conducting QMEs with a Psychology Specialty. In addition to adhering to the laws and regulations surrounding the QME process, I am also obligated to comply with the American Psychological Association Forensic Ethical Guidelines when conducting forensic evaluations, specifically Workman's Compensation Evaluations. In particular, the ethical guideline states:

11.04 Comprehensive and Accurate Presentation of Opinions in Reports and Testimony
Consistent with relevant law and rules of evidence, when providing professional reports and other sworn statements or testimony, forensic practitioners strive to offer a complete statement of all relevant opinions that they formed within the scope of their work on the case, the basis and reasoning underlying the opinions, the salient data or other information that was considered in forming the opinions, and an indication of any additional evidence that may be used in support of the opinions to be offered. The specific substance of forensic reports is determined by the type of psycholegal issue at hand as well as relevant laws or rules in the jurisdiction in which the work is completed.

Forensic practitioners are encouraged to limit discussion of background information that does not bear directly upon the legal purpose of the examination or consultation. Forensic practitioners avoid offering information that is irrelevant and that does not provide a substantial basis of support for their opinions, except when required by law (EPPCC Standard 4.04).

In complying with this guideline, it is almost impossible to digest hundreds or thousands of pages of medical records, find relevant pieces of information, sort through several hours of interview, scoring and interpreting complex psychological tests within a three-hour period. All this information requires time to process and then to write it in a comprehensive and concise manner for the report to be readable to an attorney takes much longer than three hours.

Please do not set this three-hour time limit. It is not possible to write a complex medical/legal examination within such a short period of time.

Joanne Halbrecht, MD May 11, 2018

I am an orthopedic surgeon with over 20 years of experience in private practice. I have been performing IME's since my Fellowship 22 years ago and have been a QME for 2 years. What distinguishes a simple vs complex medical-legal evaluation?

1. Number of injured body parts.
2. Number of diagnoses. For example, one can claim shoulder injury and have one diagnosis such as AC separation or have 3 diagnoses such as rotator cuff tear, labral tear and subacromial bursitis.
3. Number of injuries. A single injury to a body part is easier to assess than multiple injuries to the same/different body parts.
4. Length of time body part has been injured. An injury that occurred 1 month ago is less complex to assess than one that occurred 5 years ago.

5. Number of different treatments received. A patient who has and ankle sprain and is treated with NSAIDs and a brace is less complex to evaluate than one who has had NSAIDs, bracing, PT and surgery.
6. Volume of medical records.
7. P&S Status.
8. Impairment Rating.

Causation, apportionment and research should be eliminated from the complexity factors. Causation is intrinsic to the evaluation and is evident when the history and records are reviewed. Easy. Apportionment depends upon history and preexisting conditions. Easy. If a doctor needs to spend 2 hours on research, the claimant has been seen by the WRONG QME as they clearly lack the expertise required for the evaluation.

Denise D. Willimason, MD May 11, 2018

I am a QME in Los Angeles and I am very concerned about the proposed changes to the fee schedule.

I really think that the proposed changes to the Med-Legal Fee Schedule billing are unworkable. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report.

The proposed changes are not realistic and would result in my being willing to take on only the most basic of cases.

For instance, this evening for the past four hours I have been working on a re-eval, that I am seeing after 9 months. To be considered in this report are the following:

1. 7 prior reports
2. 6 body parts
3. 4 dates on injury: 2 CTs and 2 specifics
4. a 32 page deposition with 14 questions contained therein, including whether or not the dates of CT should extend to the beginning of employment 16 years ago, instead of what was pled
5. more than 1,000 pages of medical records over 16 years covering all 6 body parts

And I'm supposed to put together an accurate, credible, coherent report in 3 hours? I don't think so!

It took me more than an hour simply to speak the dictation after more than 3 hours of sketching out my thoughts. Once the report is transcribed, I must then edit and do internal cross-checking

to make sure that I have all the body parts assigned to the correct dates of injury and apportioned appropriately.

It seems to me that if there is going to be a cap on report prep time, then there should be a cap on the number of body parts claimed.

If I am going to be cut off at 3 hours of report prep, then I will simply refuse to see any claimant with more than 3 or 4 body parts injured (with "spine" = 3 parts, "upper extremity" = 3 parts, "lower extremity" = 3 parts), and with no more than 2 dates of injury and no other factors to be considered for apportionment.

Or perhaps I'll simply retire.

I see a LOT of claimants who have multiple body parts injured. In fact, of the 15 reports I have to complete right now, 8 have 4 body parts of fewer and 7 have 5 to 11 body parts.

As long as there are not multiple injury dates, completing the 8 with 4 body parts or less should be possible in 3 or so hours of report prep time. But for the 5 to 11 body parts? The report prep time increases proportionally with the number of body parts. I don't see how I can write a good report in 3 hours when I'm considering 11 body parts.

I sincerely hope that these changes are not enacted. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. The DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Perminder Bhatia, MD May 11, 2018
Neuro-Pain Medical Center

In the last few years, Worker's compensation has gotten more worse.

As a treating physician, it is getting almost impossible to get any medical work/ evaluation done for the injured worker. The utilization reviewers, who are mostly out of state, and out of specialty, keep on refusing the treatment. This results in significant delay in treatment, and many time by than condition becomes chronic. They refuse treatment on flimsy unbelievable grounds. I do understand, that, Opioid abuse is prevalent. But that is the first refused thing, and injured worker, suffers more and goes through withdrawals. Treatment for Epilepsy subject was challenged, not by a Neurologist reviewer, but by a family practitioner, to a neurologist consultant.

Due to this reason, I have stopped to be a primary treating physician and has significantly cut down my consultations as Neurologist for injured workers.

Your pay schedule is not better than Medicare. You have more hassle in getting paid, without report, and adjuster will not pay for report. The treatment many times is denied, even generic medicines, which are available for 4 dollars for a month are being denied. Un-necessary money is being spent on utilization review, than money spending on treatment of injured worker. MORE FOCUS IS ON DENIAL OF TREATMENT THAN APPROVAL OF TREATMENT.

Talking about QME's, the rules have been made more complicated and stricter. The payments are being made on complexity, but what about record review and compiling and correcting report. An adjuster wrote in his letter_ we have already accepted claim, so you will not be paid for causation as complexity factor, What about causation of non accepted injuries, which are industrial in my opinion.

Those days are not far away, when worker comp physician Mills, like in Los Angeles, will be left to see industrial worker, who will copy and paste 10 page report again and again, without changing even the date. (I have seen that many during my working as QME in Los Angeles area).

And only those QME"s will be left who regurgitate same history (story), during history taking, discussion and again same during future care and different parts of report.

Scott Graham, MD May 11, 2018

I have read your proposed rules changes. I can’t imagine that QMEs were represented at all during the drafting of this proposal. The document you have produced is not acceptable. Furthermore, the proposed rules changes lack consistency. One section says time is not considered in complexity, then other sections indicate time is a complexity factor. You are discounting causation as a complexity factor even though it is required for an admissible medical legal report. You further restrict use of apportionment to either multiple body parts from multiple injuries or injuries from multiple employers when the law states that apportionment needs to be addressed when there is evidence that disability is contributed to by preexisting pathology/medical conditions. What you are proposing deteriorates the quality and admissibility of the medical legal report.

Many QMEs travel substantial distances, and the vast majority work arduously to provide you with the very best and accurate reporting. What you have proposed is nothing less than devaluing our hard work further, as I remind you that there has been NO COLA in fees for the last decade. If these Draconian measures are implemented, it will no longer make sense for many evaluators to continue as QMEs. There is already a shortage of QMEs and this effort by the DWC will surely aggravate the current situation. The expected bottleneck and additional delay in providing

the needed medical legal reporting will no doubt cause further physical and economic harm to the injured worker.

In my humble opinion, what should occur is to restore the system as it was prior to the implementation of the "underground rules", and for representatives from all sides sit down and negotiate from scratch a more reasonable set of rules and regulations.

Joshua Pretsky, MD May 11, 2018

As a psychiatric QME I cannot emphasize enough how damaging the limitation to three hours for report preparation time will be to the quality of QME reports in psychiatry. Psychiatric cases are highly complex and involve multiple elements that span an applicant's lifetime. Great care must be taken to integrate all the information meaningfully in the report in order to arrive at opinions of diagnosis, causation, apportionment, disability and recommendations that meet the standard of substantial medical evidence and that are useful in helping resolve the case. A reduction in the compensation for report preparation time to a maximum of three hours will only cause further cost and resource burdens on the system as reports come in that do not meet substantial medical evidence.

How was the three hour time limit determined? Was there any study done to assess the average report preparation time documented in high quality psychiatric reports? I would at least suggest that as a starting point for any proposed modifications. However even given those findings, I'm still of the opinion that limiting report preparation time will cause problems and is a misguided effort.

I strongly urge you to not impose any caps on compensation for the number hours of report preparation time.

Anonymous May 11, 2018

Almost all regulations have a different standard for psychological injuries vs physical injuries. I think psychological reports also need to be considered separately from physical injuries. In my opinion psychological reports often need more than three hours.

The history of injury is much more complex to collect for a psychological injury. The minimum face to face time is much greater than for a physical injury. It takes much more time to then dictate and edit the additional data collected.

The social history collected must be much more thorough than a physical injury as this information needs to be carefully considered and described in sufficient detail to properly provide substantial evidence in assessing both causation and apportionment. This also takes much more time to dictate and edit just like the history of injury

More often than not it takes me more than three hours to dictate and then correct and edit my reports.

The problem that needs to be addressed is the increasing frequency of $10,000 + psych reports being generated. It is the 30 page report for which 10+ hours is billed. Particularly when 4 or 5 pages a canned and copied from report to report. Or the 80 page report which is billed as 30 hours. Again when 5 to 10 pages are copied from report to report.

Consistent with current regulatory philosophy would be an independent peer review type company the insurance company could request when the charges seem excessive. The reasonableness of the charges could be reviewed to see if they are medically reasonable based on.the complexity of the case.

Anonymous May 11, 2018

I am a claims administrator and I believe this will add more work to my already busy desk. I rely on the QME doctor for answers on causation, apportionment, complexity, future medicals and disability settlements. If I am in charge with determining this before the QME exam, I could not answer. This would leave more questions for me in resolving the claim. I suppose, it would save more money for our company, but is that the real goal here? I am puzzled as to which director did write this proposal and what carrier they work for. My supervisor was very excited about the savings and getting another raise

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Traci M. Hinden, Esq. May 11, 2018

- 9795- d "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. " If you add that, language should be added to stay: nothing herein though requires a QME to continue w/ a QME that it deems to be unfair, or may create a bias for him/herself.

- 103- (3) Requiring attachment of the materials is a copyright violations. The DWC needs to stop this practice, or at least advice the doctors of this so they can obtain permission for republication. (and on 106)

- 103 (4) (5) this new language "Any complexity factor used as a stand-alone may not be used in combination under this subdivision;" is just heartless.. If a person has a 1 hour f2f and 3 hours of record review, that was what the 104 was designed for, otherwise, what is the point? You will never meet these factors without using these stand alone ones too, so this new requirement is literally a way to prevent an physician from ever getting paid more than $625 while having to do the same amount of work. This is unconscionable, especially as they have not been raised since the inception. This would be like asking you to take on more work, but get paid what you got paid 15 years ago and and you'll never get more. Its absolutely unconscionable. Doctors need to be able to pay their overhead to maintain in this industry and they cannot do that on $625 on every evaluation

- 103 (6) new language : "provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation; Is a complete run-on unintelligible sentence and leads to so many more obscurities.
    - What parties? the lawyers? the injured worker who is represented but at the evaluation w/o counsel and has no clue what the heck you're talking about? the carrier's letter? what does this mean!
    - When prior to the start of the evaluation? A day before? a second before? a month before?
    - which is essential to the adjudication? Isn't this the fact-finder's role?
    - What benefits?
    - parties agree that the physician may use the causation as a... How is this done? What if one party does not issue a statement? does this need to be in writing? how do the doctors prove this later?

THAT LANGUAGE IS A NIGHTMARE AND OPENS UP A LANDMINE OF LITIGATION. Plus, a little punctuation, goes a long way. Keep it simple. Doctors are NOT LAWYERS. Nor should they have to be, just to answer some medical questions!

- 104 (1)(2) Where did you come up with 3 hour report writing minimum? did you poll 5-7 Orthos, Chiros, Psyches, Pain Management, Neuros, etc to ask how long its takes them on average to do report writing, or did Dr. Meister guess? It makes sense to use the practitioners in the field who are doing these reports.

- 106- report writing 3 hours! Often times the parties don't send records- it could take more than 3 hours alone to dictate and prepare the record review.

C. William Tappin, Esq.
Tappin & Associates

May 11, 2018

I have preliminarily reviewed Title 8 California Code of Regulations § 9795 proposed changes. I have been dealing with issues related to this code section for a period of time.

As a preface, please understand that all of the stakeholders including insurance carriers, third-party administrators and self-insured employers as well as doctors and medical management groups are economic entities. My comments are predicated on the economic theory that the entity will generally operate according to its own self-interest. That of course means that the payers are in a position adverse to the payees. For any system attempting to regulate the relationships and develop appropriate regulatory oversight, there must be the impression of objectivity and fundamental fairness. Any regulatory system which is out of balance among the stakeholders and gives primacy to one of the stakeholders or multiple stakeholders over another is inevitably bound to fail.

Title 8 California Code of Regulations is fundamentally flawed at the present time and the proposed regulations are fundamentally flawed. Section 9795(b) states:

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.

That is just a false assumption. The complexity of the evaluation may be considered as primary. However it is really a hybrid system including both complexity and time. For example, it is not particularly complex to review records. However it is time-consuming. It would be fundamentally unfair to funnel reports to a flat-rate ML-102 or ML-103 if the medical-legal provider is sent substantial amounts of records. You could have a situation where a non-psychiatrist medical-legal evaluator is sent 6,000 pages of records, does the evaluation and finds that the applicant is not maximally medically improved.

Under the proposed regulations unless the carrier, TPA, or self-insured employer agreed that medical causation was in dispute you could end with an ML-102 or 103 having reviewed 6,000 pages of records. Therefore, any system that does not view both complexity and time as a basis for the billing would be considered both unfair and fundamentally flawed. It would allow based solely on the defendant's failure to agree that medical causation was an issue to reduce in the above-example what is a very time-consuming and complex evaluation. In fact it would encourage doctors not to find someone temporarily totally disabled and in need of treatment in

order to bill the various complexity factors for all the time and effort he put into the examination. One would hope that wouldn't happen. However, every stakeholder in the system is an economic interest and as I said will function in its self-interest. It will be\ in the self-interest of the defendants to refuse to agree that medical causation is an issue even if it is.

It gives one stakeholder primacy over others by allowing the carriers, third-party administrators and self-insured employers to automatically veto medical causation as a complexity factor. In that case why even have it.

The economic interest of almost all of the defendants would be to veto the medical causation complexity factor.

I believe § 9795(b) be altered to allow both the hybrid concept of complexity and time to be considered.

With respect to ML-I 00 code, it states:

This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.

This should be altered. None of the doctors in the system should be carrying on their backs the obligations of either the carriers or applicants' attorneys. If someone does not appear a fee should be allowed for the administrative costs involved in organizing and scheduling the examination and the doctor's time set aside. It is clearly a lost opportunity cost because he is not doing the examination that had been scheduled. He is not doing the report. A fee should be generated for no-shows or late cancellations which would be six business days pursuant to the Code. That fee may vary depending on the specialty. Psychiatrists often use 4 to 7 hours for the examination and mental status workup and testing.

They obviously should receive more than another specialty that spends 1 /2 hour to 1 hour in face-to-face time. The only innocent party in a no-show would be the doctor and he should not be penalized in any way. The current language is merely a litigation magnet that is very unclear. Litigation will have to generate responses as to what is "necessarily owed." It doesn't say it's owed. It doesn't say it is not owed. The judges generally side with the doctor and indicate the defendant should pay the bill and if the no-show or late cancellation is due to the actions of the applicant or the applicant's attorney the defendant should have a right to pursue costs, sanctions and repayment of the monies paid to the doctor.

With respect to ML-101 this is being changed to indicate "no more than 3 hours may be billed for report preparation under this code." There should be some procedure to request additional hours based on the documentation presented, the complexity issues and the amount of records received. I'm told by many psychiatrists they spend 6 to 8 hours in very complex cases preparing the report where there are numerous records, multiple events or personnel actions as well as cumulative trauma and non-industrial factors. Things like that should be accounted for.

With respect to medical research it should be noted that we have moved to an evidence-based system under the AMA Guides. Doctors may want to do research and include research to support their findings particularly with respect to apportionment in order that their report be substantial medical evidence and advise as to the basis for the apportionment they reached. The alternative is of course to by medical fiat indicate the apportionment they feel appropriate and why without referencing any of the studies which support the finding and educate the parties and particularly the court.

With respect to ML-103(6) relating to medical causation it seems that simpler is better. Why not just make medical causation a complexity factor. This is one particular example where primacy is given to the carriers. Assuming for a moment that most entities operate in their own self-interest why would any carrier, third-party administrator or self-insured employer ever agree that medical causation was an issue. Additionally using the word parties includes the applicants' attorneys not responsible for payment and complicates the procedure. One potential change could be to make medical causation in all cases a complexity factor. If that were not acceptable one might consider indicating that if the defendant denied injury to any claim/date of injury or any body part the issue of medical causation would be presumed to be in play.

It would be a complexity factor. In order to avoid that the carrier would have to, prior to the scheduling of the evaluation withdraw their denial and accept injury for the date of injury/claim or body part. If they fail to do that they've denied the claim and medical causation clearly is an issue.

With respect to ML-I 06 relating to no more than 3 hours billed for report preparation I again think there should be a basis for the doctor to request additional hours of report preparation given the circumstances and time involved in the case. This is an arbitrary number and I have no idea how that number was reached. The same analysis would be applied to no more than 2 hours billed for medical research. With respect to medical research I think it should be allowed and included in the report not only for the doctor's edification but also to support the report, avoid unnecessary depositions and to educate the parties and the court as to the evidence-based nature of the apportionment made by the doctor. At the present time research can only be used for the doctor informing himself or herself as opposed to informing the court. I believe it would be important for the research to be included on a limited basis for that reason.

I think it's clear that the proposed changes particularly with respect to medical causation be addressed. This gives an adverse party the ability to veto in 100 percent of the cases the complexity factor of medical causation. It gives primacy to the defendant by being able to take away a complexity factor for no other reason that it won't sign a letter because it knows that it may cost more if it agrees that the medical causation is a complexity factor. It makes no sense whatsoever. In no case should a defendant be able to veto medical causation in circumstances where they have denied any injury, date of injury or injury to a body part. That would be fundamentally unfair and skew what should be an objective set of regulations in favor of a stakeholder in the system.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

These are my preliminary thoughts on the proposed changes. If we're going to change things we should address the issue of a hybrid complexity/time analysis. Additionally we should address other issues such as the uninsured employers' trust fund. Many Agreed Medical Examiners, panel Qualified Medical Examiners and independent medical examiners have to wait years for payment if they're ever made. Why should an uninsured employer receive this benefit as a result of having committed a crime by being uninsured? The Uninsured Employers Fund doesn't pay. They should be required to pay within 60 days as all other insurance carriers, third-party administrators or self- insured employers. Why should a doctor be forced into involuntary servitude. The Code says he can't refuse to see the person even though he won't be paid or won't be paid for years. We should address the issue of the Uninsured Employers Fund and require either the employer or the fund to pay at least an ML-I 03 subject to reimbursement by the doctor within 60 days if it's an ML-102. If it turns out to be an ML-104, then the Uninsured Employers Fund would have to pay the balance within 60 days. That's an equitable resolution of the problem and comports with the concept of fundamental fairness.

The real problem is the failure to understand the time and manpower required to do the evaluations, schedule the evaluations and print out records. Computers have been a great help in streamlining things. However instead of reviewing medical reports and medical records and other documents in determining what should be sent to a doctor we have a situation where if someone presses a button and everything's put on a disk and the doctors end up with 2,000, 3,000, 4,000 or more pages to review. I recently handled a case where a doctor reviewed 11,127 pages. This is time-consuming.

The doctor has to comply with Labor Code § 4628(b) which requires him to "review and summarize" the records and sign under penalty of perjury that he did so. If he is forced into an ML-103 or an ML-102 he'll be paid very little for the work that he's done.

We have a system where we have studies being done by a professor at Berkeley addressing why we have so many fewer panel Qualified Medical Examiners. Doctors won't review 10,000 pages of records and do a report for $700.00 or $900.00. They can go to the state prison system and get as much or more per hour with no overhead. This will drive more panel Qualified Medical Examiners and Agreed Medical Examiners out of the system. We've recently had a huge jump in disciplinary action or non-renewals. That drove a number of doctors out of the system or they were kicked out of the system. We're going to have very few panel Qualified Medical Examiners if this continues. Moreover, this will take the Q out of the PQME.

Hopefully the stakeholders can get together and understand that the system will only work if balanced. If any one party or parties has primacy over the others it can't conceivably be successful. Hopefully we can come up with changes that satisfy all stakeholders without causing undue concern among one stakeholder over another. I will follow up with more suggestions in the future. However I think for the time being this should be enough. I apologize for any grammatical errors as they are mine. I do not apologize for any typographical errors but do apologize for failure in editing and reviewing.

Baba Singh, Psy.D., QME May 11, 2018

I have reviewed the proposed changes to the Medical-Legal Schedule for WC. Some of the wording is helpful, such as specifying "dates" of injury instead of "injuries" in apportionment analysis. However, I disagree that all the proposed changes will help across the board. In particular, reimbursing only 3 hours of report preparation will, I believe, adversely affect psychological QMEs like myself.

Psych QME reports are notoriously long, and I agree that many reports I have read are longer than they have to be. I am very efficient in my own work and I work hard to make terse, concise reports that meet standards of substantial medical evidence. Even so, I put in 8-10 hours on average, to complete a report.

I feel like the 3-hour cap would be unfair and detrimental to my practice as a QME because I don't think I could ever produce a substantial psych QME report with only 3 hours of work. Under this proposal, I would be working my regular 8-10 hours on reports but only getting compensated for 3 of those hours.

Please consider revising this part of the new proposed changes in deference to psychological QMEs. I do agree that the DWC should crack down on waste and overcharging. But I do not agree that this particular change would accomplish that goal without unduly depriving QMEs like me of compensation for honest work as well.

Yehuda Gertel Psy.D., QME May 11, 2018

The DWC's second attempt to curb the costs of QME and AME evaluations is understandable.

What is not clear is whether the policy makers actually considered how these regulations would play itself out in real time if this draft was successful.

As a psych QME and needing to synthesize the facts gleaned from a protracted narrative interview, often copious and detailed psychological testing, inches of medical records, personnel records, seamlessly and coherently blended into a conclusive and medically substantial written opinion and with the full knowledge that a loose end, exaggerated symptom, intra-report inconsistency, overlooked factor (whether wholly material or not) departure from standard of practice, or bias toward a particular view will get fired on by one or both parties in an effort to assassinate one's credibility and disqualify the report… and all within the 30 day countdown…surely the DWC knows that this would be untenable in 3 hours.

Here is my best guess as to what would follow:

The vast majority of quality QMEs would bail altogether rather than subject themselves, their credibility and their license to impossible risk.

The majority pool of remaining doctors would be those doctors who already practice systematized delegation of report production to lower-level clerical staff, this able to come in under the report preparation time caps.

Shoddy boiler-plate reports would be issued, attorneys from both sides would happily cut these reports and their authors into pieces in deposition and correspondences, reports would be invalidated, replacement panels would be issued, more boiler plate reports, more depos, more delays, more legal costs, more workers backlogging the system instead of moving out, with no end possible to this cycle.

I suspect as well that per the CA Supreme Court/Valdez and Labor Code § 4064 we could also expect an uptake of AA-procured reports which would be far more persuasive versus a shoddy boiler plate, leading to higher costs for the IC.

Clearly the orchestrated collapse of yet another segment of the CA workers compensation system is not what the DWC wants, nor what they believe will materialize.

I write these words with the hopes of a receptive audience willing to take a long look at the negative implications of regulations.

Daniel J. King, Psy.D. May 11, 2018
Qualified Medical Evaluator
Clinical and Forensic Psychologist

I am a QME in psychology. It is absolutely impossible to prepare a psych report in three hours. Psychological QME evaluation require gathering a vast amount of data regarding the nature of numerous stressors a person has encountered throughout their life and how those stressors have impacted them psychologically. The discussions are always complex because there must be explanation addressing the relative psychological impact of each stressor. My interview data section is typically about 20 pages and my discussion of opinions section is also about 20 pages. This is not unnecessary. For resolution of the claim this amount of information and analysis is necessary. Psych evaluations are always complex and require a high level of preparation time. For an initial evaluation the minimum report preparation time is 18 hours. Not only am I typing up five hours of interview data into an organized and readable text, but I am also typing up

psychological testing section, a summary of reviewed records which may be as long as 20 pages [on psych cases there may be numerous prior and lengthy psych reports that must be summarized], a comprehensive and thoughtful analysis of information with explanations for my opinions and finally a careful editing of the report. This takes two to three days.

If there is a cap of three hours I would have to resign from doing QME work because there is no way I could write a good report under those time constraints. Instead of putting a blanket cap on the hours there should be some other way of measuring whether the report preparation hours are consistent with the work product such as number of pages and relevancy of the information on those pages. To put a cap on the number of hours does a disservice to the injured worker and the adjudication process as the quality of the report would be poor.

Thank you for your time and attention

J.R. Fruen, Esq. May 11, 2018

These proposed changes are another absurd and transparent attempt by the insurance companies to dictate policy in the State of California regarding workers' compensation laws and regulations. If these changes go into effect then QMEs will flee an already understaffed system. Report quality will go down because fewer reports will be eligible for hourly reimbursement. That means less time for doctors to spend on complex issues like Almaraz-Guzman. It also means more time and costs on supplemental reports and depositions. If you think the QME system is currently inefficient, you ain’t seen nothin’ yet!

All of this HELPS insurance companies to eviscerate the already weakened system. It is very difficult to get treatment for injured workers because of poor MPNs and malpractice mills that serve as supposed front-line treating facilities.

If the QME options are restricted in this way, workers' compensation protections in the state will collapse, and employers will essentially be paying workers' compensation insurance for nothing, as workers will get no care, and no fair value for their impairments. Why would the DWC want to legitimize private insurance corporation taxation of private businesses for no benefit to anyone but said insurance corporations? This is blatant corruption, and the fact that the DWC is considering this is sickening.

I urge the DWC and to stop this proposal now, and, in fact, to open the QME options up to further candidates, so that injured workers can actually get fair treatment and fair medical-legal analysis.

Tim W. English, Esq. May 11, 2018

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Joseph P. May 11, 2018

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I urge them to stop this proposal now, and in fact to open the QME options up to further candidates, so that injured workers can actually get fair treatment and fair medical legal analysis.

Jeffrey B. Nowicki, D.C., QME May 11, 2018

I recently reviewed proposed changes to the med legal fee schedule and have some serious concerns with them and seem to be at odds with the labor code. Specifically a physician's ability to use causation as a billing complexity factor must have written requests from both parties in order to use causation as a billing complexity factor. LC 4060 says nothing about both parties having to agree to such an evaluation regarding industrial causation in order for the QME to use causation as a billing complexity factor. It seems like the DWC is rewriting labor code as opposed to interpreting current statutes. The fact that two parties must agree to it in writing is completely arbitrary and onerous on the part of the QME and not supported by existing labor code.

Also the three-hour On report writing will result in poor resolution of disputed issues. And will further cause more QME's to leave the system as the reimbursement rate would not be commensurate with the time spent addressing all issues. In regards to medical research the limitation on the QME physician that reviewing sources cited in reports must be in the preceding 12 months is ludicrous and disturbing. Not all conditions will have research that will be performed in the 12 months preceding the QME evaluation as well as the practicality of the physician to track when the researched articles were published.

It is apparent by these regulations that the DWC finds the QME physicians as not a trusted and valued part of the medical legal system. And does nothing but confuse and cause increasing financial disincentive for QME physicians to participate.

Steven I. Subotnick, DPM, DC, QME May 11, 2018

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I just reviewed the proposed changes Limiting time billed for ML 101 to 3 hrs. for analysis and prep. Time.

Is just plain wrong and will encourage sloppy inadequate reports I have been doing Evals way before we even had the QME process I have weathered legislative changes in how to do report I have tolerated 'under ground' faulty interpretations of the codes

Just let me do my job and please. Stop rigging the billing codes against me and all of we evaluators who pride ourselves on the thoughtfulness and relevance of our reports.

Please don't make these changes and leave things as they were following the recent legal settlement.

Gennady Musher, M.D., Ph.D. May 11, 2018

The purpose of the QME is to offer expert substantiated medical legal opinion to the parties and to the trier-of-fact.

It is clear that under the present proposal that the time spent by such expert plays no meaningful role in the compensation, that ML104 would be essentially impossible to use, leaving mostly ML102 and ML103. In the case of psychiatry, this will leave the expert spending a minimum of 8 hours, in my experience, and on average closer to 16-20 hours for a fee varying between $600 and $900, covering the time INCLUDING administrative and other office expenses.

Let's compare: clinical work of the same duration would be compensated by Medicare (the lowest payer on the market) taking into account BOTH complexity AND time spent at approximately $1800 for the 8 hour version of the services. Let's compare: I get daily emails from recruiters offering psychiatrist $230+/hour in California Penal institutions and county clinics WITHOUT OVERHEAD EXPENSES AT ALL. Needless to say, private practice pays more than either one of the above payers.

So could we envision the logic for a psychiatrist to seek or maintain QME certification? 1. The love of medical legal work above all other activities in the field. 2. Overwhelming desire to serve the attorneys and the trier of fact caused by unresolved conflict in the childhood relationships with father and with siblings. 3. Obtaining a non-profit status for the practice, which would allow collection of tax free contributions from the public. 4. Can anyone think of any others?

If the DWCMU is aware of this state of affairs, why not frankly eliminate the QME as a category and let the PTP or the attorneys or the Trier-of-fact make the determinations of medical legal issues, since the value of time spent by the expert is nil.

David W. Baum, M.D. May 11, 2018

I am writing as an AME/QME internist who has participated in workers' compensation for more than 20 years. The proposed changes to the medical-legal fee schedule are so extreme that most internists could no longer participate on the panel. The cases which I am asked to evaluate tend to be complex, particularly those concerning alleged cancer and toxicologic injuries. Such cases may require many hours to review voluminous records. Addressing medical and legal complexities is essential for a report to serve as sufficient evidence. Additionally, a credible representation at the time of a deposition requires familiarity with both the medical issues and the history as disclosed in the records.

Over the course of decades, I have invested several thousand hours of research into cancers, infectious diseases and toxicologic injuries. Additional research may be required for each case, and I will not routinely duplicate references. However, the references for one case may be relevant to another, and the requirement that a medical reference not be duplicated within 12 months would compromise an examiner's capacity to provide the best supporting evidence. Admittedly, too many physicians have abused reference citations in the interest of personal advantage. However, those of us who have acted ethically will be confronted with a time consuming challenge to revisit the same topic numerous times in order to avoid duplication of relevant references.

With regard to the ML-104 charge, The DWC is presumably mandating bipartisan approval for causation with the understanding that such agreement would be unlikely. Many panel doctors would be required to invest long hours in complex cases with the expectation of negligible compensation. The cost of producing those reports in some cases would exceed the payment. Notwithstanding the potential financial impact, we would be prohibited from the option to refuse such a case.

If changes to the medical-legal fee schedule happen as proposed, there will be an exodus of internists and other specialists from workers compensation. Our cases would have to be assigned to other specialists on the panels. The required specialists, however, might no longer be on the panels, or the claimants might need to travel long distances to see marginal AME/QME doctors who would necessarily issue terse and sketchy reports. The cost of reassignment for new panels could be overwhelming.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

The proposed medical-legal fee schedule means the collapse of the workers compensation system at the expense of claimants who are already mistreated by the system. I urge the interested parties to find an alternative which respects physicians, claimants and insurers.

Ashton May 11, 2018

My name is Ashton, I manage and own a Medlegal Management Company and currently manage a small group of five QME physicians.

The past two years have been very turbulent in the Medlegal management community. It all started back in 2016 when the DWC aggressively denied reappointment's to doctors for alleged fee schedule violations based on alleged underground regulations or rather: violations of code 9795 interpretations that simply didn't exist. As a result of the DWCs actions, **one of my doctors was denied reappointment. His denial (based on alleged underground regulations) resulted in over 100 applicant cases placed in limbo for a period of seven months. As a result, applicants couldn't receive treatment, nor new QME panels, TPA's / employers had to pay additional TTD, attorneys had open ended cases, and the QMEs life and practice was turned upside down.**

On April 4, 2018 we all thought that maybe there was a respite with the settlement of the Howard vs DIR case. It was our belief that we could begin refocusing our efforts providing service to the injured workers of California without the fear of regulatory over reach by the DWC. Not within a month after the settlement, the DWC and its architects of the alleged underground fee schedule regs once again turned the Workers Comp system upside down again with its release of its proposed modifications to 9795 medlegal fee schedule.

Basically, the alleged underground rules that the DWC denied reappointment to QMES back in 2016 and 2017 are now being proposed as official changes to the billing code. The biggest issue that comes to mind is the change to the **CAUSATION complexity factor**. The change includes **"prior agreement by both parties"** in order to use CAUSATION as a billable factor. This alleged underground interpretation was used by the DWC discipline Unit to deny reappointment to many QMEs during the 2016 and 2017 re-appointment cycle. **The proposed interpretation serves no other purpose other than limiting a QMEs ability to do his job. The interpretation is not based in reality.** For example, The majority of complex cases do not have multiple parties (both parties) most are individual parties. Setting up a prior agreement with parties is next impossible to arrange with "both" parties, especially if there's only one party. **The proposed modifications would further complicate an already complicated and over regulated QME work flow.**

The proposed CAUSATION Modification would also lead to incomplete reports that would prolong the workers comp process for both TPAs and injured workers. It would be understandable if the modifications simplified the process for the injured worker, the QME, or

even for that matter the TPA / insured. The DWCs proposed changes appears to be a way to manage Medlegal costs at the expense of the QME. **The reality is this change will further increase costs, waiting times, and include QME reports that have incomplete information**.

Again, for reasons unknown to me, the new regulation proposals are not based in reality, thats unless the reality is to destroy the California QME program. **If all the proposed changes are passed I can say with certainty there will not be enough QMEs to accommodate the large demand of evaluations in the future.** Its understandable If the DWC wants to help cut costs to the California QME -Medlegal system --- But, these proposed actions are definitely not the way to do it. **The new regulations will make things more complicated in an already complicated system. Its much like lowering gas prices by outlawing car engines. The status quo should remain... CCR9795 should remain as originally written.**

I also would like to say that **if all these proposed changes are implemented in their current form, the five QMEs that my company manages will most likely dropout out of the California QME program.** There will be no upside for them to remain and I'm sure they won't be the only ones either. As for my company, if these changes are passed I will have no other alternative than to close my doors. The QME business will no longer be a viable business for me, nor a viable practice to the QMEs we manage.

My feelings are fairly representative of the QMEs and QME providers in the system. I**f these regulations are passed there will be a mass exodus of QME s and their providers exiting the system.** This will leave an already fragile California Workers comp system in a more compromised state and injured workers will suffer.

Tanya Mesirow, Psy.D. May 11, 2018
Clinical Psychologist & QME

I am writing regarding the proposed changes to the Medical Fee Schedule. As a QME in Psychology, the reports require a great deal of time, effort and expertise. Unfortunately with the new proposed changes, it appears that a QME's ability to adequately and effectively complete an evaluation and report will be compromised.

For example, the fact that Causation will require written agreement from both parties, is near impossible. In most cases, it will not be feasible to get PRIOR written agreement from BOTH parties regarding Causation, yet Causation is a very important aspect of the entire case.

Further, the fact that the "Multiple Hour Complexity Factors for ML 103 and ML 104 codes will require ALL three time components of Face to Face time, Records Review Time AND Medical Research Time" is unreasonable. Specifically, requiring two hours of medical research for each evaluation that cite sources that "have not been cited in any prior medical report authored by the physician in the past 12 months" is unreasonable and unnecessarily arbitrary.

Finally, limiting report writing time to 3 hours is untenable considering the amount of information that must be included in these reports. The DWC is asking for more regulations/stipulations while cutting reimbursement for specialists. If the DWC wants complete reports, 3 hours of report time will not be sufficient.

In summary, these regulations restrict QME's ability to submit reports that constitute substantial medical evidence. In addition these regulations further complicate the QME process. I believe you will lose qualified QMEs who do not want to try to meet the demands of an overly complicated QME system, while getting paid less. In addition, in the end, it will likely cost the state MORE money with the need for additional supplemental reports and depositions, as QME's will not have the time necessary to adequately complete their evaluations the first time around.

Dr. Patricia Wiggins May 11, 2018

I have reviewed the proposed changes to the ML fee schedule.

The changes regarding the use of CAUSATION as a complexity factor discusses "agreement" between the parties that causation is at issue.

Rules preclude the examining physician from communicating with the parties. Letters from parties often are a "template" stating "and compensable consequence injuries"
As a dual certified QME in Occupational Medicine and Internal Medicine, this type of template letter is asking about many potential diagnoses, and in my opinion is asking for a causation analysis for multiple diagnoses. In practice, it will be interesting to see how this plays out.

The other practical issue especially for Occupational Medicine QMEs, is that we often act as a gateway or "first pass" for complex cases.

These cases often involve extensive records both for the current WC case, prior WC cases and personal records especially when multiple "compensable consequence" diagnoses are proposed. When the case has not been accepted or fully worked up, the claimant cannot be deemed permanent and stationary and therefore impairment and apportionment cannot be commented on. I mention this as an example of how the use of only complexity factors and not time is not always the best way to compensate the work that goes in to preparing a good comprehensive ML report.

Thom Harpley, Ph.D. May 11, 2018
Psychologist & QME

It is difficult, if not impossible, to provide a substantive psyche med-legal report w/ less than 3 hrs report writing. If you implement this, I anticipate many psyche QME's will drop out.

Michael F. Charles MD, QME, AME May 11, 2018
Chief Orthopedic Director for the Newton Medical Group
ExamWorks

I have served as a QME since its inception in the 1990's. Per my reveal of the many excellent and many heartfelt responses of my colleagues there is little more to be added. As noted, the existing regulatory rules for QME doctors has been a system under consistent observation and change. The most recent director found it her charge to attack every nook and crannies of its existence and its regime is sound. We are already subject to competency exams and renewal requirements, fee schedules which have been altered without apparent input from physicians, scrutiny from bill reviewers without apparent concern as to how the effects of the determinations effect on the overall outcome regarding the injured worker. The new proposed amendments to the Medical-Legal Fee Schedule is simply not a viable solution to the system continuing to exist without more inevitable delays in resolving the myriad of disputed claims. Many excellent points have been offered to the FORUM and I trust they will be honestly addressed.

Christopher J. Trodden, Esq. May 11, 2018
Roland, Pennington & Trodden

Having served the interest of injured workers for 25 years, I must state the workers' compensation system is broken. Now the DWC is proposing rules to curtail and limit payment to Qualified Medical Examiners at a time when the WCAB insists on reports constituting "substantial medical evidence." How can the administration demand substantial medical evidence in reports when it imposes limitations on QMEs in the amount of time they spend in research and preparation of reports? It is simply not feasible in a great number of cases. Treating doctors will not review and comment on QMEs absent pre-authorization of this

service by the insurance company. Can you guess how many times I have been successful in obtaining such pre-authorization? Zero. So how can a primary treating doctor's report be substantial medical evidence when they have not reviewed the entire medical record of a case I submit, it cannot. I suggest the DWC explore other areas of cost savings for the insurance industry. Why not exempt from Utilization Review MPN doctor's Requests for Authorizations, or at least exempt them during the 90 day discovery period? How about capping the amount of money spent on Utilization Review, so a claims adjuster makes logical choices on which Requests for Authorization to simply sign and authorize, rather then send every single item, some for medications that cost less than $20, to Utilization Review? Please be logical in your approach to cost savings. Don't kick the injured worker harder when he/she is already down under this overregulated system.

Michael Newman, DC May 11, 2018

A limit of 3,80 characters is hardly adequate to respond to the current maelstrom.

I have provided a detailed analysis and sent it in under separate cover.

This is a much abbreviated response.

I have reviewed and analyzed the proposed changes to CCR Section 9794 and CCR Section 9795 that DIR employee **[REDACTED]** has set forth.

These proposed change go to what appears to be a denial of due process for the injured worker.

[REDACTED] has provided his opinion how the CCR Section 9795 regulations should be re-written.

Causation is out as a complexity factor.

Apportionment is out as a complexity factors unless the applicant is at the MMI.

Combination of two complexity factors that together come to 4 hours or more is out.

Combination of three complexity factor that together come to 6 hour or more is out.

Review of medical records and the time to summarize all those records, regardless of the amount of the records reviewed is now capped at 3 hours, and those three hours must include addressing all the other issues that comprise a medical-legal report.

Given **[REDACTED]** proposal that any complexity factory that is a stand-alone may not be used in combination under sections (4) and (5), and with causation and apportionment no longer billable complexity factors, this literally ends the use of the ML-103 and ML-104 billing codes.

The IW with anything more than a simple case can no longer obtain a comprehensive medical-legal evaluation to prove his/her claim and thus loses his/her right to due process.

These proposed changes effectively render almost all medical-legal evaluations billable only as ML-102.

This will likely collapse the system as the evaluators discover they are now working for free for most of the time they put into the evaluation of the injured worker.

If the goal is to end all medical-legal evaluations payable over the ML-102 rate, drive the applicant attorneys out of business, drive the defense attorneys out of business, drive out most of the workers' compensation judges from their jobs and deny the IW a fair and equitable evaluation of their claims, this is a perfect final solution.

Stopping the abusive use of research and stopping the abuse use of apportionment as complexity factors will address most of the current billing problems.

All the QMEs and AMEs are aware that a small number of medical-legal evaluators abuse the billing criteria.

We can work together to solve this problem and maybe this forum is a start.

The solution lies in bill review demanding the physician documents the work performed.

Any physician that feels bill review is wrong to cut his/her bill should be required to file a petition for costs and face a workers' compensation judge. No lien representative. The Doctor should appear and tell the WCJ why it took him/her over two hours to review a handful of documents and why he/she spent 2 + hours on research that had nothing to do with his/her opinions and conclusions.

This stops the problem.

Anonymous May 11, 2018

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

The proposed alterations and amendments to the Medical Legal Fee Schedule (MLFS): The proposed changes appear punitive and a serious underestimation of the time and professional expertise QME's must devote to the medical legal evaluation and report writing process.

Proposed alterations impose conditions which make it highly unlikely if not impossible that a physician, acting in the capacity of a Qualified Medical Evaluator, will be justly compensated completing reports requiring extensive medical record review, research, other necessary activities in the case; and face to face examination time.

By imposing additional requirements on the ML 103 and ML 104 codes, the physician will no longer be able to be properly perform of evaluations review of voluminous medical records and face to face examination time, especially when the patient needs an interpreter. Record review involves the careful reading, considerations of information and bringing that information together with the examination findings and clinical experience to form a meticulous standing opinion on the case matter. The changes will disable such opportunity.

In summary; The proposed changes to the Med-Legal Fee Schedule billing are unrealistic and will create more chaos/ confusion to existing issues. The changes will result in more waste of money due to: a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. On the other hand, the time limit will not allow that the QME expert clarify the possible inconsistencies in patient's case and this will allow losses for the defense side.

Currently, the number of QME providers we have in the system has been decreased and these new regulations will likely push many more to leave due to inability to even- pay for the cost of doing QMEs.

This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. QME reports are used to discover facts that are important to everyone involved in the evaluation, the injured worker, the employer and anyone involved. By limit the report preparation to only 3-hours, DWC will not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction. The changes will impact negatively on all parties on the case.

We request with respect that DWC pull back the proposed regulations and support QMEs to be able to continue serving the community to the best.

Robert H. Fields, MD May 11, 2018

I have been a QME physician most of my career. I enjoy the work and I get complicated cases.

I now find that some of the proposals being considered would make it hard to do the work effectively. When I need to answer the often times convoluted topic of causation, I should be paid for it.

Additionally, limiting the review of medical records would be very difficult. How do I spend uncompensated time? 1.000 pages of billing at ML102 is not practical. In order to do the work like everyone else, I want to be paid for the work I do.

A review of 250 pages takes approximately two hours. It takes at least an hour and a half to put together most reports, sometimes more, again depending on the complexity of the case. Limiting report preparation to 3 hours might be difficult on the very long complex cases.

Having to get prior approval to get paid also adds time to the work. To obtain an approval from the adjuster would certainly create a bottleneck in the process and is not efficient.

1 realize there is abuse in the system, but 1 like to think that most of us try hard to do the right thing.

I have a private practice and would like to continue with QME work, but I can't continue if every report is a basic ML102, many reports I see are basic, many are not. There is nothing “basic" about most of the WC cases and it takes hours of uncompensated time.

Anonymous May 10, 2018

I have seen some of the solutions and respectfully, I do no agree with some of them.

Some QME’s have discussed new rules to go after QMEs. Respectfully, this is not appropriate at this time. The DWC allegedly used underground regulations to go after QMEs. Also, even when the DWC was allegedly going after QMEs using the underground regulations, IBR was upholding QME billing! They settled without any consequence or admission to wrongdoing. If you are proposing new rules for QMEs now, you are basically proposing additional oversight by

a body that has overstepped their bounds in oversight and has a history of allegedly denying due process to QMEs.
In order to build trust with QMEs, those who were involved with the underground regulations at the DWC need to resign. The DWC also needs to apologize to the QME community. Furthermore, there should be a position made at the DWC of a practicing QME that is elected by QMEs to represent QMEs in Sacramento. This QME should be given equal power to accept and reject proposals. In this way, you will less likely ever have to worry about underground regulations and because there is a practicing QME there, you will never have an egregious fee schedule such as the one currently proposed, every be proposed in the first place.

Costs cannot be looked at two dimensionally. For example, you cannot say an ortho case takes 4 hours or a psych case takes 10 hours. No one wants to get into the gray of possible price fixing. If you simply say this person spends too many hours preparing his or her report or this person sees 8 people a day, that is too simplistic a model to judge a QME on. A better way to look at this is that there is wide variance. Every QME has different education and qualifications and this is reflected in the quality and size of reports. It is also reflected in the time.

Here is a simple set of solutions:

1. Pay evaluators 250 dollars an hour regardless of complexity. This will eliminate having to meet arbitrary complexity factors, this will take care of issues of raises, etc. This will also eliminate underground regulations.
2. Keep the panel system in place and make sure that the parties are doing their research! Many of us have been in the system long enough to be well known by many attorneys and insurance companies. These companies know how much QME's charge and can determine which QME is the best fit for their case.
3. The parties should both work together to call QME's together to get an estimate of what the cost are up front. Then the QME can give them a realistic idea and they parties can choose to go with the QME or not.
4. The parties can also work together to call the QME to determine what records to send. That way costs can come down dramatically and make the process more efficient.

This simple set of solutions allows a better flow of information among all the stakeholders involved. It is more transparent and cuts costs. If it does not cut costs for a particular case, it is because the parties have effectively chosen an evaluator that is the best fit for each case. Furthermore, QMEs don't have to write letters, no one has to worry about what to do with unrepresented workers, etc. Additionally, anyone who is cheating in the system, will lose because the parties/insurance company will likely not choose the evaluator again if it is a poor report or a report that is too costly. This also prevents cost fixing as the parties should not be sharing with other evaluators what other evaluators say they will charge.

I wanted to address a couple of things point by point. I have put my responses in bold.

1. Under section 9795, this was added: "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." **QMEs should be free to pick and choose their cases. Medical-Legal Evaluators across the country choose what work they do. What if one party has a history of being antagonistic toward the QME? What if you have an antagonist unrepresented worker who does not want anyone to get paid in the system?**

2. Under ML 1010: "No more than 3 hours may be billed for report preparation under this code." **We should get more history of who came up with this and how they came up with this. It does not appear that anyone who actually does the work provided any input into this.**
3. Under ML 103: "In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation." **What does "actually" and "necessarily mean?" What dos "uniquely specific to the actual evaluation being performed mean?" This sounds like an underground regulation mine trap. Can someone explain this in plain English?**
4. Under ML103: "(3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;" **This sounds like the person who wrote this has no idea about medical-legal reports. Although research is a learning opportunity, it is also used to help solidify opinions. Therefore, it should be encouraged to used the research to support opinions whenever necessary, even when it is warranted. We are talking about individual cases.**
5. Under ML103: "(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;" **What does this last sentence mean? So if you see someone for three hours, that is a standalone factor. Does that mean if I spent one hour under record review, I can't combine this to make four hours?**
6. Under ML103: (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision; **Again, what does it mean, that any complexity factor used as a stand alone may not be used in combination.**

7. Under ML103, "(6) Addressing and providing an analysis of the issue of medical causation, ~~upon written request of the party or parties requesting the report~~ provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;" **When you add, "and providing an analysis of," how is this different from simply phrasing this "addressing the issue of medical causation." Is it possible to address causation without providing an analysis of causation? If the parties do not agree that causation is in dispute, does the evaluator have to even provide an opinion regarding Causation because doing so means the DWC wants QMEs to do this for free.**
8. Under ML 103, "(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injury~~ies~~ to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more ~~or more~~ dates of injury~~ies~~ involving two or more body systems or body regions as delineated in that Table of Contents. ~~The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.~~" **So if the person has had one employer their entire life and has claimed a work related injury but has apportionment to a motor vehicle accident, a skate board accident, and a falling accident, then the physician does not need to address apportionment because the physician will not get paid for that opinion? Or are you going to force the physician to make that opinion without getting paid? If one date of injury is listed in the cover letter, is it assumed that apportionment is not to be addressed because the physician will not get paid?**
9. Under ML104, "An evaluation which requires four or more of the complexity factors listed under ML 103. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were actually and necessarily incurred for the production of the medical-legal report and required for the evaluation, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon~~ 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." **How does actually and necessarily" change this section? What does "uniquely and specifically" mean?**
10. Under Ml104,"An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician. 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;" **If it is this complex, it does not make sense to bill for only three hours.**

11. "(3) 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. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. When billing under this subdivision of the code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities." **Has anyone every received this letter from the parties? Please show us an example. How do you determine prior to the start of an evaluation that the evaluation involves extraordinary circumstances? That is weird phrasing. Only the evaluator knows when an evaluation is extraordinary. Do each party have a definition of "extraordinary?" Does an unrepresented worker know what is "extraordinary." When an evaluator the parties where the applicant is unrepresented, how would the applicant feel that the evaluator is requesting additional payment that an evaluation is extraordinary? Has the DWC talked with any adjuster to ask them if they have been given the ability by their employer to authorize an evaluation as "extraordinary."**
12. Under 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." **So if you get 4000 pages of records, you can't bill more than 3 hours or report preparation for this code?**

Basically, the person or persons who wrote this made the code worse in terms of language, significantly skewed the reimbursement codes towards insurance companies, and potentially put each and every QME in danger of a violation no matter how ethical the evaluator. Because of the history of the DWC allegedly using underground regulations and denying due process to QME's, this makes this new version of the code even worse. It comes across as there was no adequate input from anyone who does these evaluations.

Compare the solutions I proposed to the one the DWC proposed. I argue my proposals are simple, transparent, and require minimal if any oversight from the DWC. I argue my

proposals, allow choice, allow the evaluator to get a better idea of what to expect in terms of work, and allow providers to know what to expect in terms of billing.

Greggory M. Field, Esq, Partner — May 10, 2018
Goldfarb, Zeidner & Field

I oppose the proposed regulations. QMEs are tasked with doing in depth analysis of medical records, sometimes years worth of records, and applying them to the Applicant's evaluation, deposition transcripts, etc. They have to apply legal principals and understand case law. QMEs hardly get paid enough to do all that is required and the number of QMEs has drastically reduced and these regulations will continue to cut QMEs. It seems as though this is the intent of these regulations. These regulations will no doubt will drive the remaining quality doctors out of the system. Even QME doctors are setting outside of the limitations allowed. We need more quality doctors in the system. That's starts with the doctors being able to charge a fair amount and the proposed regs do not do that. The regs need to promote the opposite of what they are doing and draw more doctors in, not push them out.

Dara Saghafi — May 10, 2018

Surely, there is no dispute that the proposed changes to the Med-Legal Fee Schedule are merely meant to reduce overall costs for QME evaluations. Yet, it is obvious that only 2 possible outcomes will emerge: QMEs will quit performing this often arduous work or reports will be substandard and will not meet substantial medical evidence. In either scenario none of the parties involved will be well served. Limiting report preparation time to 3 hours or less will, in majority of cases, yield reports that will ignore much of what is in the medical records and will result in unsupported opinions that will miss essential factors that need to be taken into consideration in analysis of causation and apportionment. Presently, some QME reports simply contain statement of opinion without any rationale provided pertinent to the case. These reports will have statement such as "the injury is industrially caused" or "permanent disability is 50% industrially caused and 50% due to pre-existing factors", without any additional explanation, discussion, or rationale. If these are the type of QME or AME reports DWC and all parties would like from here on, then the new proposed fee schedule will be successful in obtaining such reports. Otherwise, if thorough and well reasoned reports that actually directly considers all submitted records it should also be expected that such report will require appropriate time for analysis of all issues.

It is not uncommon that in a corner of an obscure sheet of medical record (which may be a family physician's hand written report from years ago) that can result in a determination that an otherwise "obvious" work injury was in reality pre-existing and therefore not industrially caused

or its related disability should largely be apportioned to non-industrial cause. Such meticulous attention to detail requires time and detailed analysis of all issues and is often not a feasible in 3 hours.

If DWC is going to institute the new changes then it must also include an optional avenue for a QME to bow out and reject working for free. In many cases medical records are 2000 pages or more and medical records of more than 8000 pages are not uncommon. Reviewing and analyzing these records, whether for an initial evaluation, re-examination or for a supplemental report will require the time it takes that it takes and limiting the billable time to 3 hours is entirely unreasonable. This is no different than limiting the time of surgery, ahead of time, for a trauma surgeon to operate on a multiple gunshot wound patient regardless of the complexity of the injuries or the number of organs injured. Non of the employees at DWC work for free and the same should not be expected of QMEs.

A QME physician can chose to leave the system if forced generation of substandard reports are mandated by the new proposed Fee Schedule. Other work is always available for physicians and working as an expert witness for personal injury cases is much less burdensome and is more profitable than staying in the workers compensation system. But what will the injured worker do? They have no other option but being involved in a system that continues to become more antagonistic. These fee schedule changes will only result in the settlement of cases becoming more protracted and the litigation process will linger on longer.

In addition, expecting a written agreement in advance from both parties that causation is in dispute is absurdly unrealistic. As is, we as QMEs often get a cover letter/advocacy letter from one side only and at times after the QME evaluation has already been completed. Furthermore, how is the unrepresented injured worker expected to know or go about obtaining such a written agreement before seeing the QME?

The changes that need to be made should revolve around identifying the bad apple QMEs. We have all heard of QMEs that perform upwards of 6-8 QME evaluations in half a day or generate reports that provides no discussion or rationale to support the briefly stated opinions. Why is this still being allowed?

Any improved fee schedule should ask for input from the Medical-Legal evaluators and from Defense and Applicant attorneys and from Claim Adjusters *ahead of time*. Otherwise, the current proposed schedule will result in shrinking number of QME/AMEs and or substandard QME reports will become the norm. Instead of making the system more antagonistic, less make it practical for all parties involved.

Jody M. Lawlor, DC May 10, 2018

I am an active treating chiropractic physician and currently an active practice performing QME and IME's and medical-legal consultative examinations.

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker would be able to get back to work.

Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. The QME reports require extensive time and research already.
This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction. The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

I appreciate you taking the time to consider my objections.

Rick Shaw, MD, QME May 10, 2018

My name is Richard Shaw,MD and I am a QME and Clinical Prof. of Internal Med and Rheumatolgy at UCLA School of Med. I have been in the field of Med Legal Workers Comp. for 40 years. I have been the past pres of CSIMS and I have been through all the legislative changes and battles of the last 35 years. I have seen the quality of Med Legal reporting fluctuate all these years with many attempts to revamp the system. The most reasonable approach to reforms comes from public hearings and a transparent viewing of potential changes. The concept of capping MedLegal fees by restricting the time frames that are necessary for doing reports and needed research on each case will ultimately cause the quality of reporting to fall, increasing litigation times and will lead to increasing final determinations of impairment as physicians are rushed and pushed to do a less than stellar assessment of injured workers. The number of physicians willing to do this work will diminish and it cause an ever increasing of backlogged cases in the courts. Please reconsider the DWC approach to these changes and schedule public hearing s for these concepts.

James E. O'Brien, MD May 10, 2018

I know I've already commented here but if I may add a few other thoughts:

I understand the issue of medical research billing and why that is confounding. In my opinion it should seldom be used. I have done probably 7000 medical-legal AME QME reports and I don't believe I have used it more than ten times total. Those cases usually involved some complex toxicology. If you have to do research on routine cases, you're probably not really an expert.

However, it is not fair to punish those of us who bill modestly and fairly because of the excesses of a few. Go after those QMEs but do so fairly and with due process.

But I think we are missing the big picture. Why reform the QME system? It's terrible, a compromise that satisfies no one except doctors who couldn't otherwise get work. If you are a quality evaluator, the attorneys will come to you. Why force them to use someone they don't like or whom they do not know?

I am asking for a rational reconsideration of the entire system instead of a complicated fix that will not work and just drive good experienced doctors away.

Jerome Peterson DDS May 10, 2018

After reading the proposed new regulations for QME Report billing, I am opposed to these changes.

Attempting to write an accurate, thorough and well reasoned Complex or Extraordinary Med-legal QME report to include all the newly defined factors required in a report involving Extraordinary Circumstances, in only 3 hours is next to impossible in many circumstances. How does one accurately separate the Record review from the Report writing when the QME is required to include an accurate and thorough reporting of these records in the body of the report Discussing the records after reviewing them is an integral part of the Report. When you get 10,000 to 15,000 pages of records, which happens frequently in my practice, a discussion of the accuracy of the records and the conflicts found in the records is usually always necessary. QME's are required to give explicit and well reasoned analysis to support their findings, and this simply cannot be done in many cases when reports are limited to only 3 hours.

Regarding the issue of Apportionment, the new regulations in section (7) require combining items (A)and (B), that they must both apply in order for the report to be deemed compensable as a Complex Comprehensive Medical-Legal Evaluation. This requirement may make QME evaluators inaccurately declare the injured worker has reached MMI or has reached P&S, when

this may not necessarily be true, just in order to qualify for the higher payment amount. This rule change would definitely hurt the injured worker while benefiting the workers compensation insurance carrier to the detriment of the injured worker

With reimbursement schedules as proposed, though, comprehensive and accurate reports will be less likely, there will be a lot more AME and QME Depositions wasting the time of the doctor, and all this will be to the detriment of the injured worker.

Alan Engelberg, M.D., QME May 10, 2018

I am writing to comment on the proposed changes to the QME regulations.

I am an internist and have been doing internal medicine QME evaluations for about two and a half years.

I would note the following:
1) It takes about two hours to obtain an accurate and complete history from most injured workers, since many are not used to giving medical histories and do so awkwardly. Translators are often needed.
2) Medical research is necessary to assure that the diagnoses and opinions given are based on the most accurate and current information.
3) Usually, four hours is needed to prepare, dictate, and edit a report so that the proper amount of thoughtful consideration can be given to the issues at hand.

Marc S. Wiesner, Esq. May 10, 2018

I've heard from many physicians that these changes will force them to stop doing med-legal reports. In the SF Bay area, we're already seeing a decline in availability of reporting physicians. I have cases on the 7th panel because doctors are overloaded and cannot set evaluations within the statutory time frame. As systematic delays stack up, cases will take longer to resolve. Longer cases increases costs for insurance carriers, frustration and financial hardship for injured workers, and takes more judicial attention (increasing costs for the state).

A reliable network of QME physicians is crucial to keeping the system from further buckling under itself. Tightening the belt for evaluating physicians will not only deter physicians from remaining involved in the workers' compensation system, it will negatively impact all stake holders.

Dr. Eric Prestin, D.C., QME — May 10, 2018
Ventura Spine & Disc

I am writing in regards to the proposed amendments to the Medical-Legal Fee Schedule. The proposed regulations are not reasonable and will negatively affect the QME process. Presently, there are less QMEs performing evaluations. These proposed changes will further push more doctors away from the QME process.

Most ML102 and ML103 reports already require up to three hours of report preparation time. Capping the report preparation time to 3 hours with ML104s is unreasonable, especially with cases where voluminous records are presented for review. This will result in rushed record reviews which will affect the quality of reporting. One needs to remember that a QME report is a detailed, comprehensive analysis and explanation of a complex work injury/case.

The proposal regarding medical research is absurd. This proposal will discourage physicians from citing medical research when writing the report. This will certainly have a negative effect on the report/opinions of the QME.

Finally, the proposed regulations pertaining to causation are set up to fail. It is difficult enough in communicating with all parties at the present time. Requiring the QME and authorized parties to agree on inclusion of medical causation prior to the start of the evaluation. This is not practical nor possible.

These proposed regulations will only undermine the QME process and report. The quality of the report will suffer. If this is a cost-saving measure, it will not work. The result will require more supplemental reports, depositions, of QMEs, and create more headaches for everyone involved.

Nicholas DiSabatino, DC, QME — May 10, 2018

Yes, this is exactly the point, isn't it? There is already a dwindling pool and a difficult job and now the DWC has come out in alignment with the insurance companies. What is happening here is the insurance companies will have reports with no causation and can then litigate in court with the IW having less evidence. Under what context does this new system work except to aid the insurance company to litigate in court where they have more resources to spend. It is shocking

that the fee schedule would require two parties to sign on to the billing and to the inclusion as a complexity factor the issue of causation. Suppose there is a genuine issue of causation that needs to be addressed, but that one party would gain by not having causation addressed -- naturally that party would withhold endorsing the issue of addressing causation. It is also astounding that the issue of causation must include an agreement of billing -- naturally, if causation needs to be addressed, then it needs to be paid for not separately authorized. Put yourself into the shoes of a carrier (which obviously the DWC Medical Unit does every day), if an injured worker has a causation issue that he/she need to be addressed in a PQME , why in the world would a carrier sign on to the issue being addressed, rather than just litigating the issue in court where carrier has power of the purse and can litigate with decreased medical evidence? Would a knee scope be authorized and not paid for ? And where did the notion that 3 hours of prep time arise as always sufficient? Cleary this is all about giving the insurance companies more control and driving out the quality PQME's from the system. So unremarkably short-sided these regs are. Actually, the fee schedule has not been adjusted for inflation for how many years? But instead, the Medical Unit is trying to find ways to drive doctors out of the system, and they are doing a good job at that. Pretty soon the Injured Workers will have everything stripped away from them as the love story between the DWC Admin and carriers reaches new levels of co-interest.

Nanci Price, DC, QME May 10, 2018

This new amendment to restrict medical history review to three hours would would definitely make me drop my QME status. I cannot afford to not be paid for my time. You're punishing the QME's? Why? It is not easy writing these reports, and if you pass this ridiculous 3 hours medical history review, I guarantee you I won't be able to provide the high standard of report I'm used to providing. You'll be forcing doctors to submit sub-standard reports! Why are you not wanting to pay the QME's for our time? These QME reports I write take me away from my family, they are very very time consuming. I rarely bill for the real time I spend on these reports. It has taken me years to become a QME report writer, and I pride myself in writing excellent reports. You're punishing the doctors by not paying us for our time? Do you like to get paid for your time? Why do you expect us to work for free? Why are you doing this to us?

Jerry Fabrikant DPM FACFAS May 10, 2018

As a specialty practitioner, I regularly receive 4-10 inches of medical records on paper, or the equivalent on disc. This requires me to spend a great amount of evening or weekend time which is part and parcel of my QME responsibilities.

The new proposed regulations are nothing short of punitive actions whose purpose is to hamstring QME evaluations. I have no doubt that should these proposals be passed, many QME evaluators will elect to discontinue performing these exams.

I for one will opt out of the new QME state process as I refuse to submit to these extremely burdening record reviews, research, and lack of pay for time spent.

I hope all the new requirements do not pass, as fewer specialists will continue to provide the time as set forth, and thus impact the system worse than currently exists.

Kent Karras May 10, 2018

Requiring doctors to work and not be paid in full for their efforts goes against everything that this country stands for. The DWC should not be siding with large corporations (insurance companies) against small independent doctors. Most of us run small individual practices and do not have the resources to push back. We earn every penny for the work we do performing QME and writing reports. We have few if any routes to remedy insurance company misbehavior. If anything the DWC should be raising payment per hour for the work we do.

Paul H. Key, MD, FACP May 10, 2018
Clinical Professor of Medicine
Geffen School of Medicine at UCLA

As stated in that proposal the reasonable and appropriate metric for preparation, billing and compensation of QMEs in California would disappear! As a semi -retired full Professor of Medicine at UCLA School of Medicine I would no longer find it reasonable and appropriate to consult for the DWC. When I was recruited to perform QME consults for the DWC 9 years ago, I was told there was a great need for senior, highly respected Physicians with my Academic credentials to perform evidence based evaluations of injured workers. I saw this as a worthwhile undertaking, with modest compensation for the time spent and potential great value to the injured worker, employer and insurer. The new proposals by arbitrarily defining time limits on components of the evaluation and reporting (i.e. complexity factors) will make it no longer an economically viable undertaking for Academic Physicians such as myself. The result will be a further decline in the numbers and quality of QMEs in California, to the detriment of all involved.

Please feel free to contact me for further discussion of this ill-conceived change.

Sukhjit Brar, MD, FAPA, QME May 10, 2018
Board Certified Adult & Child Psychiatrist

I'm writing to express my concern on the changes that are being proposed. I'm psychiatric physician QME and I am noting that The proposed changes to the Med-Legal Fee Schedule billing are unworkable.

Please remember that there is a lot of time which goes into psychiatric evaluations and report writing. It's just the nature of the speciality. Even in my general practice, my evaluations and the reports are much longer than any other speciality. But I'm also trying to speak for other specialities.

The proposed changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Steve Barnett May 10, 2018

The DWC is, for the first time, proposing that there be a limit to the number of hours that can be billed for report preparation. At the same time, they are stating 3 hours would be the maximum. While many of the submissions to this forum are focusing on the 3 hour stipulation, it appears that this is distracting from the more basic question and discussion around the **wisdom and feasibility of having any limit at all on preparation time**.

What is the basis for DWC being interested in limiting report preparation time? Here are some possibilities:

QME evaluations are too expensive

Indeed they are expensive, and there are many reasons for this, first among them being the mandate for QME evaluations to be comprehensive and thorough. **The DWC-approved QME course I took to prepare for the QME exam emphasized this**, and explained that reports that are deficient in terms of history, or fail to address all the questions being asked by referring attorneys, or fail to support their findings and recommendations with exhaustive documentation are subject to, at worst, having the report disqualified by the DWC, as well as not being paid for the evaluation. Otherwise, lack of completeness invites supplemental requests and depositions, and further delays to the applicant's claim being processed to conclusion.

The cost of most QME evaluations is borne by insurance companies that have a practice of routinely denying any psychiatric injury claim. Yes, it's expensive for them, but after all, they are denying these claims as a means of controlling their costs. That's their gamble. And in doing so they are, at the very least, delaying necessary and recommended treatment, causing increased harm to applicants with legitimate work-related injuries.

QME evaluations are longer than they need to be

Yes, they can be very long. I have authored QME reports in Psychiatry that have ranged from 45 to over 300 pages (ML-104), with much of the variation due to the volume of medical records we are expected to review and to summarize in written form as part of the finished report. **I doubt that my longest reports could be read (closely and with comprehension) in 3 hours, much less written.** Again, the mandate for thoroughness cannot be taken lightly under the present system lest the QME physician be subject to the consequences mentioned above.

These QME reports are my sworn testimony to the DWC court. Since QME's do not testify in DWC court (ordinarily) in person, it is even more important that all possible relevant history, records, questions, impressions be documented and analyzed in detail.

Were the DWC to stipulate some specific reporting format or template that would be more streamlined or succinct, I would be able to comply with that change. However it would certainly open the door for supplemental requests and depositions. Would defense attorneys be open to forgoing these after-report requests if the DWC approved a more streamlined, less costly reporting format?

There are too many QME evaluations

Individual QME physicians have little or no control over how many evaluations they are asked to do (via panel or otherwise), and certainly no control over the number of requests within the overall system.

If there are too many evaluations, one must look at the insurance companies' practices regarding handling of mental health claims, and their high rate of denials.

The number of re-evaluations is increased by another routine practice by insurance companies, i.e. **failing to follow treatment recommendations given in the initial QME** report. I have had many applicants return to me for 2nd and 3rd re-evaluations, when they have never been afforded the treatment I had recommended. Evaluation after a period of treatment is a necessary part of the QME process, and delays and denials of such recommended treatment prolong the entire endeavor, since the untreated re-evaluation recommendation will always be that of the applicant still needing treatment. I have had applicants whose recommended treatment needs could easily have been covered by the cost of a single re-evaluation report. I have had two occasions where, after recommending treatment, I was subsequently asked to provide a supplemental report or re-eval, in which I would find the applicant at P & S status because "the applicant states they do not want treatment." Discussions with these applicants revealed that this was not the case, and that they clearly wanted the recommended treatment.

In both these most recent proposed DWC changes, and the recent litigation regarding complexity factors **suggests a bias within the DWC administration against QMEs**. Given the absurdity and unfeasibility of these proposals, I can come to no other impression.

Gennady Musher, MD, Ph.D. May 10, 2018

The purpose of the QME is to offer expert substantiated medical legal opinion to the parties and to the trier-of-fact.

It is clear that under the present proposal that the time spent by such expert plays no meaningful role in the compensation, that ML104 would be essentially impossible to use, leaving mostly ML102 and ML103. In the case of psychiatry, this will leave the expert spending a minimum of 8 hours, in my experience, and on average closer to 16-20 hours for a fee varying between $600 and $900, covering the time INCLUDING administrative and other office expenses.

Let's compare: clinical work of the same duration would be compensated by Medicare (the lowest payer on the market) taking into account BOTH complexity AND time spent at

approximately $1800 for the 8 hour version of the services. Let's compare: I get daily emails from recruiters offering psychiatrist $230+/hour in California Penal institutions and county clinics WITHOUT OVERHEAD EXPENSES AT ALL. Needless to say, private practice pays more than either one of the above payers.

So could we envision the logic for a psychiatrist to seek or maintain QME certification? 1. The love of medical legal work above all other activities in the field. 2. Overwhelming desire to serve the attorneys and the trier of fact caused by unresolved conflict in the childhood relationships with father and with siblings. 3. Obtaining a non-profit status for the practice, which would allow collection of tax free contributions from the public. 4. Can anyone think of any others?

If the DWCMU is aware of this state of affairs, why not frankly eliminate the QME as a category and let the PTP or the attorneys or the Trier-of-fact make the determinations of medical legal issues, since the value of time spent by the expert is nil.

Joel Weddington, MD May 10, 2018

As an orthopedic QME in California I reached out to several QME colleagues about the proposed ML fee changes. Some of us are concerned enough about this to start looking for new work, in preparation for resigning as QMEs. The proposed reductions are likely to put us at the hourly pay rate of a Physicians Assistant or an RN, who make up to $75-100 an hour plus benefits. This is a careful calculation based on the current amount we earn subtracted by the projected new cuts. As independent contractors for Medlegal groups, which is how most QMEs in California work, we typically get 60% of the collections, which is $150 per hour based on the ML hourly fee schedule of $250, but we pay for our malpractice insurance, medical education and licensing fees, transportation and hotel costs (many of us travel out of town to do QMEs).

Causation as a complexity factor will drop out in most cases because of the rarity of getting two parties to agree on this issue. The cap of 3 hours for ML-104 report prep time is punitive, as it comes at a time when cases are becoming increasingly complex, with more body parts to examine, more older patients with degenerative changes and pre-existing pathology, and epidemics of obesity, opioid dependency, and diabetes. These factors heavily impact work injuries by increasing disability and prolonging treatment, and need to be addressed in detail in causation, apportionment, and future medical care sections. These reports easily requires more than three hours to compose and edit the exam findings, symptoms, ADLs, impairment ratings, and above listed sections, which are often protracted by detailed rationales and an exhaustive number of data points.

Limiting supplemental reports to 3 hours will backfire. QMEs will have to watch the clock and when time is up, send in what we have done. Working for $150 an hour without benefits does not give a cushion to go overtime without pay. If our fee-capped supp does not address the issues fully, it will trigger another supplemental or a deposition. Not a very efficient way to move the case towards settlement. I personally have done many lengthy supps over 3 hours that tied together disputed issues, closed the case, or prevented a scheduled deposition.

In recognition of the DWCs perceived need to reduce payments to doctors, we offer that a few (maybe 5-10%) of our colleagues have figured out how to use medical historians and report writers to save time, allowing them to increase their volume without increasing their time. This may be a root of why these changes are proposed, but it is unfair. Some of our colleagues do use shortcuts to increase their numbers of evaluations, doing 40-50 or even more per month. Some have done 10-15 thousand reports. Most of us aren't comfortable or capable of doing however. These fee changes will hurt the majority of QMEs who are taking as much time to do the reports as they are billing. That will in turn hurt the system as numbers of us will be obligated to reduce our participation or leave the QME system entirely. We strongly urge to keep the current fee schedule, if not to increase it.

Richard Horevitz, PhD, ABPP, QME May 10, 2018

The proposed three-hour limit for report preparation is, in my opinion, ill-advised. A three-hour limitation would make it impossible to prepare a psychological/psychiatric report that would constitute substantial medical evidence. It would not allow a sufficient amount of time for thoughtful review of all the materials and evidence as a whole or completion of the many sections of a psych evaluation, e.g. the Work Function Evaluation Form. The critical differences between psych QME/AME evaluations and other medical-legal evaluations are the level detail required, the number of topics covered [Title 8 1.1. Section 43], and the requirement to address the unique difficulties analyzing psychological causation in a logical and persuasive manner. Psychological/psychiatric reports are unique in that *Rolda* analysis may be required.
The *Rolda* analysis is complex and time-consuming requiring a determination of the amount of causation attributable to each factor or alleged event whether industrial or non-industrial.

There are ways in which a psych report can be prepared within three hours but they are all odious. For example, the report can be based on a template that requires very limited case-specific input substituting generalized prepared opinions matching the examiner's pre-existing conclusion and determination. The number of psychological tests can be restricted and the analysis reduced to the severity rating or with the MMPI-2, MBMD, MCMI - III/IV analysis limited to a cut and paste of a computerized interpretation, and the ethical violation of taking test results that are provided as interpretive *hypotheses* for clinical evaluation and treating the

interpretation as "fact" concerning the patient/applicant. Another by-pass to limit preparation to three hours would be for the AME/QME to create a computerized self-report background questionnaire covering all the mandatory topics listed in the "Psychiatric Protocol" (Section 43) which the applicant completes such that the applicant's responses are digitally added to a pre-existing template. The likelihood that an applicant's responses are selective, partial, and inadequate is very high.

While these workarounds could be employed, it seems unlikely that conclusions and the reasons for the conclusions would reach the level of substantial medical evidence. The legal determination of whether the report meets substantial evidence criteria would not likely permit the AME/QME to opine that the report is the best that could be done within the three-hour limitation. The physician's billing limitation would not be germane. The WCJ could send the report back or order a supplemental report meeting substantial medical evidence. Presumably, this would not be billable but if it were, many psych cases would wind up with the WCJ and medical evaluation re-creating the time-consuming process involved in obtaining a *Rolda* analysis in *Fujimoto v. Caliber Collision Centers* (2014) 2014 Cal. Wrk. Comp. P.D. LEXIS 118 (WCAB panel decision).

Finally, quite apart from report quality and substantiality, are the ethical and financial demands placed on the psychiatric / psychological evaluator. Certainly, there will be evaluators who cannot trim report preparation to three hours. I would be one of those who could not. The pressure of my own ethical concerns would make writing three-hour reports impossible other than to spend ten hours or more preparing and writing the report and only billing for three hours. I would rethink serving as a QME from both ethical and financial concerns. How many current psych AME/QME would continue to perform comprehensive medical-legal with a three hour or a five hour or even a ten-hour time restriction? Certainly, it would be a sufficient number to cause further delay and harm for applicants. Certainly, it would reduce the number of high-quality reports. With a three-hour report limitation, would the report actually assist the parties in contested cases? Would judges and the WCAB find reports adequate? Has the court or WCAB found psych reports with three-hour (or less) report preparation time adequate in the past? How often?

Michael Smith May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Chris Lee, MD May 10, 2018

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The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Daniel Kaplan, MD, QME May 10, 2018

I have been a QME since the program started. If the proposed changes are implemented, I will resign.

Elliot Gross May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

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Thank you for your consideration of this request.

Hooman Melamed May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

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Thank you for your consideration of this request.

Chris Fleming May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

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Thank you for your consideration of this request.

Nadine Cain May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

We will not have any physicians left in the workers comp industry. These injured workers cannot even find treating doctors anymore.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need

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We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Ricardo Castro May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

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These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Lanny Rudner, MD May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

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These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Eve Se May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule. The change will encourage low quality evaluation and reports.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
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These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Rina Jain, MD May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

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These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

Robert Markison May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

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These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

I have trained young surgeons on 2 faculties for more than 30 years, and none have expressed an interest in doing complex medlegal evaluations.

If you pass the proposed changes, the outlook for current and future high level case resolution is truly grim.

A number of expert surgeons have recently vacated the system, and more will soon follow.

Thank you for your URGENT consideration of this request.

David Lewis May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.
- Not allowing payment beyond 4 hours of record review unless accompanied by medical research will make discourage AME/QMEs to accept cases with voluminous records to review, or encourage a haphazard, cursory, or incomplete review of these records.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Thank you for your consideration of this request.

If passed, I for one will resign as a QME as it will not be worth the time and hassle to continue to provide this line of business to our injured California workers. As it is, onerous regulations coupled with declining reimbursements, have led me to severely curtail my availability to treat injured workers.

Ronald Perelman May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Jack O. Piasecki, M.D. May 10, 2018
Orthopaedic Surgeon
Optimal Orthopedic Medical Group

The California Orthopaedic Association sent me an email regarding proposed changes to QME billing. I have a problem with all of these recommendations, but in the interest of time I would like to address the issue of record reviews.

I review so many records that at the end of the month I fill two large bins measuring 18 inches x 18 inches x 32 inches with records for recycling. It is not unusual to receive an entire banker's box of records on just one patient.

The problem largely resides in Northern California, where patients get their nonindustrial medical care at Kaiser. When they have an industrial injury, they go to the occupational department at Kaiser.

Typically, an overzealous defense attorney not only makes arrangements to send the records that are directly relevant to the Workers' Compensation claim, but they also request that all of the Kaiser records be sent to the doctor in the hope that something will be found in the records that may result in either denying the claim or apportioning disability to nonindustrial causes. The attorneys themselves never bother to review these records.

It would certainly save us a lot of time and it would save the State of California a lot of money if the attorneys sending the records would take the time to review and pull out the pertinent records rather than sending a box of records to the QME.

It is surprising to me that the DWC wants to punish the QMEs for an issue that is not under their control. The DWC should be punishing the overzealous attorneys, particularly defense firms.

Given the volume of records on many of the cases I receive it simply would be an impossibility to review the records in 3 hours. So what is the answer?

The first approach would be to review 3 hours of medical records and stop. It is usually easy to find the pertinent occupational records and separate them from any non-occupational records. I would then provide my conclusions, and the attorneys could decide on how they want to proceed if all the records are not reviewed.

Another approach would be to review the records in a piecemeal fashion. If, for example, I have to spend 6 hours reviewing records, I would do one report reviewing 3 hours of records and then we could have the attorneys send the remainder of the records and we would do a supplemental report reviewing another 3 hours of records.

Neither of these alternatives is particularly attractive, they can potentially hurt the patient, and it is going to lead to delays in settling claims.

The applicant attorneys typically are happy with just presenting those records that are directly related to the case.

John Foley May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

Not having a cost-of-living increase since 2006 four this is also unacceptable compared to inflation and time invested. Life is not about cutting corners it's about quality that can be given. This cut proposed is a severe mistake. Just look at the back up you have in your system at this time and your risk of losing qualified QME doctors.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Sam Bakshian May 10, 2018

I respectfully urge you not to move forward with the proposed changes to the Medical-Legal Fee Schedule.

The proposed changes will discourage AMEs/QMEs from tackling tough cases where the injured worker claims multiple body parts are injured and has significant volume of medical records.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need

to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases. Moreover, without adequate time to review all of the records within a 3 hr time frame, will result in less than substantial medical evidence in the reports will result in many more depositions and unnecessary delays in case resolution.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Robert Henrichsen May 10, 2018

The proposed changes will discourage AMEs/QMEs from tackling difficult time consuming cases where the injured worker claims multiple body parts are injured and has significant volume of medical records. As you are aware some of these cases are complex and span a variety of years.

Specifically, the changes that I oppose are:

- Raising even higher the standard for when causation can be counted as a complexity factor. I fail to see why the claims adjuster would ever agree to allow the evaluator to use causation as a complexity factor even in disputed cases. There will be delay in scheduling the evaluation while the QME/QME attempts to get agreement of the parties. More time that the evaluator will need to spend with no reimbursement. If they cannot reach agreement, there is no option for the QME/AME to decline to perform the evaluation.
- Limiting the ML-104 report preparation time and the ML-106 supplemental reports to only 3 hours will discourage AMEs/QMEs from being willing to take on the tough cases.

These changes are unfair to injured workers and to the evaluators who are trying to resolve disputes.

We urge you to delay implementation of these changes and instead convene a Work Group of stakeholders to discuss possible changes to the Medical-Legal Fee Schedule to address concerns that the Division may have identified.

Stephen Dell, M.D., QME May 10, 2018

I am an active treating physician (neurosurgeon), with as well a significant practice performing AME, QME, IME and medical-legal consultative examinations.
I have already posted comments to these proposed changes. However, I would like to add the following:

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Fahmy Ibrahim May 10, 2018

Good Morning . I'm doctor Ibrahim, psychiatric QME . I oppose the new amendments.
I believe the proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours,

DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Shane P. Hutton PhD May 10, 2018
Forensic Neuropsychologist

The proposed changes to the billing schedule are draconian in nature and will lead to a lower standard of care for QME/AME evaluations. The later are assumed to be complex evaluations in nature. Otherwise why not rely on the PTP's report?

There is usually some sort of dispute regarding liability thus in many cases AOE/COE is the predominant question. To limit report preparation to three "hard hours" is absurd and arbitrary. Further, as a psychologist our reports are by very definition "extraordinary" or complex. We often need to separate "buckets of distress" (e.g. physical injury, pain, personnel actions, undue-work stress, over work, internal medicine, etc.) for apportionment purposes. Assumable any combination of these mentioned examples will have a different date of onset.

We are often tasked with completing a Rolda analysis when there are at least substantial personnel actions. This adds further complexity to an already complex evaluation. To limit report preparation to three "hard hours" is arbitrary, at best. The conceptualization of the case is lost in this 3 hour math, and as a result the injured worker will ultimately suffer unreasonably.

Finally, the requirement to "ask for permission" to address causation is redundant as most if not all attorneys request this. I honestly, do not believe it will be difficult to obtain this "permission" however, it is an unnecessary step that simply gives the insurance carriers a very unfair advantage over physicians in the workers compensation system. A pendulum swing, which if adopted, will inevitably swing another way in the future. Let's get a balance now.

Kathleen Longwell, Ph.D., QME May 10, 2018

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I am writing with my concerns about the proposed changed to the medical-legal fee schedule. Please take this into consideration.

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Marty Krell, MD May 10, 2018
QME Neurosurgery-Spine

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

The proposed amendments appear to have been done in an arbitrary manner, without a survey of extensive QME reports nor input from QME doctors.

Whoever is in charge of the DWC QME processing is more interested in cost savings than caring for injured workers.

John Finkenberg MD, QME May 10, 2018

I have been a QME for over 25 years and can tell you it would be impossible to derive a fair evaluation of a workers injury if I was restricted to 3 hours of medical history review. I have been willing to take on complicated cases as I know it is important to the worker and I will be fairly compensated. My colleagues currently refuse to participate as the work even with current reimbursement is arduous. I can star without question that the quality of our reviews will be significantly compromised if this amendment is adopted. Please realize that there are very few of us that are willing to do this very important work already.

Saravanan Ram DDS May 10, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

I have been a QME since 2010 and I have written high quality reports which have taken several hours of report writing time most of which involved my personal time over weekends and weekdays. Sometimes my report writing time has well exceeded 15 hours excluding research

time and record review time. Do not dictate my reports but instead type it up by myself. Please reconsider these regulations as moving forward with these new regulations is a huge disincentive for me to spend time to write high quality reports.

Alan Berkowitz, MD, QME May 10, 2018

The proposed changes to the Med-Legal Fee Schedule billing are unworkable. The changes will result in a substantial increase in unresolved claims and a significantly extended time frame before the injured worker is able to get back to work. Currently, the number of QME providers we have in the system has been decreasing and these new regulations will likely push many more of us to leave the QME process. This proposal arbitrarily puts a cap on report preparation and the use of research without concern for the quality of each med-legal report. Our reports are used to discover facts that are important to everyone involved in the evaluation, most importantly the injured worker. By trying to limit the report preparation to only three-hours, DWC must not have the data necessary to make an informed judgement because the majority of the cases could not meet that time restriction.

The proposed changes are not realistic for our industry and would result in less QMEs that will only be willing to take on the most basic of cases. Trying to cut corners to meet an illogical timeframe is not in the best interest of an employer, injured-worker, or any other stakeholder. DWC should pull back the proposed regulations and have an actual stakeholder process rather than jamming ill-conceived regulations through the process.

Todd Baldini. Regional Vice President May 10, 2018
ExamWorks

The proposed amendments to the Medical-Legal Fee Schedule <u>will</u> cause irreparable harm to injured workers in California and to a key component of the workers' compensation insurance system that exists to protect them. DWC is charged with continuing to look for ways to wring avoidable costs from the workers' compensation system, but without inflicting more harm on injured workers. DWC's proposed amendments fail on both elements of its charge and are inconsistent with the enabling statute, Labor Code section 5307.6. A brief overview of the arbitrary, unreasonable, and unnecessary proposed amendments and their inevitable consequences:

- The three-hour cap on report writing will result in inadequate reports and parties waiting even longer to resolve their disputes. The proposed limit will leave QME physicians with three options: (1) rush through the report writing process and produce inadequate reports, which will inevitably result in costly supplemental reports, depositions, and litigation; (2) exceed the three hour limit knowing they will not be compensated for the additional time and effort (highly unlikely); or (3) leave the system and seek more lucrative opportunities elsewhere.
- The stringent requirements on the medical research QME physicians may perform will only deter QME physicians from citing authoritative sources in their reports. The prohibition on QME physicians reviewing sources cited in reports in the preceding 12 months is particularly bewildering: setting aside the impracticality of QME physicians (let alone DWC) tracking which sources were previously cited and when, it discourages physicians from consulting, reviewing, and citing persuasive sources that further the cause of aiding the treatment and recovery of injured workers. The result will be QME reports that are largely devoid of references to relevant medical research.
- The proposed amendments unreasonably burden QME physicians with yet another responsibility: seeking and obtaining the written agreement of both parties—*before the actual evaluation*—that medical causation is a disputed medical fact. Even in the unlikely event QME physicians find a way to actually undertake and administer this responsibility, experience confirms that parties will not even respond to those efforts let alone provide the necessary consent in disputed cases. Asking QME physicians to act as arbiters of disputes over threshold legal and factual issues is well outside the bounds of what should be asked of physicians. In effect, this aspect of the proposed regulation is granting employers and carriers a de facto veto power of whether an applicant may use a QME to further dispute resolution.

As acknowledged in the research studies relied upon by DWC in developing the proposed regulations, QME physicians have been leaving the convoluted system, even with prior changes actually increasing financial incentives to stay. The proposed amendments—which further complicate the process and create a disincentive for the remaining QME physicians—will only hasten the ongoing attrition.

The existing regulatory regime for QME physicians is sound. QME physicians are already subject to competency examinations and renewal requirements, a labyrinthine fee schedule, scrutiny from bill reviewers, and the administrative oversight of DWC. The proposed amendments all but guarantee QME physicians—on which the workers' compensation system depends—will leave the system en masse. Those that remain and adhere to the changes effected with the proposed amendments will produce inadequate reports, and any hypothetical savings will be lost to the need for subsequent supplemental reports and depositions, and the costs that will result from the inevitable delays in resolving disputed claims.

Anonymous May 10, 2018

Consider adding language that requires the QME to bill under their direct corporate tax ID or social security number. They cannot use a 3rd party / management companies tax ID when billing a QME report. This will maintain transparency and accountability between the QME, management company and carrier.

Secondly add language that requires all duplicate and triplicate overage payments be returned to the carrier. I believe that many QMEs possibly pocket the duplicate payments. If written into regulations then it should keep the honest ones honest.

Michael Newman, D.C. May 10, 2018

I have reviewed and analyzed the proposed changes to CCR Section 9794 and CCR Section 9795 that DIR employee **[REDACTED]** has set forth.

I have prepared my response with my thinking that the DIR does want input from the medical-legal evaluators as well as from the applicant and defense attorneys, such that the problem of inappropriate billing of medical-legal reports can be solved.

I find the proposed changes go far beyond being not well thought out and irrational. I find specific sections of the proposed changes to be internally inconsistent. Those section are criteria 4 and criteria 5, cited below. I will discuss this internal inconsistency later in this response.

These proposed change go to what appears to be a denial of due process for the injured worker.

I begin this response by noting that I have 38 years of experience as a medical-legal evaluator and I am well versed on the correct billing procedures for medical-legal reports as set forth under CCR Sections 9795.

I appreciate that my responses to the proposed changes of CCR Section 9795 should be as brief and to the point as possible but the proposed changes are so arduous that my responses have to be more expansive.

Think of my responses as more akin to an ML-104 billing code than an ML-102 billing code.

I am not one to mince words and I am not one who tries to be politically correct.

The issue at had is the abuse of the ML-104 billing code by AME and QME medical-legal evaluators and **[REDACTED]** responses to this problem.

This billing code is comprised of 10 billing criteria very clearly set forth under CCR Section 9795.

I will go over the ML-103 and ML-104 billing criteria and comment on what I have observed in my rebuttal comprehensive medical-legal evaluations.

Criteria 1. Two hours of more face to face time.

Criteria 2. Two hours or more on records review.

Criteria 3. Two or more hours spent on medical research.

Criteria 4. Four or more hours spent in <u>any combination of two</u> complexity factors. This counts as two complexity factors.

I have set forth Criteria 4 due to proposed changes to CCR Section 9795 that are frankly non-sensical and irrational and are discussed later in this report.

Criteria 5. Six of more hours spent on any combination of three complexity factors.
This counts as three complexity factors.

I have also set forth Criteria 5 due to proposed changes to CCR Section 9795 that are equally non-sensical and irrational and are discussed later in this report.

Criteria 6. Addressing the issue of medical causation upon written request of the party of parties requesting the report, <u>or if a bona fide issue of medical causation is discovered in the evaluation.</u>

This last sentence, <u>or if a bona fide issue of medical causation is discovered in the evaluation</u>, is a major issue BECAUSE the face to face encounter is a fluid interaction between the IW and the evaluator and many causation issues are discovered during this fluid face to face encounter.

Criteria 7. Addressing the issue of apportionment. This is a complexity factor if the physician must evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region, or two or more injuries involving two or more body systems of body regions.

This criteria is very specific and exact.

Most of the QME and AME medical-legal reports that I rebut fail to meet the specific apportionment criteria but still cite apportionment as a complexity factor.

The primary issue that has spurred **[REDACTED]** in his quest to address medical-legal billing irregularities is the medical-legal evaluator's failure to meet all of the above CCR Section 9795

billing criteria required to justify the ML-104 bill code but still billing the evaluation under the ML-104 billing code.

If the above criteria is not met, it falls to bill review to deny the submitted bill or process the submitted medical-legal bill under the ML-103 or ML-102 codes.

Bill review can require documentation as to the time spent on review of medical records.

Bill review can require documentation as to the time spent on research.

The medical-legal evaluator can object to the reduction of the bill and proceed with independent bill review.

The medical-legal evaluator can then file a lien or a petition for costs and go before the WCAB and resolve the dispute.

The medical-legal evaluator can try to explain to the WCJ why he or she did research and for what purpose and can explain why it took 2+ hours to review a half-inch of medical records.

My point is that IF CCR Section 9795 billing criteria are followed by Bill Review, most of the problems with the inappropriate use of the ML-104 billing code will go away.

I doubt most of the abusers of the ML-104 billing codes want their day in trial to explain to the WCJ how they billed their medical-legal report.

Now on to the issue of the proposed changes to CCR Sections proposed by **[REDACTED]**:

The DIR recently settled with Howard et al. The issue was the underground regulations that **[REDACTED]** had applied to what he perceives makes up the CCR 9795 billing criteria.

[REDACTED] chose to interpret CCR Section 9795 NOT as it is written.

It was NOT his job to interpret the California Code of Regulations.

[REDACTED] has now been assigned to make changes to CCR Section 9795 and bring his personal interpretation of how the CCR Section 9795 should be written into how he wants it to be written.

I have reviewed his proposed changes on a line by line basis and this is my analysis:

CCR Section 9794. Subsection 3. **[REDACTED]** writes "No other charges shall be billed under the Office Medical Fee Schedule in connection with a medical-legal evaluation or report".

Comment: Medical-legal reports are NOT BILLED under the Official Medical Fee Schedule. They are billed under the Official Medical-Legal Fee Schedule.

CCR Section 9795. Subsection (d). **[REDACTED]** last sentence reads: "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".

Comment: This is a meaningless sentence.

ML101. Last sentence. **[REDACTED]** has added the sentence " No more than 3 hours may be billed for report preparation under this code.

Comment: A follow up re-evaluation often includes review of medical records. There is no limit to the quantity of medical records that the evaluator may be asked to review. An evaluator simply cannot discuss and review a large quantity of medical records, or a small quantity of complex medical records and address all the issues of causation, apportionment, periods of temporary total disability, period of temporary partial disability and how all regions of injury are most accurately rated with an imposed arbitrary time limit of 3 hours to prepare, edit, proof read and review a medical-legal report.

[REDACTED] has just made up an imaginary number for the time he thinks it should take to prepare a medical-legal report, unrelated to the complexity of medical-legal report preparation.

Each medical-legal evaluation is a unique case and the complexity of each case can vary greatly. The time spent to review whatever quantity of medical records that are provided, summarize those records, prepare the report, and review, edit and proof-read the report will rarely come to 3 hours.

Is it reasonable to expect the evaluator to review large volumes of medical records and summarize those records and spend all the time it takes to formulate and delineate a well-reasoned opinion in 3 hours?

The IW with a complex case will be unable to obtain a comprehensive medical-legal evaluation because the physician will soon learn they cannot work for free.

ML-103. **[REDACTED]** has inserted the sentence that the physician shall clearly and concisely specific which of the following complexity factors were "actually and necessarily incurred for the production of the medical-legal report and were require for evaluation, and circumstances uniquely specific to the actual evaluation being performed" which made these complexity factors applicable.

Comment: This language to vague. It is unknown by any evaluator what **[REDACTED]** means by "circumstances uniquely specific to the actual evaluation being performed"

Subsection 2. [REDACTED] writes: "An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed".

Comment: Labor Code 4828 (a) (2) already requires a review and summary of prior medical records but dose NOT require that the summary be placed within the body of this report.

The task of summary of prior medical records has no limit on the quantity of medical records reviewed. At times medical records can be 5,000 pages, 10,000 pages or more.

It takes many hours to review large volumes of medical report and it takes many hour to write up the summary of the review of medical records.

[REDACTED] has proposed a cap of three hours total time on preparation of a medical-legal report inclusive of review of any quantity of medical records.

The IW is tasked to prove his/her claim of industrial injury and residual impairment.

The evaluator will not be able to provide a report that addresses complex issues and requires significant time to review and summarize large volumes of medical records and provide a well-reasoned opinion within the allotted 3 hours that **[REDACTED]** has proposed.

Is it really conceivable that a medical-legal evaluator will spend 5, 10, 15 hours to review thousands of pages of medical records and summarize that review - yet be unable to bill for the time to provide a cogent summary of those medical records?

This goes to the issue of the IW being denied due process to prove his/her claim.

Subsection (3). Research. **[REDACTED]** states that the evaluator "explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue".

Comment: [REDACTED] has now raised the issue of a disputed medical issue as a basis for doing research. Research can be used to address the issue of need for future care. It can be used to address rating by analogy. **[REDACTED]** has now limited research as a complexity factor only to a disputed medical issue wherein research can and often is necessary to address other issues.

Subsection (4). [REDACTED] has stated that any complexity factor used as a stand-alone may not be used in combination under this subdivision.

Comment: This is a perplexing sentence. As this sentence stands a face to face encounter at two and a half hours is a stand-alone factor. Review of records at one and three quarter hours is not a stand-alone factor. The time 2.5 hours and 1.75 hours comes to 4.25 hours but since the 2.5 hours is a stand-alone factor there can be no two complexity factors.

Subsection 4 allows combining only two factors. If either complexity factors is 2 hours or more it counts as a stand-alone complexity factor and cannot be used.

If two complexity factors are each less than two hours they do not count as a stand-alone complexity factor BUT also cannot add up to the threshold of 4 hours or more.

Get It? You cannot add less than 2 and less than 2 and get 4 hours or more.

I will state this again so the point cannot be missed. If face to face time is two hours or more and review of records is less than two hours, or research is less than two hours there would be only one complexity code.

Subsection (5). This section allows for three complexity factors for any combination of face to face time, research or review of records, BUT notes than any complexity factor that is used as a stand alone factor cannot be used in combination in this section.

Comment: This means that if face to face time or review of records time or research is two hours or more, then three complex factors cannot be used.

The same math applies. Research at 1 hour and 59 minutes is not a stand-alone complexity factor and review of records at 1 hour and 59 minutes is not a complexity factors BUT if face to face time is 2 hours and 2 minutes, which makes for 6 hours total, the face to face time cannot be used because it is a stand-alone complex factor. Face to face time would have to be less than two hours to NOT be a stand-alone complexity factor.

Same as the above section: Less than 2 hours and less than 2 hours and less than 2 hours is less than 6 hours.

Based on this language there are no combinations of face to face time and/or review of records, or research that will come to six hours or more, and count as a 3 complexity factors, since any of the factors at two hours or more is excluded. This simply means that there cannot be any combination of these factors that comes to 3 complexity factors.

Section (6). Addressing medical causation, **[REDACTED]** proposes that the physician and the parties agree prior to the start of the evaluation that the issue of medication causation is a disputed medical factor.

Comment: As noted earlier in this response, the issue of medical causation is often discovered during the medical-legal evaluation. The applicant attorney or the defense attorney may raise this issue in a cover letter to the QME or AME. As this language now stands no carrier will ever agree to the issue of addressing causation as a complexity factor. This again goes to the issue of denial of the IW due process to prove his/her claim.

Section (7). Apportionment. **[REDACTED]** has taken the current language of three of more injuries to the same body system or body region and changed it to three or more dates of injury to the same body system or body region.

Comment: This means that for the IW that cannot recall the date of any prior injury, this complexity factor cannot be used.

[REDACTED] has also taken the current language of two or more injuries to two or more body regions or systems and changed it to two or more dates of injury to the same body system or body region.

Comment: Again, this means that for the IW that cannot recall the date of any prior injury, this complexity factor cannot be used.

Based on this change in language any IW that has suboptimal recollection of any prior dates of injury limits the evaluator from billing for this complexity factor.

Section (7) (B). **[REDACTED]** now limits apportionment as a complexity factor if the IW is not at the maximum medical improvement.

Comment: Apportionment is likely the most complex issue in a medical legal report. The current CCR 9795 criteria does not require that the IW be at the MMI in order to address apportionment.

Cases are often settled after the applicant has seen the QME or the AME, and prior to a determination that the applicant is at the MMI.

Apportionment is a major issue for all the parties and can certainly be addressed as an issue before application of specific percentages of impairment are applied.

The only issue of apportionment for which the applicant must first be at the MMI is the determination of the exact percentages and an explanation of how those percentages were determined.

ML-104. The changes to this section include all the changes to the ML-103 complexity factors and adds that no more than three hours can be billed for report preparation.

Comment: This means that for a complex case with around 1,000 to 5,000+ pages of medical records and medical-legal issue to address, to include a summary of those 1,000 to 5,000 pages of medical records, and likely 10-15 hours of report preparation, that the evaluator is limited to billing only for 3 hours for report preparation.

ML-106. This changes to this section adds that for a requested supplemental report, that no more than three hours can be billed for report preparation. This also includes complex cases with

around 1,000 to 5,000+ pages of medical records and medical-legal issue to address, to include a summary of those 1,000 to 5,000 pages of medical records, and likely 10-15 hours of report preparation, that the evaluator is limited to billing only 3 hours for report preparation.

Comment: This means that for a complex case wherein the IW is not seen but with around 1,000 to 5,000+ pages of medical reports and medical-legal issues to address, to includes a summary of those 1,000 to 5,000+ pages of medical records, and likely 10-15 hours to report preparation, that the evaluator is limited to 3 hours for report preparation.

[REDACTED] has provided his opinion how the CCR Section 9795 regulations should be re-written.

Causation is out as a complexity factor.

Apportionment is out as a complexity factors unless the applicant is at the MMI.

Combination of two complexity factors that together come to 4 hours or more is out.

Combination of three complexity factor that together come to 6 hour or more is out.

Review of medical records and the time to summarize all those records, regardless of the amount of the records reviewed is now capped at 3 hours, and those three hours must include addressing all the other issues that comprise a medical-legal report.

Given **[REDACTED]** proposal that any complexity factory that is a stand-alone may not be used in combination under sections (4) and (5), and with causation and apportionment no longer billable complexity factors, this literally ends the use of the ML-103 and ML-104 billing codes.

The IW with anything more than a simple case can no longer obtain a comprehensive medical-legal evaluation to prove his/her claim and thus loses his/her right to due process.

These proposed changes effectively render almost all medical-legal evaluations billable only as ML-102.

This will likely collapse the system as the evaluators discover they are now working for free for most of the time they put into the evaluation of the injured worker.

If the goal is to end all medical-legal evaluations payable over the ML-102 rate, drive the applicant attorneys out of business, drive the defense attorneys out of business, drive out most of the workers' compensation judges from their jobs and deny the IW a fair and equitable evaluation of their claims, this is a perfect final solution.

I am aware that there is a problem with medical-legal evaluators not following the billing criteria under CCR Section 9795.

I do not think these proposed changes are the answer.

The proposed changes will result in much greater problems for our workers' compensation system than the problem of physicians overcharging for their medical-legal reports.

I think the answer lies in CCR Section 9795.

Causation should always be a complexity factor and there should be no need for any party to request it be addressed.

Face to face time needs to be documented with start and stop times, signed under penalty of perjury.

Review of records also needs to be documented, also with start and stop times, signed under penalty of perjury.

The same goes for research BUT the physician needs to explain the purpose of each cited research document and discuss each document that is researched and how it applies to the issues the evaluator is addressing.

Apportionment needs to be a complexity factor but I see no need for it to include three employers.

The issue is the region of injury and if it was injured in the past or re-injured after the industrial injury. Hence the criteria of three or more injuries to the same region or body system needs to be changed to two or more injuries to the same body region or body systems.

If the IW never suffered any prior injuries to the same body region or system and never suffered any subsequent injuries to the same body region or system, then apportionment is out as a complexity factor.

Stopping the abusive use of research and stopping the abuse use of apportionment as complexity factors will address most of the current billing problems.

The solution lies in bill review demanding the physician documents the work performed.

Any physician that feels bill review is wrong to cut his/her bill should be required to file a petition for costs and face a workers' compensation judge. No lien representative. The Doctor should appear and tell the WCJ why it took him/her over two hours to review a handful of documents and why he/she spent 2 + hours on research that had nothing to do with his/her opinions and conclusions.

This stops the problem.

Anonymous May 10, 2018

In addition to my previous message, I see three main cost drivers in the QME system. They are the following:

1. Depositions by the parties during which when one party that does not like the report will do their best to impeach the QME on minor details.
2. Unpredictable amounts of records and cases that can go on for years. We may be asked to do evaluations or supplemental reports years after seeing the person.
3. The parties using other doctors involved in the case to undermine the opinion of the QME. Sometimes these turn into personal attacks.

All of these significantly increase the length, depth and complexity of reports. This is a significantly antagonistic process and any one of these pitfalls can lead to the QME's opinion not being considered substantial medical opinion. You have basically designed a system that requires these kind of reports.

Adam Kremen, Ph.D., QME May 9, 2018

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.

My first concern is the proposed revision in the rules for ML101 and ML 104 billing limiting billing for report preparation to 3 hours at most. There are two reasons to hold grave misgivings regarding this proposed regulation. These follow from the fact that it is impossible to write a report that has complexity factors in 3 hours or less and do 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 suggestions 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, symptoms, current and pre-morbid psychological functioning, to name a few, as well as a review of medical records and objective testing. As many have argued on this forum, 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 than it will be more. Thus, one major problem with the proposed revision limiting billing for report preparation to no more than 3 hours is that QME's who take the necessary time to write an adequate and legally useful report will be unfairly compensated. The second problem is that this proposed revision will pressure QME's to cut corners and thereby produce inadequate reports. As many have noted, this 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.

Another concern regards the requirement that "the physician and the parties agree, prior to the start of the evaluation," either for using medical causation as a complexity factor (including whether medical causation is a disputed fact essential to the adjudication of the claim) or for claiming that that the evaluation involves extraordinary circumstances (in which case "any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request").

In the case of causation, what will happen if an agreement prior to the start of the evaluation with the parties (does this mean both parties?) is not received, yet medical causation is found to be a disputed fact? It appears that in this case the physician will not be able to bill for complexity factors even if the report requires a complex and time-consuming analysis to be adequately rendered. More generally, the requirement that the parties agree around a complexity factor appears to place an extraneous and not pertinent demand on the definition of this complexity factor. The definition of complexity should rest on factors of the evaluation, not on whether or not there is an agreement between parties at a time when all the parties may not be in possession of the facts.

In the second case, I am worried that in many if not most cases the requirement to articulate the "factors of extraordinary circumstance" before the evaluation is conducted will be impossible to meet. Some of the hurdles to this requirement include 1) in some cases attorneys' letter are not received before the evaluation; 2) in some cases medical records are not received before the evaluation, and; 3) in almost all cases, it is highly unlikely that the "factors of extraordinary circumstance" will be known before conducting the clinical interview. I speak here mainly for psyche cases. It is often only in the evaluation that many of the issues of apportionment that may occur in a psyche case can be discovered.

There is a requirement in the proposed revisions that forbids QMEs to refuse to perform an evaluation on the basis that they did not receive authorization to use the causation complexity factor or to bill under ML104(3). When there are problems receiving authorization for billing for complexity yet the completion of an adequate report is time-consuming, this requirement along with the requirements for authorization may lead to further erosion in the value and usefulness of QME reports, with all the additional inefficiencies described above.

John MacDonald Stalberg, M.D., J.D. May 9, 2018

Many of today's applicants are much older than just 10-15years ago. There is a more complex, convoluted history--many employers, many injuries and surgeries, internal medical disorders, and more prior litigated WCAB cases.

The applicants have lengthy important family histories-multiple spouses, many children and grandchildren who have all sorts of health problems-illnesses, incarcerations, and death.

There are more hospitalizations, traffic accidents, and personal lawsuits.

The days of the average 25 year old applicant with no prior significant medical or legal history are long gone.

The average medical file is very large, taking much longer to comment on in the report.

Chris Rapoff, DC May 9, 2018
Chiropractic Works

I have had the opportunity to review the DWC's regarding the changing rules complexity factor determination in our QME reports, and I am confused as to what you are trying to accomplish... If you still require a report that qualifies as a substantial medical opinion, these changes just will not work.

1. The matter of causation: Why, why, why put this option to the discretion of the parties and not the examiner? Prior written authorization for the complexity factor is just crazy. Are you going to guarantee that the parties will respond to our request in a timely manner?

2. We already have a difficult time trying to comply with the requirement for Diagnostic Imaging. Again, we have to rely on an imaging firm to actually read and respond to our imaging requests... it just does not happen in a timely manner. Who is held responsible? The examiner...

3. The fact that "6 or more hours" or any combination of ANY OF THE THREE COMPLEXITY FACTORS is just asking for trouble. In a musculoskeletal exam involving 6+ body parts (CT injuries... all too common nowadays), I easily spend 4-5 hours face-to-face time PLUS anywhere from 2-6 hours records review. This should easily qualify for 3 complexity

factors. Now, you are going to force us to find an obscure condition/symptom/imaging finding to provide 10 minutes of research... Is this really worth it? What does that prove?

4. Finally, report preparation time reduced to 3 hours... I could probably comply IF I went from the Review of Records directly to the DISCUSSION section. That way, the actual particulars (with all examination findings) of the exam can be omitted here and just requested in a Supplemental Report if the parties have a desire to review them.

In summary, I didn't mean to be sarcastic with my points above, but put yourself in our position... what you are proposing are just NOT doable for QME's. You will be losing those of us who provide a quality medical report with qualifies as a substantial medical opinion

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Vlad Gendelman, MD, QME May 9, 2018
Orthopaedic Surgery

This letter shall serve to bring to your attention the matter revolving the *Official Medical Legal Fee Schedule*. After having reviewed the proposed changes to the medical legal fee schedule, I have noticed a concerning change that would gravely effect the manner in which QME's would treat and service patients.

In regards to using *causation* as a "billing complexity factor" under ML103 Factor 6, the current rule states that causation may be used as follows:

(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjustment of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

The problem in the proposed mandated is that, "the parties agree prior to the start of the evaluation that the issue of medical causation is disputed medical fact…" However, the applicant, defense attorneys, and claim administrators have no legal mandate that requires them to specify prior to the evaluation what medical facts are in dispute that has necessitated the QME evaluation. In fact, there is no legal mandate that requires the parties to even provide the QME with a charge letter or instructions prior to the evaluation.

If the changes were to remain in effect, then the QME is left to communicate with both parties to find out what medical facts are being disputed and, specifically, if causation is in dispute. As previously stated, due to the fact that there is no legal requirement enforcing the parties to respond to the QME's request, more often than not both parties will not respond to QME's request, this leaves the QME with the responsibility of evaluating what is *causation*.

Moreover, this is further proven when; one party will ask the QME in regards to causation "if the biomechanics of the claimed injury are consistent with the claimed injury," or if a party tells the QME in a multi-body part claim that only certain body parts have been accepted but not others have been accepted by the other party. Such dispute inevitably leaves the QME with having to address an obvious *causation* problem or dispute with regard to the body parts not being accepted by the claims administrator or the defense.

Furthermore, the claims administrator or defense is not a neutral party to the case, and would likely not provide a written agreement in advance that causation is in dispute, because it would not be in their financial interest to do so.

Based on my professional experience, I believe it is quite evident that the proposed rule of having a QME submit an analysis of medical causation prior to treatment is largely impossible to accomplish given the circumstances. The change places a significant burden upon the QME, who is often stuck with having to make significant *causation* determinations in a claim without any legally required cooperation by the parties.

The proposed language would gravely effect how QME are seen and must be changed.

Additionally, it is my opinion that the 3 hour limit to report preparation time for ML 101 and ML 106 is not sufficient. There are incidents when copious records are provided and additional time is required for thorough report preparation. I am currently working on a file in which over 3000 pages of records were provided for a ML106 report. In this instance, it would be impossible to complete the report in 3 hours, as proposed by the new changes. It has been my experience that with complex cases (multiple body parts injured, multiple dates of injury, previous work comp injuries, etc.) accumulate multiple records, which requires time to provide the most appropriate recommendations

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Mason Bledsoe, Applicant's Attorney May 9, 2018

These changes will lead to unintended consequences. These changes may not survive judicial scrutiny.

Injured workers have the burden of proof to show that they should receive benefits in the workers' compensation system. LC 4620 defines ML expenses as expenses incurred by workers to prove their claim. 4621 says that workers get reimbursed for expenses reasonably, actually, and necessarily incurred.

This requires a case by case analysis of the charges. Blanket regulations will violate these rules. I propose adding to the changes that these charges are rebuttably presumed reasonable.

3 hour limitation

Many doctors apparently bill far in excess of what would otherwise appear reasonable to the case at hand. We need something to deal with that – however this seems like using a nuclear weapon when a scalpel would suffice.

Under these changes if a doctor has a more complex case, or if for whatever reason they hit the three hour mark, they then either work for free (unlikely) or they just stop writing.

Remember workers have the burden of proof.

ML reports are the primary tool they have to meet their burden. This limitation will mean some workers cannot get the evidence needed to prove up their claim because as stated above the doctor stops writing at three hours.

The regulation should make these charges rebuttable as that solves the problem.

Agreement

Why would the carrier ever agree to allow the doctor to discuss causation in a consequential injury circumstance? If carrier accepts the arm and the worker gets problems with the opposite arm the doctor must explain causation or the worker loses that issue. The carrier obviously would prefer that the doctor did not discuss that body part or region so why would they ever agree? The workers' right to evidence can't be predicated upon the agreement of the carrier.

Unless the suggestion is that the doctor must do it for free, which they won't.

Fees in General

9795 was put in in 1993. Prior to that, there was a flat fee schedule, where for example in 1989 for an orthopedic evaluation was 1025 or 1001. In those days however the table made it clear these amounts were *rebuttably* presumed (emphasis in original) Table 12, Matthew Bender Workers' Compensation laws 1992.

In the bay area where I practice the median home price for a 3 bedroom home was $268,100 in 1993. Nearly 25 years later this regulation apparently wants to give evaluators a significant paycut. We already have case after case where no evaluators are available within the statutory time frame. In my local area I am not familiar with even one new, young, orthopedic surgeon QME. I can name off the top of my head 10 QMEs who have not treated a patient for 20 years and have birthdays preceeding World War II. How long will we have them?

Research

Some doctors abuse the research factor but that should be dealt with on a case by case basis. Let's imagine a case where an internist had to research something just under a year ago. They don't remember what they learned, or they think perhaps new studies have come out. Shall the evaluator make it up? Perhaps delay the report a few weeks so they can research it again?

Realistically if the doctor needs to research something everyone wants him to research it. The report is worthless without it. Some doctors overcharge and that is a problem – but insubstantial reports cost the system far more than a few bad apples.

Again I think the problems I outlined here mostly could be fixed by making it clear that these charges are rebuttable with WCAB jurisdiction reserved in case of dispute.

Tigran Garabekyan, M.D.
Board Certified Orthopedic Surgeon
Sports Medicine and Joint Replacement
Southern California Hip Institute

May 9, 2018

I am a board-certified orthopedic surgeon and am fellowship trained in hip surgery. I have been a QME since 2015.

Before discussing the proposed fee schedule, I would like to comment on the CURRENT fee schedule. The reimbursement of the fee schedule as it stands today is woefully inadequate. The upper limit that I as an orthopedist can earn to serve as a QME is $250 per hour. I understand that this has not changed since the fee schedule was introduced in 2006. This is absurd. I can think of no other industry in which a professional's fees are not adjusted over the course of twelve years to account for inflation. During the past 12 years, doctors' costs have risen but reimbursement has not. While the top amount QMEs can earn of $250 per hour has NOMINALLY remained constant, the reality is that the REAL dollars earned per hour has been eroded away due to inflation. This has meant a reduction in real dollars earned by the physician. In the 12 years from 2006 to 2018, there has been a total inflation of 26%. That means that QMEs should be reimbursed $315 per hour now in order to be compensated the same amount as $250 in 2006.

Further, over the past 12 years, everyone else in the system has had their income adjusted to reflect inflation. Attorneys are free to set their rates and insurance carriers modify their premiums charged to reflect inflation. I would be surprised if anyone at the DWC is earning the

same amount that they were earning in 2006. But somehow QMEs, the expert physicians that the system relies upon for swift and impartial adjudication of claims, are supposed to tolerate earning the same amount in 2018 as in 2006 which is actually a massive erosion in real wages.

Contrast this with what expert witnesses make in other, non-QME markets. I routinely serve as an IME (Independent Medical Examiner) in auto insurance and general liability claims. My hourly rate in that market is over $700 per hour. I know several orthopedists who charge over $800 per hour. Spine specialists and neurosurgeons charge over $1000 per hour. These cases are much simpler than worker's compensation cases. There aren't issues with case laws like Almaraz-Guzman and Escobedo, there's no apportionment analysis, and there's no DWC waiting to deny you reappointment or claim that you are misbilling everything under the sun. This is the real reason why the QME system is in such a crisis. Decent orthopedists would much rather do medical-legal work in the civil litigation world than worker's compensation. This is why you see bright, articulate, and young orthopedists in civil litigation whereas most orthopedic QMEs are generally at the tail end of their career or retiring. The DWC really needs to think about how they are paying doctors (and treating them for that matter) if they want to attract an adequate number of qualified orthopedists.

Now, let's look at the proposed fee schedule changes. There is no doubt that the effect of these changes will result in a FURTHER REDUCTION of QME's income, and the situation becomes even more untenable. QME orthopedists are currently an endangered species. If these changes go into effect, they may well become extinct. Having reviewed the DWC's proposed changes to the medical-legal fee schedule, I feel compelled to express SERIOUS CONCERNS regarding the future of QME evaluations and my involvement in the system.

First and foremost, the requirement to have ALL parties 1) agree that causation is in dispute AND 2) agree that the QME may use causation as a complexity factor for billing purposes is prohibitively cumbersome and serves no one. We typically receive only one cover letter for most cases and often the parties have little interest to find common ground on most issues at hand. While the parties may quickly return phone calls when the DWC is on the line, the DWC must realize that the parties are too busy to respond to these sorts of pre-authorization requests the DWC is suggesting. Additionally, I have been advised by several carriers that their internal policies do not allow them to sign pre-authorization agreements.

The bottom line regarding the new causation complexity factor is this: the DWC is creating a roadmap for the parties to **require the QME to do extra work for free**. Here's how they do it. The parties 1) agree that causation is at dispute, 2) agree that the QME has to address and analyzing this issue and then 3) either party simply has to decline authorization for the QME to use causation as a complexity factor. What a sweet deal for the carriers! They now have the option of having doctors do more work for a) more money or b) for free. We may not all have PhDs in mathematics but I think we can guess which choice most carriers will make.

The provision to limit the time for report preparation to 3 hours will discourage QME's from spending the appropriate amount of time on complex cases and limit the scope of evaluations. If

I were an employer, I would be very worried about this one. Why? Because capping report preparation at 3 hours will **discourage QMEs from discussing apportionment.** Apportionment is probably the most complex part of each evaluation. It is also usually the last topic addressed by the physician. If a QME physician has hit 3 hours of report prep and still has to write the rest of the report, then they will not want to work for free and will speed through the rest of the report. Instead of writing a well thought out apportionment analysis, I predict seeing a lot of reports that merely state, 100% of the disability is industrial. That is the easy way out and the burden of proof is on the defendant to show apportionment. Employers and carriers might end up saving pennies by having shorter QME reports but they will lose real dollars in foregone apportionment.

Another common issue in the QME industry is the declining quality of reports. I see conclusions without an explanation of rationale, apportionment without consideration of nuances, and failure to address issues not strictly listed on the claim form. It is questionable whether these reports constitute substantial medical evidence. Poor report quality significantly limits the parties' ability to resolve disputes. Rather than proposing a more stringent fee schedule that is only going to make underpaid QME's get even less reimbursement, I suggest that the DWC consider increasing fees to market rates in order to attract physicians who will write higher quality reports.

Stephen Dell, M.D. May 9, 2018

I am a California-licensed physician (Neurosurgeon), actively treating both injured workers and the general adult population, specializing in spine and with a significant Workers' Compensation evaluation practice as well (AME, QME, IME, consultations, etc.).

I write in regard to the proposed QME Medical Legal Fee Schedule Changes.

Several comments are germane:

1. There has been no cost-of-living or other increase for medical-legal evaluations since 2006.
2. There is no data available regarding the time required across specialties for complex evaluation report preparation. Psychiatric, complex neurological, complex medical and other such cases must require much longer preparation time, but no information is presented upon which the DWC will base its restrictions.
3. There is no requirement that the parties 'reasonably agree' or even respond to the pre-authorization request for ML104(3)s cases. This ensures – as no doubt, it is intended to – that such case designations will cease to exist.
4. The requirements governing the use of the causation complexity factor are ambiguous and unworkable, seemingly designed to ensure the practical impossibility of employing this factor. The need for a causation evaluation is implicit in the denial by the insurance

> or defense party of any claim or part thereof. The award of any permanent impairment (total or partial) requires causation of injury and/or disability to be present: thus it is 'essential to the adjudication of the claim for benefits.' To ask that the parties agree that 'the physician may use causation as a complexity factor for billing purposes' suffers from the same weakness as the 'extraordinary circumstances' requirement (see: 3., above).

These constitute by no means the entirety of the illogicality, unworkability and impracticality of the proposed changes. The independent assessment of work injuries and the fair assignment of benefits requires a revision of the Medical-Legal Fee Schedule that will preserve its originally embodied ruling principles: that payment should track the complexity of the medical-legal problem(s), for which time spent is the most appropriate surrogate indicator.

Lauren Papa, D.C., Q.M.E., I.M.E. May 9, 2018

I have been an active medical provider in the California workers compensation arena for the past twenty years, in the capacity of either a primary treating physician (PTP) or panel qualified medical examiner (PQME). I have reviewed the proposed changes for PQME fee schedule. The following are my comments:

REPORT PREP TIME:

The proposed time cap for a PQME to issue an appropriate and objective supplemental report is not fair to the PQME, nor is it appropriate to enforce when the parties are asking the PQME to provide informed opinions on numerous issues.

As the parties are aware, the job of the PQME is to perform an objective examination, review available medical records, review the injured worker's history of injury, job duties and medical history, and then correlate this information with the objective findings of the physical examination and diagnostic studies.

For the DWC to impose time restrictions limits the PQME's ability to do his/her job in opining on the issues in supplemental reports. These issues include, but are not limited to: MMI, apportionment, causation and impairment. Each case is individual and requires individualized periods of time on different issues and there is no way to predict which claims will require more research or review.

CAUSATION COMPLEXITY FACTOR:

According to the proposed changes, in order for a PQME to address issues of Causation, there are four requirements have to be met, including the agreement of the parties, including agreement of

all parties on the dispute of the facts and complexity factors. The whole point of a PQME is to decipher the disputes as pertains to the claim.

To require the PQME to procure the agreement all parties in order to provide a medical-legal report is defeating the purpose of the exam. Each applicant is individual and each claim has its own set of complexities.

How is the PQME expected to get all of the parties to agree on the complexity factors of Causation when the reason for the PQME is *because* the parties are not in agreement in regards to Causation in the first place?????

In the case of some injured workers, there are a myriad of complexity factors such as pre-existing, non-industrial illnesses that may or may not have been exacerbated by the work environment, or may/may not affect the injured worker's ability to procure treatment.

PQMEs REQUIRED TO PROCURE AUTHORIZATION FOR DIAGNOSTIC STUDIES:

Again, the primary goal of any PQME/AME *should* be to assist all parties, including the injured worker, in moving the claim toward resolution.

The only way this task can be accomplished on the part of a medical provider is to properly work up and diagnose an injured worker's injuries and then provide a treatment plan.

NO examining doctor, not a medical-legal examiner, not PPO/HMO provider, not a Medicare or Medi-Cal provider should be restricted in his/her ability to refer a patient for a medically appropriate diagnostic work-up.

Without access to diagnostic x-rays, MRI, ultrasound, CT or electrodiagnostic studies, there is no way an examiner, much less a PQME (medical-legal), can address issues such as MMI, apportionment, causation, whole person impairment or future medical treatment. It is unfair to expect any doctor, to opine on treatment blindly and without access to diagnostic tools.

Sometimes, for whatever reason, there are delays in procuring authorization for treatment or diagnostic work-up. Other times the requests are flat out denied, even in the medical-legal arena.

The ability to refer a patient for appropriate diagnostic work-up in order to recommend a treatment plan should be the right, (not a privilege) of any medical provider, especial a PQME. In my experience, when there are delays in procuring authorization for something as basic as diagnostic work-up, an injury that initially should have required relatively conservative treatment in the form of epidural injections and physical therapy, (for example), results in surgical intervention. It is also my experience that a delay of appropriate diagnostic work-up results in a need for a more invasive surgical intervention than what should have been required if there had been no delay.

The consequences to the employers/carriers are stagnant claims and prolonged TTD. The consequences to the injured worker can be catastrophic.

On the other hand, sometimes there is really no need for and injured worker to undergo medical treatment. Diagnostic studies can reveal evidence of pre-existing or non-industrial injuries/illness that assist the examiner in opining on issues of causation and apportionment.

In order for a PQME (or any medical provider) to appropriately opine on the issues at hand, we have to have access to reasonable diagnostic work-up without waiting for authorization.

Additionally, PQME has to wait for authorization for diagnostic studies to rule out a need for treatment, and for whatever reason the authorization is delayed or denied again, an MMI report is issued later than what should have be anticipated and the claim lasts for an unnecessarily prolonged period of time.

If the PQME is unable to procure authorization for diagnostic work-up the applicant attorney will likely file a DOR with the Workers Compensation Appeals Board (WCAB). All this does is cause an unnecessary back up at the WCAB and unnecessary delays.

In my experience, this is reason that a claim, which *SHOULD* last only for a few months to slightly over one year, remains open for years, for no good reason.

MEDICAL RESEARCH RESTRICTIONS:

To forbid a PQME from using the same research material on more than one occasion during a twelve month period is unpardonable. Many PQMEs do use research materials in order to issues some reports. For example, sometimes we have to research the effects of a pre-existing, non-industrial illness such as Multiple Sclerosis, diabetes mellitus (NIDDM & IDDM), rare congenital anomalies, etc., as pertains to the industrial injury(ies). For the DWC to require PQME to research more articles only results in more time spent on subsequent reports, unnecessarily.

In summary, when the concerned parties request a medical provider to perform a medical-legal examination and subsequently issue report, it is unreasonable to require the examining physician to literally *jump through hoops* in order to address the issues.

As the parties are well aware, the reports issued by any PQME/AME can affect an injured worker's ability to resume their job or at least re-enter the job market in whatever capacity. A report issued by a PQME/AME can also affect an injured worker's ability to procure reasonable medical treatment and resume their pre-injury personal and professional lives. Like many PQMEs, I take this responsibility very seriously. Therefore, I spend a lot of time on each PQME report issued from my office. For the DWC to impose more restrictions can have even more devastating effects on an already complex system.

Emile P. Wakim, MD
Pacifica Orthopedics

May 9, 2018

Members of the DWC, the COA has notified me and its other members of orthopedic surgeons regarding a proposal to change the Medical-Legal Fee Schedule in ways that would significantly and adversely affect all QME's and AME's performed in the state of California.

As you are undoubtedly aware, California legislators and other bureaucrats have recently made proposals regarding the provision of medical treatment going so far as to recommend a single payer system in California to manage costs. No one in Sacramento has considered the enormous costs incurred through big, corporate entities like "Big Pharma", medical goods/instruments suppliers or the ever-greedy Insurance companies themselves.

If the proposed changes to the ML system occur, an already poorly-reimbursed Medical-Legal QME/AME system will likely implode. There will no longer be even a modest incentive to perform this often rigorous, frequently frustrating and definitely time-consuming work for the good of ALL parties involved. I fear that a great deal, if not nearly all, physicians will stop performing these examinations given the currently modest financial reimbursement present. Already, California has a reputation for being the worst or near the worst state in the union for physician reimbursement for these medical-legal examinations. At meetings it is frequently discussed that the system is in serious need of a serious fiscal boost of payments to physicians to retain the physician talent currently participating and, yet, a proposal is placed to further decrease any incentive to perform these examinations.

I urge you to strongly consider dropping the proposal and instead perform the following...

1) Sharply curb the outlandish and very expensive use of Utilization Review in worker's compensation treatment that significantly delays the care of the injured worker and costs more to the system than treatment of the injured worker itself.

2) Bring our ML fee schedule up to 2018 levels (consistent with the corresponding inflation) since it has not been increased since 2006.

3) In cases of disputed care, I also recommend earlier use of a Panel QME or AME in order to concisely and accurately render an appropriate treatment plan. Oftentimes, the QME or AME has only been used after a great delay in care and/or over-utilized care many months or years removed from the industrial injury in question.

I hope you find this email to be not only sincere but helpful to make an appropriate decision regarding a critical aspect of governance for the treatment of the injured worker. I fully support

changes to the system but, I firmly oppose the proposal to the ML fee schedule in front of the DWC currently.

Anonymous QME May 9, 2018

I propose the following changes for consideration, my proposed additions are in gold, and deletions are ~~struckout~~:

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

(a) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each evaluation is calculated by multiplying the relative value by $15.00~~$12.50~~, 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 and the time required to review the records provided are ~~is~~ the dominant factors determining the appropriate level of service under this section; the time~~s~~ to perform procedures and testing is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service. 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.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

CODE	*B.R.*	*PROCEDURE DESCRIPTION*
ML100	5	~~*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.~~ *Missed Appointment or Appointment Cancellation within 14 days of the evaluation for a comprehensive or Follow-Up Medical Legal Evaluation.* The physician shall be entitled to bill for missed or late cancelled appointment as 8 units at RV-5, or his or her usual and customary fee, whichever is less, for each quarter hour. In addition the physician is entitled to bill in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour for any time spent reading/reviewing/summarizing records prior to written receipt of the cancellation notification.
ML101	5	*Basic Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation which occurs within nine months of the date on which the prior medical-legal evaluation was performed, entails records consisting less than 100 pages, and only records from treatment provided during the interim nine months. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than 3 hours may be billed for report preparation under this code.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML102	50	*Basic Initial ~~Comprehensive~~ Medical-Legal Evaluation*. ~~Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.~~ Includes evaluations which require less than 1 hour face to face time, involve fewer than 100 pages of records, in which neither party disputes causation, and involves injury to a single body part or region.

CODE	*RV*	*PROCEDURE DESCRIPTION*
ML103	75	*Comprehensive Initial or Follow-Up Medical-Legal Evaluation*. Includes evaluations which do not meet the requirements to be a ML102 Basic Medical-Legal Evaluation and require three or fewer of the complexity factors set forth below. ~~require three of the complexity factors set forth below.~~
		In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were ~~actually and necessarily incurred for the production of the medical-legal report and were~~ required for the evaluation~~, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation~~. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon:~~
		(1) Two or more hours of face-to-face time by the physician with the injured worker;
		(2) Two or more hours of record review by the physician. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;
		(3) Two or more hours of medical research by the physician, using sources that are not routinely cited by the evaluator on the basis of diagnosis, treatment, or type of report. ~~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 this complexity factor.~~ An evaluator who specifies this complexity factor must also (A) ~~explain in the~~ incorporate the research into 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~~. All criteria except the amount of hours must also be satisfied to

		use medical research in combination under subdivision (4) and (5) of this code;
		(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors~~, provided that some portion of time has been devoted to each of the three factors.~~ Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(6) Addressing and providing an analysis of the issue of medical causation.~~, upon written request of the party or parties requesting the report~~ Causation is presumed to be in dispute unless all parties agree and stipulate in writing prior the start of the evaluation that medical causation is not in dispute. ~~physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation~~;
		(7) Addressing the issue of apportionment, when one of the following conditions applies: ~~items (A) and (B) below both apply:~~ ~~(A) The~~ ~~determination of this issue requires the physician to evaluate and provide an apportionment analysis of~~ (i) the claimant's employment by three or more employers, (ii) three or more dates of injury~~ies~~, whether industrial or non-industrial, to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more ~~or more~~ dates of injury~~ies~~, whether industrial or non-industrial~~,~~ involving two or more body systems or body regions as delineated in that Table of Contents. ~~The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published~~

		~~by the American Medical Association, 2000, is incorporated by reference.~~ ~~(B)~~ ~~The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.~~
		(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
		(9) The evaluation is being performed by a Qualified Medical Evaluator or Agreed Medical Evaluator.
		~~(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.~~
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML104	5	*Complex Comprehensive Initial or Follow-Up Medical-Legal Evaluation* The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for face-to-face time, record review, medical research, and report preparation:
		(1) An evaluation which requires four or more of the complexity factors listed under ML 103. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were ~~actually and necessarily incurred for the production of the medical-legal report and~~ required for the evaluation~~, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon 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.~~ ~~-~~
		~~(1) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician. 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;~~
		(2) A comprehensive medical-legal evaluation for which the physician and the parties agree in writing within 5 business days of the date of evaluation or the receipt of the applicable records, ~~prior to the start of the evaluation~~, that the evaluation involves extraordinary circumstances. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. The request by the physician may be served on the parties by facsimile. If a party does not respond to the request by 5:00 PM Pacific Time, on the 5th business day following receipt they are deemed to have agreed that the evaluation involves extraordinary circumstances. When billing under this subdivision of the code for extraordinary circumstances, the physician shall include attached to ~~in~~ his or her report either; (i) a ~~clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and~~ copy of the signed agreements from the parties; or (ii) a statement under penalty of perjury that the party or parties failed to respond to the request for agreement that the evaluation required extraordinary circumstances. In either event, the evaluator must also provide verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

CODE	*RV*	*PROCEDURE DESCRIPTION*
ML105	5	Fees for medical-legal testimony. 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 up 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 one hour for a scheduled deposition.~~ The physician shall be paid the minimum fee of one hour at the rate of RV 5, or his or her usual and customary fee, whichever is less prior to the commencement of the deposition. Prior to closing the deposition record, the doctor can present a written invoice and state for the record an accounting of any applicable preparation time, travel time, and/or time in excess of 60 minutes spent in deposition rounded up to the next quarter hour. Within 30 days following the date of the deposition.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML106	5	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 at least five business days prior to the date of the med-legal evaluation ~~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~~.~~ ~~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.~~

(d) The services described by Procedure Codes ML101 through ML106 may be modified under the circumstances described in this subdivision. 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:

-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.

-93 Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML 102 and ML 103.

-94 Evaluation and medical-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 1.25. If modifier -93 is also applicable for an ML-102 or ML-103, then the value of the procedure is modified by multiplying the normal value by 1.35.

-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) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable and shall be reimbursed in the same manner as set forth in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1.

(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments; (2) medical-legal testimony provided on or after the effective date of the 2006 amendments; and (3) supplemental medical legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.

The proposed changes do not take into account the concerns of or problems faced by the QME's in the Workers' Compensation system. The Insurance Companies on the other hand clearly had a great deal of influence in the proposed revisions to the Med-Legal, fee schedule. In particular the rule limiting providers to "3 hours of report prep time" is ludicrous on its face. I can only assume it was a "throw-away" designed to distract people from the lack of needed reform provided by the rest of the proposal. There are a number of issues which need to be addressed. I present these in no particular order.

1. A very large part of the problem is that the current Med-Legal fee schedule is woefully inadequate in terms of compensation for the various level of reports below ML104. Since 2006 the RV 5 rate of $12.50 per unit has remained unchanged. During this 12 years, the minimum wage has increased over 60%, and as a result staff wages have increased dramatically, inflation and housing costs have increased tremendously, and costs for rent and office space for providers have increased. During this time the expectations of attorneys to provide a thorough report factoring in any and all factors they can imagine, and requirements as the result of case law (Escobedo, Rolda, Fujimoto, Benson, Larsen, Ferrell, Dawson,) for writing a "substantial medical evidence report", rise every year.

If you look back at the original text of the previous iterations of section 9795 change these regulations you will see that the original text of ML102 and ML103, indicated the reports were expected to take 150 minutes hours and 4 hours respectively (A copy this can be found in the Suzanne Honor-Vangerov Honor Vangerov declaration in the now settled lawsuit Howard v. DIR). Hence why, when "Four or more hours spent on any combination of two complexity factors face to face time, record review, and medical research required more than 4 hours, it automatically gave you two complexity factors, and when any combination of 1, 2 or 3 of the factors that of the three factors required more than six hours, this counted as 3 complexity factors. ("any combination" in plain english necessitates that one or two of the three could not be used) The point was that an evaluation that takes more than six hours, not including report writing and preparation time, is already considerably more involved that the 4 hours expected for a provider to issue an ML 103 report. The goal should not be to make it harder for QME's to bill at an appropriate level. There is a complete disconnect between the work that QME's are required to perform, and the Med-Legal fee schedule.

2. These days it is not uncommon to receive more than 1,000 pages of records. Attorneys and claims handlers routinely send everything they have, and everything they can subpoena, I have seen cases with over 20,000 pages of records, of course many of which are duplicates, but the doctor still has to read/review and parse through them to know that they are duplicates. The system could save a great deal of money if there was

some level of care in not providing the QME with redundant and duplicative records, or otherwise completely irrelevant records. Unfortunately this is a tedious burden that the claioms adjusters and attorneys are all too happy to pass off to the QME's. Assume a well educated competent QME can read/comprehend/summarize/sort 180 pages per hour (one page every 20 seconds on average, a feat nobody can actually do), 1000 pages requires 5.5 hours. It can be a single reference to a diagnosis, treatment, accident or medication, on a single page out of thousands that is the key to a forensic case.

a. Take a sample psychological report with 2.5 hours face to face time(not including testing time), 4 hours to read and review 600 pages of records (which is an unrealistically fast rate of 24 seconds per page), then write/edit/serve a 40-50 page report that probably takes them a solid 8 hours. The applicant is not MMI and Causation is not an issue. The doctor has 14.5 hours into the case and the regulations expect them to bill an ML103 for $937, less than $65 per hour. This does not take into account the doctors overhead, such as staff, rent, utilities, etc….

b. Another sample would be an internal medicine report with 10,000 pages of records, 1.5 hours face to face, the applicant was not MMI, and causation is not an issue. The provider will easily spend 40 hours just to read through the records assuming they can read 250 pages an hour (a rate of 1 page every 15 seconds), and they are expected to bill $937, that works out to less than $23.50 per hour if all they had to do was read the records.

3. Regarding the new language that "No more than 3 hours may be billed for report preparation under this code.". As previously mentioned, this is such an arbitrary rule it can only be viewed as a throw away bargaining chip meant to discarded in order to say that the DIR/DWC is compromising as they bully QME's into accepting the rest of their proposal. Even proposing this limitation demonstrates the complete lack of understanding the people who drafted these regulations have regarding what it takes to perform a QME evaluation and write a report. You cannot place a limit on the time a physician can bill to prepare a report, while simultaneously allowing the parties to provide unlimited records which the physician must read, and the incorporate a summary thereof into a "substantial medical evidence" report. Good arguments must be supported with the evidence and a good forensic differential diagnosis must also explain why the alternative hypotheses are not correct. Generally speaking; more records = more evidence = longer report = MORE TIME TO WRITE. Even a relatively simple 20 page report takes more than three hours to draft, edit, and finalize.

4. Regarding the issue of Medical Research. The issues surrounding the use of the medical research complexity factor stem directly from the problem that unless QME's can meet the requisite complexity factors there is no way to be adequately compensated for the work, time, expertise, and effort that it requires to generate a "substantial medical evidence" report. Simply put $937 is not enough to compensate a qualified forensic medical expert for the time, resources and expenses it takes to issue a report that requires more the 4 or 5 hours of their own time, let alone the office staff and behind the scenes time spent, scheduling, tracking records and cover letter, printing and serving the

reports…….and lets not get started on trying to actually timely collect the payment for the work that was done.

5. Regarding the Causation complexity factor. The responsibility should not be on the QME or AME to determine whether or not causation is an issue. The attorneys/parties should very clearly indicate whether or not causation is at issue, and if the parties cannot agree that no part of causation is at issue……guess what…….it is an issue. I propose that the parties be required to very plainly and concretely, in-writing either in the cover letter(s) or in another letter, inform the evaluator if all parties have agreed that AOE/COE causation is NOT at issue prior to the start of the evaluation.

6. A complexity factor should be available for a PQME/AME evaluation. If the services of an expert forensic evaluator are required because the parties cannot resolve the claim on the basis of other available resources, records, and reports, by its very nature the evaluation has some inherent level complexity. If the report meets three or more other complexity factors it is clearly going to take well over the 4 hours originally intended to be required for an ML103 report.

7. At any time the employer/defense counsel/claims adjuster can contest the reasonableness of a QME/AME providers billing. I have personally stood in front of a judge when defense counsel tried to argue that 40 hours of record review was unreasonable…….The judge looked at me like I was a complete fraud, but when he was informed that defense counsel had provided over 25,000 pages of raw records, and that the record review portion of the billing was already substantially discounted, in that 40 hours translates roughly to one page every 5.7 seconds, he very rightly turned his disbelief towards defense counsel.

8. ML 100 needs to be revised to provide adequate compensation for the providers.

   a. When applicants do not show up for the evaluation the doctor is required to remain there for one hour, time which cannot be recovered, and a good QME will have spent considerable time reviewing the sometimes thousands of pages of records prior to the evaluation. Not to mention the block of time which was set-aside for the entirety of the appointment, which can be the entire day for complex case, or a case occurring at a satellite office which may be hours away from the doctors' primary office. Many QME's have offices in distant locations where they serve communities that otherwise may not have a QME within many miles.

   b. The same problem occurs when an appointment is cancelled within close proximity (1 to 2 weeks) of the evaluation. This is especially if there are more than a few hundred pages of records, a good QME may have already started reviewing these documents, or their medical transcription company will have already started summarizing the records. Then when the appointment cancels, the provider is left holding the bag for their own time and/or the record transcriptionists time. This issue becomes even more problematic in cases with voluminous records. In order for a provider to be prepared for and perform and comprehensive evaluation they should have read the records prior to the evaluation. Unless you have read the records there is no way for the forensic

evaluator to adequately address discrepancies with the applicant, formulate appropriate queries as to the applicants condition(s) before, during and since the injury, address whether the applicants memory and faculties are intact, etc…….

c. The point is that the QME should not be left holding the bag because the applicant failed to attend, the parties cancelled a few days prior to the evaluation, or one party objected to the panel and nobody notified the QME who reviewed the records provided and appeared at the evaluation.

9. The payment for depositions needs to be clarified for the sake of all parties involved. I propose that the minimum fee for one hour of deposition time be tendered at or prior to the commencement of the evaluation. The doctor can then present an written invoice at the deposition and state on the record an accounting of any applicable preparation time, travel time, and/or time in excess of 60 minutes spent in deposition rounded up to the next quarter hour. The party who requested the deposition then has 30 days to pay the additional amount or contest the reasonableness of the charges in writing through the Non-IBR process. I have been in more than one hearing because an attorney wrongfully believes there is a flat $500.00 fee for expert depositions

The overall point being that we need to simplify the billing system, and fairly compensate QME's and AME's for the service they provide. If the billing system was set up to adequately address the issues concerning the requirements on the doctors time and office resources, not just checking off complexity factors in order to ensure you are paid more than $937 when you have to read 2000 pages of records, there would not be an incentive for providers to stretch to reach complexity factors. There is already a mechanism through which the parties can contest the billing. Bad providers can be weeded out and appropriately disciplined, but in order for the system to work QME's need to be adequately and fairly compensated for the work they do.

Perry J. Carpenter, DC, QME May 9, 2018

I have reviewed the DWC's newly proposed language which changes the language of the complexity factors under CCR 9795. Like the former "new interpretation" of the complexity factors in effect prior to the 4/3/18 "QME Settlement Agreement", I see some problems. The DWC's proposed new language effectively makes it near impossible to qualify for a bona fide ML104 and in so doing, the DWC succeeds in driving the QME's hourly rate down to next to nothing. As examples:

- Causation – the new proposed language requires a written agreement from the parties so that the parties can decide if the QME can use "causation" as a complexity factor. The new language puts the control in the hands of the parties! Are you kidding me? So, the

doctor gets hours of new work in writing back and forth to the parties, begging one or the other to quickly write back and authorize "causation" as a complexity factor? Just what we need – MORE WORK for LESS PAY! We already learned that obtaining a written agreement from the parties is a task approaching impossible with the prior "new interpretation" of the complexity factors wherein QME's were required to obtain a prior written agreement in order to establish the "extraordinary circumstances" of the ML104 (3) evaluation. The parties have NO incentive, and NO urgency to provide the QME with a written agreement that indeed "causation" is a disputed medical fact. In the alternative, why don't we educate the Claims Administrators in writing their Cover Letters so that, when the QME receives a written request to address "causation", the QME can assume that this is a bona fide request from the person who KNOWS the issues, and who ordered the evaluation? Said a different way, let's make the authors of the Cover Letters responsible for the accurate content of the Cover Letters, and let's let the QME respond to Cover Letters as they receive them without making the QME chase rabbit trails begging for written agreements.

- 6 or More Hours on any combination of three complexity factors – the new proposed language requires *some time* in each of the 3 complexity factors – 1) face to face time, 2) review of records time, and 3) medical research time. So, as written, a QME who spends 4 hours face to face, and 4 hours on review of records will NOT qualify for this complexity factor unless he spends at least ONE minute on unnecessary medical research. Are we all to fabricate a new library of medical research in order to qualify for this complexity factor – when the case doesn't require medical research? I rarely need to do medical research in resolving neuromusculoskeletal cases – but I frequently have more than 6 hours between 1) face to face, and 2) review of records. Will you force me to compose 10 minute snippets of medical research in order to capture this complexity factor?
- Report Preparation – the new proposed language caps reimbursement for "report preparation" to no more than 3 hours. This is workable – if the parties can accept the consequences. What are the consequences? Well, for one, it takes an average of 45 minutes – 60 minutes just to input examination findings – for a single body part - into the body of the report. Shall I omit this to save time? How about this "Examination findings were significant for L5 radiculopathy?" Will the parties be satisfied with THAT as the "Examination" section of the Report?
    - How about Diagnostic Studies?:
        - Do the parties expect the QME to review the studies and provide his/her own Report of Findings? Takes time!
        - Do the parties expect an analysis of motion segment integrity on spine x-rays? Takes time!
        - Do the parties expect measurements of cartilage intervals on lower extremity x-rays? Takes time!
        - Do the parties expect measurements for carpal instability on wrist x-rays? Takes time!
    - How about Permanent Impairment?:

        - Do the parties expect opinions and conclusions that qualify as substantial medical evidence? In other words, do the parties expect "how" and "why" reasons in support of the opinion? Takes time!
        - Do the parties expect a consideration of Almarez/Guzman in those cases that involve Permanent Impairment? Takes time!
        - Do the parties expect a "substantial" opinion on Almarez/Guzman (requires 1) a strict impairment rating, 2) an alternative rating within the 4 corners of the AMA Guides, 3) an explanation as to why the strict rating is not accurate, and 4) an explanation as to why the alternative rating is the most accurate rating)? Takes time!
    - How about Apportionment?:
        - Will the parties be satisfied with the conclusory portion of the opinion ("In my opinion 50% of the Impairment is due to the industrial injury, and 50% is due to "other factors")? Or do the parties insist on an opinion that qualifies as substantial medical evidence? Takes time!
    - Summary: I and other QME's will have NO problem shortening "Report Preparation" time to no more than 3 hours. Just realize that it will be a much different Report than what you are currently expecting.

I think you get the point. The larger point is that the DWC is blocking and putting barriers in the way of the use of each of the complexity factors to make it more difficult, more difficult, more difficult and nearly impossible, to qualify for a bona fide ML104. The DWC is demanding that we work just as hard, for way less.

Robert Weinmann, MD, QME May 9, 2018

Newsline # 2018-35 dated 3 May 2018 actually muddies some of the already not-to-clear waters:

-- Here's one of them: addressing medical **causation** is reportedly already required lest the report be rejected as not fulfilling requirements.

-- We're told that when medical causation isn't an issue in uncontested cases it isn't a complexity factor. We're also told that causation must be discussed or the report won't qualify as a QME report because it omitted an issue of substantial medical evidence.

-- One of the parties or both of them may request analysis of causation. We're also told that if a carrier has accepted liability there is no reason to discuss causation. There are often additional factors of causation that won't be discussed if causation isn't an issue. We're advised that

discussion of causation is supposedly mandatory for a QME report to be admitted as substantial medical evidence.

-- Clearly, if causation is not discussed because it's precluded as a complexity factor because the employer is already paying benefits, there will be times when the employer will be paying for something that isn't of industrial causation or is only partially of industrial causation.

-- At the least such an issue should be rebuttable and remain under WCAB jurisdiction. Better yet, the issue of causation should be kept as a complexity factor even when the parties forget to mention it in their cover letters.

Sandy Klein, Ph.D. May 9, 2018

I am a QME that performs neuropsychological and psychiatric evaluations. If I see an examinee for a re-evaluation, it generally means I was not able to find him P&S at the first visit. Often, by the re-evaluation,the examinee has gotten more treatment and can then be rated. Things not addressed in the first report now must be addressed, including permanent impairment ratings, which may involve both cognitive and psychiatric ratings.

Apportionment and return to work issues need to be addressed as well- often for the first time. Thus the re-evaluation report will usually be more time consuming than the original report. The proposed 3 hour limit on report preparation seems inappropriate for these reasons.

William W. Deardorff, Ph.D., ABPP, QME May 9, 2018

I assume the reason for these proposed changes is to stop egregious billing by certain parties. I am certainly in support of that goal, but I think it must be done without punishing or driving away quality and ethical QME doctors. Unfortunately, we are not provided with any information about the inappropriate billing practices.

I have commented on various issue in another post. I would like to suggest the following:

In my experience, most panel selected QMEs do an ethical job at a reasonable fee given the complexity of the questions they are mandated to address. The QME selection process does not allow for any one person to do “a ton” of these evals like in the “old days”. The evals are spread

out by the selection process. I would keep the med-legal fee schedule the same as it is currently for Panel-Selected QME evaluations.

I believe that PTPs and STPs are also billing under the med-legal fee schedule even when it is NOT a panel QME. For everything other than Panel QMEs the med-legal fee schedule could be changed per the proposal. I suspect this is where the egregious billing is occurring. This might reign in these costs while maintaining a quality Panel QME system.

Another suggestion is to NOT alter the current med-legal fee schedule for psych (aside from non-Panel QME per above). A psych QME is inherently different and much more time-consuming and complex than other types of QMEs. I know I could not even come close to completing a psych QME report for 3 hours total of report prep time. If that is implemented, you are going to get a 3-hour QME reports that are essentially worthless (all templated, few details, and done by QME doctors willing to do all lien work).

Jorge Kim, MD May 9, 2018

My name is Jorge Kim, MD. I am a QME evaluator for the past 3 years. My reputation notes my ability to write excellent comprehensive QME reports in a timely fashion. After reading some of the changes in the medical-legal expenses regulations, I do not agree with any of the changes regarding caps on hours billed (3 hours) for preparation time, under most of the new regulations. I want to point out that each case reviewed has varying amount of medical records, number of injured body parts, and multiple topics to be covered. I understand a 3 hour cap if records are less than 1.5 cm and the case is straightforward. But in many cases, I review records > 10 cm, multiple injured body parts, and multiple complexities not considered in the billing schedule, that cannot be billed as a ML 104, and defaulting to a ML 103.

If there is a cap on billing in these cases (with lengthy medical records, multiple injury dates, multiple injured body parts), I will need to resign my QME license and this type of work. As a physician, I find it disrespectful to my experience, education, and time, to pay such low rates to a report that is substantially significant for helping an injured worker and resolving workers compensation cases. However, my time and experience is valuable, and when the issue hits the fan, it will not be worth my time to provide these services. A common maxim in economics, is you get what you pay for.

Neena Madireddi May 9, 2018

Please allow at least some fee for record review for extensive records. Recently I received over 21 pounds of records for review and under new fee schedule it may not meet complexity factors. If this is not implemented then there would be a number of competent QMEs who will leave this work. Thank you.

Peter J. Sofia, MD, FAAOS May 9, 2018
Orthopedic Surgery

As a QME and AME of over 25 years experience, I am surprised and disappointed over the proposed changes. There has been no fee increase since 2006 even though inflation has totaled around 27%. In addition, we are supposed to review hours of records FOR FREE.

These changes are confusing and difficult to comply with. Why would insurance carriers, who clearly have a financial interest, agree to admit to increased complexity factors, and thus agree to pay more, when the DWC is essentially posting barriers to increased ML pay?

Were any QME's consulted about these proposed changes? It certainly does not appear so, but the insurance companies' interests seem to be well represented at the DWC. Why not organize a round table discussion with payors and providers, so the parties could share ideas about a fee schedule that would be agreeable to all parties?

Why do attorneys, with just three years of post-graduate training, receive $350-400 per hour, when I, who has 9 years of post-graduate training (4 years of medical school and 5 years of orthopedic residency) get paid only $250 per hour? This is simply not reasonable. The Labor Code states the MLFS shall reflect "comparable work". In civil cases, I am paid $350 per hour or more ($3500 for a half-day of courtroom testimony, for example) for my professional time, so the MLFS clearly does not reflect comparable work.

If the goal is to destroy the QME system, this proposed fee schedule is a good start.

Please reconsider these changes, which will cause QME's like myself to exit the system.

Ken Sabbag, MD May 8, 2018

I am against the proposed changes to the medical legal fee schedule for the following reasons. I have perused the proposed changes to the medical-legal fee schedule. I perform QMEs and AMEs. The proposed changes will apply to a small part of my work, but this issue will come up. Some evaluations are straightforward and are billed as an ML102. When the exam is more complex and complexity factors are met, the evaluation is billed as an ML103 or ML104 as appropriate.

A great deal of time is sometimes spent reviewing medical records (ML106) or during a re-evaluation within 9 months(ML101). If the service takes 45 minutes, I bill 3 units. If it takes 4 hours, I bill 16 units. The time it takes is the time it takes.

I often receive assignments with over 1,000 pages of medical records. It is not reasonable to expect a person to review such a volume in under 3 hours. When a re-evaluation addresses multiple body parts, multiple injuries, and medical records, it may take more than three hours. This is a fact of our system.

Finally, authoring and editing an admissible and complete report is not trivial. If the report is less than thorough, we may not settle the issues in dispute. This takes time.

It is not clear what the goal of the change in the regulations is except to put the burden on the medical evaluator. In fact, paying by the hours seems to be the most fair way to pay a medical professional. Capping the times does not make sense. If this in enacted, then there must be mechanism by which a QME or AME can reject an assignment if it cannot be accomplished in the prescribed three hours.

The proposed changes are asking the doctors to do part of their work for free. That is not just. I would never ask my staff to work for free or my landlord to accept less than full rent. The State of California certainly will not allow me to pay only a portion of my taxes. J

Charles Seaman, M.D. May 8, 2018
Psychiatry QME

I am a university-trained forensic psychiatrist who has performed psychiatric QMEs for more than 20 years. My evaluations and reports are designed to provide objective analysis and opinions supported by facts gathered from the applicant and the records.

As a psychiatric evaluator, it is my job to look for inconsistencies, symptom magnification, distortion of causation, and possible non-industrial stressors or causations. This is not an easy task and requires a considerable amount of time. Even more time is needed for dictating the report, proofreading, and editing. To withstand legal scrutiny, the body of my report contains the information needed to support my diagnosis and opinions.

If the goal of the QME process is to produce evaluations and reports that meets the expected legal standards, then limiting the report preparation to no more than three hours is not consistent with this goal.

Limiting the report preparation time would result in reports that do not contain the information and analysis necessary to articulate or support reasoned opinions. This would likely result in more depositions and testimony that would raised the cost. Reports that lack supporting evidence would also increase attorney's fees and may result in unjust awards to the applicant or defense.

I also object to the proposal that no more than three hours may be billed for supplemental medical-legal evaluations. I have had many cases where several thousand pages of loose records were received after my original report and the supplemental report took many hours.

I have no objections to declaring under the penalty of perjury the time I spent in the face-to-face interview, review of records, research, or report preparation. My bills have always reflected the actual time I've spent working on the cases.

I understand that there are likely to be some QMEs who may submit excessive bills but limiting the report preparation time will not solve this. Those evaluators who abuse the QME system are not interested in producing thorough objective reports and could get around the proposed fee-schedule changes simply by increasing their volume of cases.

Limiting the report preparation time would defeat the true goal of the QME process, to produce detailed, objective, and well-reasoned, reports that will stand up to legal scrutiny.

It is my opinion that, if adopted, the proposed changes of the medical-legal fee schedule would force many good QMEs to leave the worker's compensation system. Those who remain will be the high volume evaluators with little concern about their professional integrity or the quality of their work.

Anonymous May 8, 2018

In the recent past, the DWC has become significantly antagonistic to doctors. Relatively recently, they were accused of using underground regulations to go after QMEs. It may seem a noble pursuit to go after doctors who are in violation, but when the enforcer allegedly is using underground regulations and denying due process, the enforcer of the regulations is no better, and arguably worse, than the person they are going after. Using underground regulations led to false positives being identified and doctors having to sue to clear their good name. The case settled without anyone at the DWC, who were allegedly participating in enforcing the underground regulations, ever facing any consequences.

All of us in the front lines in the QME community know that insurance companies have been in violation of billing rules by arbitrary denials, saying they don't have the bills, etc. For example, they will say "not authorized" as a way not to pay for a QME evaluation. They never face the level of scrutiny or consequences of QMEs.

I think people in the QME community thought that the DWC was going to read the regulations as written and were going to work with the QME community to come up with regulations that would simplify the existing regulations regarding reimbursement.

Now that the case regarding alleged underground regulations has settled, the DWC has now proposed turning what previously were allegedly underground regulations into actual regulations. During the time they were allegedly enforcing underground regulations, they were accused of getting rid of ML104. These new regulations go a step further in regards to making it more difficult to attain ML104 and now, even if you attain the ML104 level, the DWC only wants to reimburse three hours of report preparation time. Arguably, the DWC, post settlement, is going a step further against the QME community.

Everyone knows that the lawyers will never come to an agreement as to whether causation is in dispute or not. Also everyone knows that parties do not come together to agree that an evaluation requires extraordinary circumstances. Has anyone ever gotten those letters? When the DWC was trying to enforce the allegedly underground regulation of the parties getting two parties to write to the QME as to whether causation was in dispute ever get a letter? I'm sure if anyone did, it was a rare occurrence. Additionally, what qualifies the parties to necessarily know whether an evaluation is extraordinary? They do not conduct the evaluations and therefore have no expertise in making this determination. Even without records, an evaluation can be extraordinary. Parties may not even know causation is an issue until after the QME evaluation.

How is an unrepresented worker supposed to know if causation is in dispute or an evaluation is extraordinary? The answer is they don't. Most, if not all, barely know how to navigate parts of this significantly complicated system.

The DWC knows many reports take much more than three hours to complete. They just want to limit billing using this arbitrary number. Has the number of "three hours" ever been studied as an adequate number of hours to complete a 25 page report? How about a 50 page or 75 page report? It hasn't been studied. This is an arbitrary number to cut down on billing. So if a QME gets 2000 pages of records, they can only bill for 3 hours of report preparation time. If they get 5000 pages of records, they can only bill for three hours of report preparation time. If they get a complicated evaluation, they can only bill for 3 hours of report preparation time. Again, it comes across as the DWC being antagonistic towards the QME community.

What is particularly disturbing is that under these new regulations, a QME cannot refuse to do QMEs. For example, if a QME gets 5000 pages of records and potentially a multi hour evaluation, they may effectively be denied many hours of pay if they do not meet ML104 and/or

if their evaluation takes many hours to prepare. That means the DWC is effectively forcing QMEs to do free work. The DWC does not take into account that while they are effectively going to force the QME to do free work. This means that the practices of QMEs will suffer. This affects quality time spent with families, etc. If the QME knew how much work is involved, they should be able to tell the parties, that because of the DWC regulations, they cannot afford to do an evaluation of such complexity.

The DWC should also survey applicant and defense attorneys before making any proposed changes. How do these entities feel about how these new proposed regulations will affect their ability to get their clients a fair report that is substantial medical evidence?

In conclusion, the DWC appears to have become doubled down and become increasingly antagonistic to QMEs. If the DWC wants to turn this around, they should take this proposal off the table and work with the QME to come up with a sensible way to cut costs, simplify the regulations, and make a friendlier environment. Make it possible for QMEs to refuse evaluations if it is going to affect their financial ability to practice. With the QME community getting older, these proposed new regulations, the recent purging of QME's by the DWC, and the antagonism by the DWC, the QME community is likely to continue to significantly shrink and the quality of the reports and the system will worsen.

Dr. Robert Dickman, D.C. May 8, 2018

Clearly putting a time limit cap on producing the medical legal report (i.e. the time necessary to provide substantial medical evidence to all parties) in many cases will force the qualified medical evaluator to work for free, and more likely than not result in a sub-standard evaluation. This is analogous to putting a time limit on a surgeon (e.g. to be paid a maximum of 3 hours to perform the open heart procedure). These proposed changes make no sense, are unethical, and borderline on promoting malpractice. Furthermore, the stipulations surrounding the factor of causation basically takes this billable factor off the table, once again forcing the qualified medical evaluator to work for free.

James E. O'Brien, M.D. May 8, 2018

Capping supplemental reports at three hours is unrealistic and if actually enforced would be a form of forced free labor. You must pay the QME for his/her time as no professional can be expected to work for free.

Try going to a respected attorney's office and demanding that he review 10,000 pages of documents, but admonish him that you will only pay him for three hours work. You can scream as loud as you want while you are forcibly escorted out of the building by security.

If you're going to cap reimbursement, cap the work requirement. No more than 200 pages per supplemental, or 60 if it is a deposition.

The King James Bible is 1200 pages. I often get 1200 page supps. Ask someone to read it in three hours and be ready to answer any questions about the details in a deposition.

Basically this will drive QMEs out of the system, and I have to say after thirty years I'm ready to go and anyone who doesn't is an idiot if the expectation is now for free forced labor.

Joseph Nevotti, Ph.D., Q.M.E. May 8, 2018
Forensic Psychologist

Regarding the draconian and counter-productive rule changes which I'm sure will please the insurance companies, I offer the following comments:

First, regarding those who re-bill "Medical Research" *ad infinitum*, they should be tracked down and punished. I have done the "medical research" necessary to discuss the eitology of the mental disorders involved in my cases as required in a thorough PQME or Supplemental Evaluation. When necessary, I do additional "medical research" to examine the latest developments regarding the diagnoses I use. Such research has never required more than a few hours of my time. Furthermore, it is only billed ONCE, for the particular case I'm working on. While the fruits of that research are incorporated into future discussions involving similar cases, ***I have never even considered re-billing for it***. As far as I'm concerned that is unethical, if not fraudulent behavior. DWC should go after those who do, and file complaints with the licensing board of the party involved. I respectfully request DWC stop painting all QMEs with the same foul brush of corruption.

Second, DWC knows who the guilty parties are. Rather than punish all of us, I recommend you work up the courage to go after the guilty parties.

Third, there is no way to write a ML104 in three hours **UNLESS** all parties (a) accept brief, incomplete sentences (or maybe a form with boxes to check?) in place of the reasoned discourse necessary to answer the questions that must legally be addressed; **AND** (b) the almighty insurance carriers are prepared for an onslaught of numerous and lengthy depositions to allow the QME to

explain and discuss her/his findings which have been so capriciously and arbitrarily eliminated. Personally, I love to be deposed, and welcome the opportunity to do more of it.

Fourth, I have no problem getting approval for a discussion of causation ahead of time as long as BOTH attorneys involved are ready to grant this condition in their cover letter to me, and their cover letter arrives prior to the QME exam.

Fifth, Should your absurd rule changes take place, I look forward to the flood of $1750 PQMEs that I and a few remaining QMEs will receive, given that 90% of my fellow QMEs will abandon DWC and the QME's obviously idealistic attempts to actually help injured workers get the care they deserve.

Finally, should DWC decide to take the moral high ground and do something of a surgical nature to eliminate problems, I recommend you investigate the "QME Mills" to make absolutely sure no "ghost writing" of reports is taking place, and to eliminate those mills that routinely tack on a few hours' billing to cover "administrative fees."

Paul Aubin, D.C. May 8, 2018

I have reviewed the proposed changes to the medical legal fee schedule and I while the majority are quite reasonable a few have given me very grave concerns.

Limiting report preparation time to a maximum of 3 hours under ML-101 and ML-104 is adequate in the vast majority of cases, but some cases are quite complex and will require more time. I recall a particular case involving more than 5,000 pages of records and more than 20 prior injuries to the injured worker. The time it took to consider and comment on the issue of apportionment was considerable, as you might imagine. Why not allow the parties to stipulate to additional report preparation time when the circumstances clearly call for it?

My biggest concern, however, has to do with the way the proposed regulations deal with the issue of causation. Requiring the QME to obtain written permission from both parties prior to utilizing it as a complexity factor is problematic to say the least. In my experience the vast majority of QME evaluations come and go (appointment call, evaluation, report preparation and submission) without ever receiving any records or communication of any kind from either party, despite my specific request in the cover letter that accompanies my Appointment Notification Form for a letter from each party detailing which issues are in dispute and specifically whether the issue of causation is one of them. Since there is no statute or regulation requiring the parties to respond to such a request the QME is often left dangling in the wind.

Furthermore, the issue of causation is very often the primary if not the sole issue in dispute. In the vast majority of cases referred to me the defendant has already denied liability for the alleged

injury, either in whole or in part. For that matter, in the absence of the affirmation of causation in my report all other issues (impairment, apportionment, QIW, etc.) are rendered moot. In short, if there is no industrial causation, there is no claim. Clearly, of all the potential issues that a QME might be asked to address in a report, causation is the indispensable linchpin. Indeed, in a case where the defendant has denied liability, a report that does ***not*** address the issue of causation would fail to perform its most basic function of identifying and resolving disputed medical legal issues. Since it is clearly incumbent on the QME to address causation in his report in order for it to rise to the level of substantial evidence, it is nonsensical to compel the QME to obtain prior permission from the parties before using causation as a complexity factor.

I urge the DWC to consider changing the proposed language involving causation. Left as it is, it will create many more problems than it solves.

Dr. Bahman Omrani May 8, 2018
Sylvan Medical Center

I just read the proposed document regarding reimbursement for medical-legal services and would like to voice my immediate concern. As you may be aware, the carriers already abuse their power in down coding or denying medical-legal services that they requested. As a QME, we have to utilize countless hours of staff time simply to get the carrier's attention and often have to wait 180 days or more to get reimbursed. The proposed ruling will have adverse outcome as it will strengthen the abusive hand of the carriers and will cause many many qualified QME's/AME's to exit the system. The ruling is simply not fair and severely biased toward the carriers and not the injured worker.

Robert Fisher MD May 8, 2018

I do not want to belabor all the points that have been brought up regarding the proposed changes in the billing of reports by all of the respondents to your forum. Suffice it to say that I agree with the letters dated 5/3/18 by Dr. Meth and by Dr. QME. I have been doing QME exams since 1989 and basically every letter from the attorney states that if disability is found that causation must be addressed. Having a special note regarding causation prior to an evaluation seems redundant since we are asked to comment on disability, and if present, comment on industrial versus non-industrial causation. I believe the proposed changes will only complicate the proper evaluation of the injured worker and make it more difficult to adjudicate each claim since a

"Readers Digest" version of a complex case will lack much of the necessary information upon which to make an intelligent and informed decision.

Dr. Elisse A. Blinder, Ph.D., QME May 8, 2018
Clinical and Forensic Psychology

The proposed changes in billing will result in completely substandard evaluations or else working for free. I will do neither. I will have no respect for anyone who does.

Med-legal QME psychological evaluations are by definition complex require much thought, and significant time to conduct and write up the findings and discuss the various med-legal opinions. It is simply not possible to produce a report including substantive evidence in 3 hours time.

Mark McDonald, M.D. May 8, 2018
Adult, Child, and Adolescent Psychiatry

I am a psychiatrist and QME and object to the proposed fee schedule regulation changes.

1. It is not possible to complete an adequate record review and write a report, as a psychiatrist, in under three hours. Record review alone takes approximately one hour for every hundred pages of records reviewed. I routinely receive over 1,000 pages of records per evaluation. Report writing and preparation takes over 10 hours per evaluation. Supplemental reports often require more than three hours for record review alone, depending on number of pages provided.

2. Eliminating billing factors such as causation will prevent reports from receiving fair and just consideration for high-complexity payment, as all psychiatric evaluations are. Adjustors have already begun abusing their privilege of reducing fee payments in arbitrary, capricious ways. The proposed changes in billing factors will further encourage this behavior, leading to increased claim denial rates without cause.

3. Eliminating the option of making use of research by restricting the use of a research document to once per 12-month period will place arbitrary restrictions on the use of valid research, with no discernible benefit.

Every change proposed has already been adjudicated and rejected by the workers comp court. This new proposal appears to be a run-around of the court system and will gut the QME system. The real question is what will replace it?

Robert Ghatam, MD May 8, 2018

This morning I edited my report that is 4 different ADJ # and 6 different body part.

I will not be able to spend time sort out many other things involved with this case though for non complex cases the regulations will be fair is it is adopted. Happy to provide you with the 17 pages of this AME on your request.

Erik J. Marquis, President May 8, 2018
E-Billing Solutions, LLC

I run a healthcare revenue consulting firm and I represent several QMEs. I reviewed the proposed changes to the Med-Legal fee structure and i have a couple comments.

Limiting the preparation of a report to 3 hours is going to result in incomplete reports. This will require more follow-up reports and delay the entire process. A better way to mitigate abuse is to provide transparency to attorneys regarding how much time QMEs average in the preparation of their reports. We don't want to sacrifice quality of the reports and delay the care of an injured worker.

The best way to cut waste in the QME process is to reimburse QMEs to outsource Record Review. Reimbursing providers $250/hour to sort and collate records is not a good use of funds. Additionally, if providers were to outsource Record Review, they do so at their own expense. They are not incentivized to save the system money. If the fee schedule reimbursed third parties $50/hour to review records, the DIR would save $200/ hour.

Lisa Wolf, Psy.D May 8, 2018
Licensed Psychologist

I am writing in response to the proposed changes to Labor Code §9794: Reimbursement of Medical-Legal Expenses.

As a psychologist, licensed in California since 1999 and designated as a QME since 2002, I have performed hundreds of psychological evaluations, in my capacity as either a QME or AME. In those sixteen years, I have never prepared a single comprehensive medical-legal evaluation report in three hours' time. As a result, I have never, to my knowledge, had a report rejected for failing to meet the standard of Substantial Medical Evidence.

The proposed three-hour limit for report preparation, even in the case of an ML104, would make it impossible for me to continue preparing reports that constitute Substantial Medical Evidence. As clearly outlined by Dr. Armstrong (above), the law requires that a comprehensive psychological evaluation address, in depth, the applicant's early/family history as well as his or her educational, marital, occupational, military, medical, psychological, drug/alcohol and legal histories, in addition to the history of the injury or injuries in question. In fact, the 2016 edition of the *Physician's Guide to Medical Practice in the California Workers' Compensation System* indicates that, although one hour of face-to-face time is required by law, "**A psychiatric evaluator more typically will spend two to three hours with the patient**." It is not uncommon for me to spend four hours in face-to-face time with a claimant, depending on his or her age and the complexity of his or her personal and occupational histories. Translating the vast amount of historical information gleaned during a three-hour interview into a coherent, chronological history requires at least three hours of report preparation time, before one begins to integrate that historical information with the (potentially voluminous) medical records in order to arrive at well-reasoned conclusions on the medical-legal issues at hand. Because it would represent an ethical breach for me to submit an incomplete, inadequately substantiated or otherwise invalid work-product, the proposed changes would make it impossible for me to continue functioning as a QME within the CA Workers' Compensation system while maintaining my psychology license in good standing.

The proposed changes to the criteria required for billing an ML104 would also make it impossible for me to continue preparing reports that constitute Substantial Medical Evidence:

Complexity Factor 6 requires that "the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation." It is not specified whether or not this "agreement" must be in writing. If not, who and by what method will it be verified that "agreement" has been reached? More importantly, as has been noted, above, by numerous other QMEs familiar with the real-life process of functioning within the CA WC system, it is virtually impossible to get an adjuster or claims examiner to answer the phone, return a voice mail message or respond to an email, regarding ANY aspect of the claim. It is extraordinarily unlikely that one would ever agree to the terms outlined, above. Therefore, Complexity Factor 6 is moot.

Complexity Factor 7 is fatally flawed, on its face, as it appears to address apportionment between employers, between claimed dates of injury and between claimed body parts but not

apportionment between industrial and non-industrial causes of permanent impairment, which is the issue of predominant concern.

Option (3), allowing for a comprehensive medical-legal evaluation to qualify as an ML104 on the basis of agreement "prior to the start of the evaluation, that the evaluation involves extraordinary circumstances," is absurd; **it cannot be known, prior to the start of the evaluation, how complex a psychological evaluation will be**. That, among other things, is determined during the three plus hour interview. Furthermore, no criteria are specified by which "extraordinary circumstances" are defined. The issues raised, above, regarding the availability and responsiveness of adjusters applies here, as well.

The proposed changes beg the following questions:

1. What is the intent of these changes and what empirically identified problem(s) are these changes designed to address?

2. If, as many commenters have suggested, these changes result in the loss of hundreds of additional QMEs from the CA Workers' Compensation system, what will happen to the system which relies on such evaluations to move cases forward? If the evaluator/provider segment of the system is eviscerated to the extent that Workers' Compensation is no longer a feasible, fair, timely, safe remedy for injured workers, how can it reasonably remain the Exclusive Remedy? At some point, the Grand Bargain will be nullified by insurers' failure to meet their obligations to workers, returning work-injuries to the Tort system from whence it was extracted.

Joshua Kirz, PhD May 8, 2018

Like a lot of bad ideas, this one started out as a good one. There is abuse in med-legal billing.

(Of course, there is equal or more abuse by adjusters, insurance companies, UR, IMR, treating doctors, injured workers, and attorneys - on both sides. Unfortunately, there are bad apples in every walk of life, and that is far from limited to the WC system.)

Regardless, there is no argument against cleaning up *any* kind of abuse, and that extends to med-legal billing.

The Division chose to issue an educational module, and that was a good idea. For example, I do not bill causation as a complexity factor in accepted cases. Other doctors did so because they did not know the rule. Further, not every report is an ML104; some are 102s. Highlighting these issues was a good idea, and I think had the effect of decreasing the erroneous overbilling.

Then the good idea turned bad: new interpretations of the regulations by the enforcement unit, suspensions of QMEs, lawsuits, and now these proposed changes.

I won't belabor the arguments already made in this forum. A few points:

1. When adjusters and attorneys definitely want an opinion on causation, they do not pre-authorize causation as a complexity factor. They don't pre-authorize anything. This is an impossible standard.
2. Similarly, adjusters and attorneys do not pre-authorize "extraordinary circumstances." How could they? They haven't seen the med-legal report yet to know if there is anything extraordinary involved. Another impossible standard.
3. Mandating at least some time spent in research in ML103s and 104s? Huh? Not every case needs research, even complicated ones.
4. 3 hours of report preparation is just fine for a basic 6-page orthopedic report. Even some of my psych reports can be close to 3 hours, if unusually straightforward. However, most psych reports require more, as do many complex orthopedic and internal cases, depending on the history. You are asking your medical expert to work for free or issue a report that falls well below the standard of substantial medical evidence.

When I am reviewing records, I am often sent social security disability medical and psychiatric evaluations. They are so laughably bad they always make me cringe. It's clear the doctor read no records and spent five minutes with the patient. I get it – the doctors are paid $500 per case. Still, it's embarrassing to read these reports.

The question for the DWC is if they want that outcome for QME and AME reports as well. To my mind, the purpose of QMEs and AMEs is to resolve medical disputes, move cases forward, and help injured workers regain as much of their health as possible.

The proposed changes accomplish none of the above. Quite the contrary, medical disputes will increase and remain unresolved. There will be tons of supplemental reports and depositions. Costs will go up. Cases won't settle, causing a huge backlog at the WCAB. None of this is good for injured workers, nor for anyone.

I propose that the DWC go back to the original "good" idea: educating QMEs about the system, including how to appropriately bill under the current and very adequate MLFS.

Robert Armani May 8, 2018

For the amount of work and the time and efforts it takes it is not worth it to do QMEs anymore, it's an absolute mistake and disservice to the injured workers and all parties involved, by cutting and limiting this area of workers Comp system you will not accomplish anything other than

getting very poor and inadequate reports and it will hinder the decision making of the QME Doctor, It will be social communist medicine and nothing good will come out of it,

I highly recommend that you do not make any changes and leave it alone, let the QME doctors do a good job as they are doing it right now

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William H. Mouradian, MD May 8, 2018

I agree with Dr. Moldawer whole heartedly **[Comments were submitted by Dr. Todd D. Moldawer and are contained within this document]**. There are existing mechanisms in place to correct problems with, "outliers."

Adel Mostafavi, MD, QME May 8, 2018

As a QME for nearly a decade I can state without any reservation that it would be impossible for this proposed change to reflect the actual time a QME spends on preparation time. This is by far the most time intensive portion of the evaluation. With the known challenges to receive reimbursement in a timely manner, adding such regulations will further limit any interest or ability of QMEs to continue providing the services that are necessary to keep patients whole. With fewer QMEs there will be fewer evaluations completed. Ultimately, patients will suffer longer delays in treatment and lead to further physical and psychiatric damages. Especially those in the most dire need. Will payers be held accountable for such delays and damages to patient lives?

SangDo Park, M.D. May 8, 2018

As a young orthopedic surgeon in my early 40's, I actually enjoy doing the QME work and feel that I am contributing to the worker's compensation system as it is an important matter that affects all of us living in the state. We all pay into it one way or another.

However, the new proposed reimbursement guidelines are misguided, inappropriate, and will make it economically impossible to continue performing the QME work.

It will be near impossible to use causation as a complexity factor as it is extremely difficult to get the adjustor/parties to agree to anything prior to the evaluation in a matter that affects billing. I've tried it. It doesn't work. I've tried it after receiving banker's box full of medical records. The response (if I get any), is along the lines of, "we don't deal with that, that is up to

bill review." There is nothing which compels the adjustor/parties to respond. Therefore, they will not respond. Moreover, it is in the interest of the adjustors to not agree because they are the ones paying for the examination. AND we cannot refuse the examination because of lack of agreement. By the way, I have never been paid with interest plus penalty for late payments on any of my reports. When it comes to reimbursement for QME reports, this is a very unfair, one-sided game.

In addition, what quality of reports do you expect with 3 hour limits on ML-101,104, and 106's? Some of the evaluations are extremely complex with the amount of medical records , prior QME evaluations, multiple injuries and awards, etc. Can we just stop writing the report once 3 hours is up?

Also, regarding "six or more hours spent on any combination of three complexity factors... provided that some portion of time has been devoted to each of the three factors..." What happens when I get banker's boxes full of records and do 10 plus hours of record review and 2 hours of face to face but zero amount of research? And the adjustor does not respond to my request to bill causation as a complexity factor despite head to toe, sex, and sleep claimed as injury? This should be paid as ML 102 ($625) for minimum 12 plus hours of work? Does this seem right?

I admit I have encountered some QME reports which have billed absurd amount of hours (ex: supplemental reports which billed 2 hours to review 2 MRI's and billed 6 hour of report prep time to basically copy and paste the previous report and state, "my opinion has not changed"). Yes, those are inappropriate. Why not go after the individual offenders? Why punish everyone?

In summary, the proposed regulations will result in decline in quality of the reports as more and more QME's will see less incentive to write well thought out reports. It will also increase the amount of poor quality ML102's which are worthless as some providers will seek volume over quality since it is extremely difficult to bill as ML103's or ML104's anyways. It will also cause young doctors like me to seriously consider giving up QME work entirely as it makes zero economic sense to continue doing so.

Basically, QME work in the State of California will be funneled into ML-102 mills. Is that what the DWC wants?

Jed M. Sussman, Ph.D May 8, 2018

Some of the proposed changes are arbitrary and will prevent doctors from issuing the type of reports needed to move cases along and settle cases as well. For instance, a 3 hour maximum limit of report preparation for some medical-legal evaluations is anti-productive. I can tell you

from personal experience as a QME and AME for over 30 years, many times there are boxes and boxes of records to review and incorporating them into a probatively useful report takes more than three hours of time.

Additionally a requirement for a QME or AME to obtain pre-authorization for a report involving extraordinary complexity is onerous. Many times and despite the fact cases are lenghty, have many records to review, bodily psychological components and drug components in addition to non-industrial factors - obviously making the case extraordinarily complex - the parties often ignore requests for pre-authorization. This leaves the doctor having to put in far many more hours than what he is paid. This is a real disincentive and will drive good doctors out of the system. Having far fewer good QME's and AME's will only result in greater costs.

Similarly a requirement for parties to pre-authorize using causation as a complexity factor for billing is troublesome as many times one party does not provide a cover letter or does not respond to letter requesting pre-authorization.

If you are looking for ways to improve the AME/QME process, you should do so with a systematic thoughtful approach after conferring with expert workers' compensation doctors, attorneys and insurers.

Harrell Reznick May 8, 2018

Please count me as another QME opposed to these changes proposed by the DWC. There is no clinical/medical rationale for these arbitrary rule changes. In particular, the proviso that research articles not be repeated in any 12-month period has no medical justification apart from the DWC's obvious motivation to reduce QME billings when it's been shown that thorough QME evasions actually reduce benefit payments. Moreover, this rule change requires bookkeeping tasks that impose yet more obstacles to doing my job.

As a psychologist, I am faced with additional complexity factors that routinely involve causation. Assessing causation in claims of injuries to the psyche are usually more involved than with other claims. The DWC recognizes this in mandating greater minimum interview times than with non-psyche claims. The proposed additional requirements regarding causation are not only medically inadvisable--they are onerous.

Elliott A. Schaffzin, MD May 8, 2018

Having had an opportunity to review the DWC’s proposed changes in the MedLegal fee schedule, I believe that the changes tend to complicate a confusing system of medical legal

billing, and that this is an excellent opportunity to simplify billing to the benefit of all parties. In 2005, there was a need to control costs in the workers' compensation system. One of the significant changes that was made by the legislature was to provide for independent, rather than Applicant-Defense ("the dueling docs") system of determination of disability and impairment, work-relatedness of the patient's condition, etc. As QMEs and AMEs, we have made every effort to provide quality medical evidence, assisting injured workers and balancing the interests of all parties. I suggest a simplified system that will provide a stable means of QME/AME billing, relieving the Carriers and DWC of a good deal of time and effort expended on bill review. As a QME, I feel that we should be fairly reimbursed for time spent, but the present system is confusing and it takes into account multiple issues such as research and separate billing for issues of causation and apportionment. Let's get a simple system that is fair to the Carriers and to the evaluators, and that relieves the DWC of the arduous process of bill review. The following seems to be a reasonable approach to address concerns for potential upbilling, and which is fair to all parties:

1. Provide a single reimbursement for each evaluation based on an amount appropriate to the level of expertise necessary to provide an excellent, well thought out report. At a minimum, evaluation and reporting, including any instances where medical research is necessary to provide substantial medical evidence. A basic fee of i.e., $1000-$1,200 which would include time for record review of i.e., 200 pages.

2. A small amount of per-page payment for the total number of pages in a report and

3. Reimburse the physician at the present, or higher level (the present fee schedule has been in effect for 10 years or more - i.e., a schedule based on cost-of-living or some other method that takes into account increasing costs of all issues, office personnel, rental for office space, etc.) for each hour of medical record review beyond the basic amount.

4. By simplifying the billing process, issues of causation, apportionment, medical research will no longer be at issue. Medical research, which I feel is often a valuable and necessary component of the report to explain the rationale for a decision, will simply be addressed as a component of the complete report. There will be no issue as to whether causation or apportionment are billable issues, as they will always be addressed as a component of the report.

As a QME for as long as the system has been in place, I have made every effort to fairly and adequately address injured workers' issues, spending enough time with the patient (not always possible by the treating physician) and not infrequently finding issues preventing an individual's return to work that have not been adequately assessed and treated. The goal of the system is a return to work, and we as Qualified Medical Examiners are an integral part of the legislature-established system.

Let's take this opportunity to improve, rather than to increasingly confound, an already difficult and confusing system of medical legal billing. I appreciate the opportunity to add this comment.

Kent Karras May 8, 2018

I have read the proposed regulations concerning the changes in the QME fee schedule. As usual these changes continue to favor the insurance and penalize the Evaluator.

The changes contain many flaws:

- When if carriers now stop sending records in a timely fashion for initial evaluations and the Evaluator is now required to review records and other diagnostic materials while performing supplemental evaluations and reports. Essentially the insurance carrier can use these loop holes to force Evaluators to write reports and pay a minimal amount for them. Having to make sure that causation and other items have been agreed to prior to the examination puts the Evaluator at the mercy of both Applicants and Defense Attorneys. If they don't do their jobs or are not on top of the the Evaluator is penalized. Why is the law being changed and who is requesting this? Requiring an Evaluator to write an exam seems to go against and individuals rights. Why is there no push back or Avenue for appeal for the Evaluator? Insurance companies are large and Evaluators are small individuals the WCAB needs to protect Evaluators and stand up for their individual rights. I am disturbed that the WCAB would even consider such unfair rules that clearly can be manipulated to not pay the Evaluator and force work soon him.

Dmitriy Sherman MD May 8, 2018

In my opinion 3 hours for report preparation is insufficient for psychiatric PQME

In my opinion it's simply impossible to provide psych PQME report representing substantial medical evidence while having only 3 hours for report preparation.

If the decision has been made anyways and regardless of QME's opinions please ,at least consider to increase allowed time for psych cases at least to 5 hours.

Thank you for your time and consideration

Ashton May 8, 2018

I manage and own a Medlegal Management Company and currently manage a small group of five QME physicians.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

The past two years have been very turbulent in the Medlegal management community. It all started back in 2016 when the DWC aggressively denied reappointment's to doctors for alleged fee schedule violations based on alleged underground regulations or rather: violations of code 9795 interpretations that simply didn't exist. As a result of the DWCs actions, **one of my doctors was denied reappointment. His denial (based on alleged underground regulations) resulted in over 100 applicant cases placed in limbo for a period of seven months. As a result, applicants couldn't receive treatment, nor new QME panels, TPA's / employers had to pay additional TTD, attorneys had open ended cases, and the QMEs life and practice was turned upside down.**

On April 4, 2018 we all thought that maybe there was a respite with the settlement of the Howard vs DIR case. It was our belief that we could begin refocusing our efforts providing service to the injured workers of California without the fear of regulatory over reach by the DWC. Not within a month after the settlement, the DWC and its architects of the alleged underground fee schedule regs once again turned the Workers Comp system upside down again with its release of its proposed modifications to 9795 medlegal fee schedule.

Basically, the alleged underground rules that the DWC denied reappointment to QMES back in 2016 and 2017 are now being proposed as official changes to the billing code. The biggest issue that comes to mind is the change to the **CAUSATION complexity factor**. The change includes **"prior agreement by both parties"** in order to use CAUSATION as a billable factor. This alleged underground interpretation was used by the DWC discipline Unit to deny reappointment to many QMEs during the 2016 and 2017 re-appointment cycle. **The proposed interpretation serves no other purpose other than limiting a QMEs ability to do his job. The interpretation is not based in reality.** For example, the majority of complex cases do not have multiple parties (both parties) most are individual parties. Setting up a prior agreement with parties is next impossible to arrange with "both" parties, especially if there's only one party. **The proposed modifications would further complicate an already complicated and over regulated QME work flow.**

The proposed CAUSATION Modification would also lead to incomplete reports that would prolong the workers comp process for both TPAs and injured workers. It would be understandable if the modifications simplified the process for the injured worker, the QME, or even for that matter the TPA / insured. The DWCs proposed changes appears to be a way to manage Medlegal costs at the expense of the QME. **The reality is this change will further increase costs, waiting times, and include QME reports that have incomplete information** .

Again, for reasons unknown to me, the new regulation proposals are not based in reality, that's unless the reality is to destroy the California QME program. **If all the proposed changes are passed I can say with certainty there will not be enough QMEs to accommodate the large demand of evaluations in the future.** It's understandable if the DWC wants to help cut costs to the California QME -Medlegal system --- But, these proposed actions are definitely not the way to do it. **The new regulations will make things more complicated in an already complicated**

system. It's much like lowering gas prices by outlawing car engines. The status quo should remain... CA9795 should remain as originally written.

I also would like to say that **if all these proposed changes are implemented in their current form, the five QMEs that my company manages will most likely dropout out of the California QME program.** There will be no upside for them to remain and I'm sure they won't be the only ones either. As for my company, if these changes are passed I will have no other alternative than to close my doors. The QME business will no longer be a viable business for me, nor a viable practice to the QMEs we manage.

My feelings are fairly representative of the QMEs and QME providers in the system. I**f these regulations are passed there will be a mass exodus of QME s and their providers exiting the system.** This will leave an already fragile California Workers comp system in a more compromised state.

Frederick Butler II, MD, QME May 8, 2018

I am an Internal Medicine QME. In regards to the proposed fee schedule changes:

I can guarantee you I will not be able to prepare a Quality ML 104 with only 3 hours of report preparation time.

Most ML 103s and some ML106s I can do with 3 hour report preparation.

Please keep the fee schedule the same, it is accurate and appropriate.

William W. Deardorff, Ph.D., ABPP, QME May 8, 2018

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.

Daniel J. King, Psy.D., QME
Clinical and Forensic Psychologist

May 8, 2018

I am a QME in psychology. It is absolutely impossible to prepare a psych report in three hours. Psychological QME evaluation require gathering a vast amount of data regarding the nature of numerous stressors a person has encountered throughout their life and how those stressors have impacted them psychologically. The discussions are always complex because there must be explanation addressing the relative psychological impact of each stressor. My interview data section is typically about 20 pages and my discussion of opinions section is also about 20 pages. This is not unnecessary. For resolution of the claim this amount of information and analysis is necessary. Psych evaluations are always complex and require a high level of preparation time. For an initial evaluation the minimum report preparation time is 18 hours. Not only am I typing up five hours of interview data into an organized and readable text, but I am also typing up psychological testing section, a summary of reviewed records which may be as long as 20 pages [on psych cases there may be numerous prior and lengthy psych reports that must be summarized], a comprehensive and thoughtful analysis of information with explanations for my opinions and finally a careful editing of the report. This takes two to three days.

If there is a cap of three hours I would have to resign from doing QME work because there is no way I could write a good report under those time constraints. Instead of putting a blanket cap on the hours there should be some other way of measuring whether the report preparation hours are consistent with the work product such as number of pages and relevancy of the information on those pages. To put a cap on the number of hours does a disservice to the injured worker and the adjudication process as the quality of the report would be poor.

Todd D. Moldawer, MD May 8, 2018

Please accept this correspondence as a formal objection to proposed rule changes regarding QME allowable charges and reimbursements. First, I object to the "cookie cutter" approach to determine how much time can be spent on record review and research in preparing a report that by law must provide "substantial medical evidence" to be credible and admissible. Every injured worker has a unique injury pattern, various treatment responses, and underlying non-industrial medical conditions all of which must be considered in the evaluation of an injured worker. I don't think you would ask an architect, engineer, or designer to build your home without performing all of the due diligence that the task requires. I remember no course in medical school advising to provide a diagnosis or treatment protocol without all of the pertinent data that such a decision deserves.

Additionally, there appears to be no "public benefit" to the proposed regulations other than to deprive injured workers of their one and only opportunity to obtain an independent, accurate, and thorough assessment of their injury and impairment rating. California's injured workers have suffered enough under the radical changes brought by SB 899, and asking them to have the fate of their QME evaluation hamstrung by these proposed regulations is both unfair and unjustified.

I have no doubt that these proposed regulations are a response to abuses by a very small percentage of the hard-working and dedicated physicians in California who are willing to take on the burden of continuing education for QME recertification, the cost of the QME certification process, and the administrative burdens on office staff to meet the statutory requirements for timely reports and deposition testimony. The remedy for these "outliers" can be addressed with existing regulations and enforcement mechanisms.

In summary, I hereby recommend AGAINST the proposed regulatory changes.

Daphna Slonim, MD May 8, 2018

This is in response to the suggested changes.

Writing a comprehensive psychiatric evaluation in three hours is impossible. However it may be possible to agree with the parties in advance to lengthen the time.

However, the suggestion for ML101 makes no sense whatsoever.

When I write a supplemental report i.e. Psychiatric P&S report I often have thousands pages of additional medical records to review, complicated questions I have to address for the parties regarding apportionment, I usually spend hours with the applicant to clarify the issues. It usually take me at least 8 hours to compose such a final report.

There is no way I could complete composing complex psychiatric report in three hours!

Anne C. Welty, MD May 8, 2018

The proposal to limit the preparation time of a QME report to three hours is ludicrous- how on earth can a thoughtful, quality QME report be produced in three hours?

I routinely spend at least 1- 1.5 hours simply dictating the QME report, as well as an additional 1-2 hours editing the transcribed report. Then I spend, depending on the amount of medical records forwarded, hours and hours in review and dictation.

This doesn't even account for the time needed for formulation of opinions and producing a quality report.

This is an extremely disappointing proposal and represents a move toward poorly executed QME reports.

Don Pompan, M.D. May 8, 2018

Your proposed changes will make it easier for insurance companies to damage the injured workers. Ultimately, doctors need to get paid for their work. We sometimes get thousands of pages of records to go through to analyze the case. Most of the time the insurance company is denying the worker treatment or benefits. Doctors should be incentivized to go through these records carefully. The process may take hours. Then there is the process of preparing a coherent persuasive report that can go in front of a judge.

Under the proposal, especially in regards to causation, it will be extremely hard to bill for an ML 104. ML 103 will become the maximum code. That is capped around $1,100. Thus, a doctor

can easily put in 8 hours of work for that $1,000. Given that 50% of the fee goes to administrative costs, that leaves $550 to the doctor for 8 hours of work. What quality of physician do you believe that you will get for $60 per hour???

So, what will happen is that doctors will not spend the time to meticulously go through the records, and this will compromise the quality of reports. Who gets hurt? The worker, the same person you are trying to protect.

The only agreement I have with the changes is in regards to research. Doctors abuse this and I see it in reports. If you are a specialist in a field (I.e. I'm an orthopedist), you should not have to do research for a med-legal examination.

Larry R. Moss, MD May 8, 2018

As an AME/QME psychiatrist with 30 years of work comp experience, I typically spend anywhere from 5-7 hours of report preparation for each new evaluation. This includes time spent formulating my opinions and dictating the report. There are often several dates of injury as well as complex histories that combine physical injuries, alleged harassment, and multiple personnel actions. The issues in psychiatry are particularly complex. To reduce the report preparation time to three hours would result in shoddy work and would do a disservice to the applicant, to the attorneys involved, and to the WC system in general.

Leonard Kalfuss, MD, QME May 8, 2018

I object to the proposed change in the reg's re: 3hr., limit for Supp reports, as I frequently receive up to 6 in., records, the need to obtain written authorization for use of causation as a complexity factor or that it is essential to the adjudication of the claim for benefits, as this cannot be determined by a QME and only by the WCAB or attorneys.

These new regulations will cause many very competent and experienced QME's to resign.

John Parke, Psy. D. May 8, 2018

I think these new QME restrictions fall within reasonable bounds. My only concern is the causation change. It will cause problems if implemented as stated.

What if one party wants causation addressed and other does not? What if one party provides a scant cover letter that does not address it clearly? Or, the language they use asks for causation analysis without using the word "causation?"

A simple solution would be to make the parties legally responsible to state a clear yes or no on causation in every cover letter, and if they don't- it is considered a yes or left to the discretion of the evaluator.

Thank you in advance for considering my input on these issues.

William Stearns May 8, 2018

The proposed changes to the payments for QME physicians will accelerate the abandonment of the system by those of us trying to do a careful and thoughtful analysis of each case.

Ron Perelman May 7, 2018

It appears that what is being done is to legitimize the prior "underground regulations" basically trying to prevent QMEs from billing ML104s. This is an attempt to make what should be a simple procedure into a nightmare. Please stop this and be sensible. Prior to 2006 ML 104s were just time based. Let's go back to that. If a good rateable report is needed, then multiple hours and staff are needed. It takes time to evaluate most of these patients and the production of a sound report can be expensive. The present system is designed to pay doctors less and will result in poor reports and many doctors feeling that it is simply not worth the effort. Please go back to a simple time based system

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Gary M. Stewart, M.D. May 7, 2018

I have been performing workers' compensation evaluations in internal medicine since 1981. I have been a QME since the initial QME examination was administered. I am a universally respected and highly experienced medical-legal evaluator.

I am offering observations regarding the proposed modifications to the medical-legal fee schedule 8 CCR §§ 9794 – 9795.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I have made every effort to keep these remarks pertinent and respectful. I also have organized these very clearly regarding to which provision I am referring.

PROVISION	COMMENT
§ 9794 (a)(1)	The phrase "adequate medical information" is vague and subjective. This is open to abuse by claims administrators who will refuse to pay while claiming that "adequate" information was already available. A more specific phrase such as "equivalent" or "recent identical" diagnostic tests would be better.
§ 9795 (b)	The final sentence here places the evaluating physician in an untenable position, precluding the ability to ensure that the reporting being requested represents substantial medical evidence. The time limitations (see below) create the scenario that in many cases, absent a prior agreement with the claims administrator as to the ability to exceed the arbitrary time limits in these newly proposed revisions, the physician would be unable to comply with the billing requirements and simultaneously compose and submit valid, reasoned, non-assertive and therefore arbitrary medical-legal opinion addressing the available medical data. In the performance of my medical-legal reporting in internal medicine, the complexity of the case directs the time required, and absent a thorough analysis, and a report setting that forth, and the basis for it, my opinion would be subject to valid challenge, and even dismissal from consideration by the WCAB. Such dismissals threaten my QME status. This is unacceptable. In my view, it should be within the rights of the physician to refuse to undertake evaluations and reviews if the billing limitations that eventually may become operative preclude the ability to comply with his or her duties with regard to the threshold of presenting medical-legal opinion that constitutes substantial medical evidence. If such a refusal issues, the claims administrator may then comply with the physician's request or seek an Order from the WCAB to seek out a new QME or name a new AME. While cumbersome and time-consuming, it has the merit of avoiding placing the evaluating physician in an untenable position.
§ 9795 (c)	
ML101	Here is the first, of numerous instances in these revisions, in which the arbitrary limitation of 3-hours is placed on "report preparation." **This 3-hour limit is unrealistic and completely out of touch with the reality of report writing in complex cases. Further, it would force the physician to issue opinion that would not constitute substantial medical evidence**. It is commonplace that, as an AME, in particular, but also as a QME in internal medicine, I am referred claims that have been in progress for many years, even spanning decades, with medical records best measured in feet, rather than inches, and naming numerous body systems that fall to internal medicine.

I have never once been advised by a single claims administrator or defense counsel that the times spent in the various categories of medical-legal evaluation have been excessive or unwarranted. Never once. The parties have continued to name me as an AME in internal medicine fully knowing that the complexity of the case involves the need to spend a lot of time to gather the information, analyze it, and present it, along with the opinions as formulated, justified and defended. **I consider this time limitation unwarranted, misguided, and guaranteed to lead to more litigation and expense, not less.**

ML 102 The phrase "uniquely specific to the actual evaluation being performed" is vague, and what is being required here, and the rationale for it, is not evident.

This type of requirement for further detail is only reasonable in cases where the report is more complex than the entry level evaluation and charge.
The addition of this language to billing code ML-102, the fundamental and most simple form of QME (billed at exactly $625.00 in all cases), only serves to provide the claims administrator with the option of refusing payment based upon a vague, subjective claim that these "circumstances" as described by the physician are in some fashion not sufficiently "unique" or "specific."

This billing category is a minimum charge. What justification can possibly be necessary? The charge cannot be less than $625.00.

This language should not be added – it is vague, serves no useful purpose, and is prone to abuse based upon arbitrary assertions by claims administrators.

I also offer objection to the requirement to specify in the report exactly what information has been reviewed or researched and relied upon, as that has no impact upon the charge, which is the minimum allowed for in any basic case.

ML 103 The language here regarding circumstances "uniquely specific to the actual evaluation being performed" I have already commented on above in the section regarding ML 102. This is vague and useless and it has no specific impact upon the billing being submitted, which derives from the use of complexity factors that have their own, specific internal definitions and criteria.

ML 103 (2) I offer no objection to the requirement for the physician to provide detailed information as to the medical records reviewed. **However, I point out that even this requirement impacts the issue of the arbitrary time limit on report preparation**. Complex records, even presented as a list, often entitled "Medical Index", or "Medical Record Exhibits", and attached to the records or mentioned in appointment letters from counsel, are multiple pages long, and just the process of providing here what is required in the reporting begins to

substantially erode the ability of the physician to comply with the arbitrary 3-hour report preparation time limit. **This is especially true in that long lists of records that accompany supplemental requests for record review must be meticulously compared with records already reviewed in previous reporting, sometime involving multiple reports composed over a period of years, so as to avoid re-reviewing information already incorporated**.

ML 103 (3) I do not object to the obvious effort here to prevent physicians from billing a second time for medical research completed within the previous 12-months. I have many times over the years personally commented about it when I have seen physicians billing multiple times for years for medical research carried out once. This is obvious when long boilerplate cut-and-paste language is found in the Discussion section that can extend for many pages with zero reference to the case at hand.

Be that as it may, this is not entirely clear and unexpected complications arise.

If I need to research IARC monographs to address a specific point of Causation or address points relevant to the legal presumption for cancer, for example, that could involve revisiting similar documentation, but the search is for different information. This would be evident in the language of the two reports, but according to the language of this proposed revision, it could be argued that I should be precluded from including this as time spent. Here again, this begins to impact the arbitrary 3-hour report preparation limit.

ML103 (3)(A) The reason the research is necessary is evident from the nature of the information and the arguments deriving from it. The universally applied explanation as to the need for the research will be, "I didn't know this and I needed to find it out in order to give opinion." No physician is going to know, as fundamental/general medical knowledge, the specifics of percentages of prevalence of a given condition in a given population, the exact dates of latency periods of every known infection, etc., etc. That is the information that the medical research commentary is going to provide. **The presence of this language in these proposed revisions is superfluous and useless, and it is not going to impact what evaluating physicians do or the billing they submit.** If a physician performed medical research on the subject of measles in a case involving herpes zoster, they could still, dishonestly, claim that the medical research was relevant as to, for example, "the effects of stress on the course of viral infections." This language is not going to prevent abuses. It is only going to serve to adversely impact all evaluating physicians with the need to provide vague wording that will no doubt lead to further litigation as a distraction from the actual case at hand. There is already a robust opportunity for claims administrator to file complaints about evaluating QMEs, and if a QME engages in obvious gamesmanship on this

issue and performs totally irrelevant medical research for the purpose of padding a bill would and should generate a valid complaint.

I have no objection to providing a description of the information reviewed and/or relied upon. That is something the credible reporting physician already routinely do.

ML 103 (5) The requirement here that anytime this provision is utilized to justify naming three complexity factors it must involve activity in all three categories, is misguided. **Not all cases that involve the need to review massive records necessarily require medical research. The amount of detail and medical data may be overwhelming to sort through and make sense of it, but the diagnoses and medical mechanisms involved may be well understood from the standpoint of fundamental/general medical knowledge. This requirement that this provision can only be utilized if the physician spends time on both medical record review and medical research should be omitted**. The time spent performing review of massive records is just as much a form of valid physician time as that expended performing medical research. This requirement will only force physicians to game the system by carrying out some modicum of medical research in order to qualify for this provision, which will only increase the size of the medical billing while failing to further inform the case or advance it towards resolution. In fact, such research will only open the case to increased costs and litigation, with Applicant and/or Defense counsel challenging what was reviewed as a basis for the medical-legal opinion submitted, and/or with the claims administrator asserting that that the medical research was not medically necessary. Here again, this language is misguided and will only increase costs and delay claim settlements.

ML 103 (6) This language should be clarified. **If there is going to be some form of requirement that there be explicitly stated, prior to the evaluation being undertaken at all, that Causation is in dispute, and that the physician therefore needs to address it, and that therefore the use of this provision of the billing categories is satisfied, it must be made clear that this is warranted and justified if ANY party submits that this is so. There shall be no challenge to that party's request.** Otherwise, it can be expected to occur with some regularity that one party will request that Causation be addressed, while the other party will claim that is not necessary, and the physician would be subject to sanction by the Medical Unit if Causation is not addressed, but denied payment when they do. **The language here that there needs to be some form of general agreement with all parties ("provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact") is unworkable**. The physician is in no position to require or direct the parties to agree to anything. This kind of "agreement" is only likely in the context of an AME, not a QME, since in most QMEs there are

separate advocacy letters that oftentimes do not overlap at all and are clearly in disagreement regarding multiple points and issues, including Causation. There is also the issue that we physicians are required to address what we find, and that includes the presence of what we consider to constitute valid industrial injury issues, even if these have not been named by any party. That is another area where physician expertise may be brought to bear on the issue of Causation, yet denied recognition, and payment denials may then issue.

ML 103 (7)(i) Just to clarify, this requirement that there be "three employers" would include employers where non-industrial injury relevant to the claim took place – for example, previously stressful periods of work with two other employers besides the one against whom the claim was filed, when the claim names injury in the form of a stress-responsive condition such a coronary artery disease.

ML103 (7)(iii) **The naming of the system headings in the *AMA Guides* here as to the determination of the number of "body systems" to be addressed in a complex apportionment, is unworkable**.

The current rules allow designation of injury in the form of diagnoses and conditions that do not comply with or fall within the system headings noted in the *AMA Guides* Table of Contents. Such conditions are well-recognized to exist, and there is specific discussion in the *AMA Guides* as to the appropriate method for addressing the assignment of impairment to an "unlisted condition" (Page-11, *AMA Guides*), by analogy, particularly if the condition is one that is "poorly understood" (Page-11, *AMA Guides*).

Such conditions are not amenable to naming within any of the Chapters named in the Table of Contents.

This makes the requirement specified in (7) (iii) inapplicable in cases where valid Causation and Apportionment is addressed to two dates of injury involving more than one "body region."

One or more of the required two or more "body systems or body regions" may not comport to the Table of Contents, yet be a valid condition to be addressed, while still remaining within the four corners of the text.

ML 104(1); (2), (3) I have already addressed above the unworkable phrase "uniquely and specifically applicable" as to the evaluation.

I have already addressed above the arbitrary and unworkable 3-hour time limit for report preparation.

I have already addressed above the lack of logic in requiring that to qualify for 3-complexity factors when many hours of record review have been necessary, to also require that medical research is part of the time spent on the evaluation.

ML 104 (3) This provision, while well-meaning, is unworkable, as written.

What purpose is there that the report has to include an explanation of the "extraordinary circumstances" for the use of this billing category, since the parties have already agreed, "prior to the start of the evaluation", that extraordinary circumstances are involved???

Would this then allow a bill review service to question whether the evaluation involved "extraordinary circumstances", even though the claims administrator and Defense counsel already agreed in writing that it did?

The explanation as to whether "extraordinary circumstances" exist already had to be submitted to the parties prior to the evaluation going forward, if an agreement on that point was already established. Clearly the physician had to provide explanation to the parties before any such agreement would be forthcoming. To re-name it only opens possibilities for after-the-fact challenge and dispute.

The exact factors that the physician and the parties agree warrant the use of this billing category are not named here, which is appropriate; this is entirely at the discretion of the parties to agree or not agree that the circumstances of the evaluation are or are not "extraordinary", whatever types of situations that term is considered to encompass. The fully-documented decision on the part of the claims administrator that the evaluation involved "extraordinary" circumstances should not be subject to any form of after-the-fact challenge or denial.

This provision could, in the alternative, reasonably require that the physician state under penalty of perjury, specific language to the effect that such an agreement was reached, and that there is written documentation to that effect, for example, but not also be required to justify it a second and superfluous time, which would only lead to confusion and potential after-the-fact challenge.

ML106 (A) Note that the requirement here that no fees will be paid for reports involving review of previously reviewed information also impacts the 3-hour time limit for report preparation.

It is routinely the case that my office receives extensive records with a request for a supplemental report, yet various pages or portions of the records, sometimes

embedded in an otherwise very large volume of records, represents records reviewed in a report composed years ago.

To satisfy this preclusion from re-review, it is necessary that the records be carefully compiled and compared with what has been mentioned in previous reporting. This is time spent in report preparation, and this further demonstrates the unworkability of the arbitrary 3-hour time limit on "report preparation."

ML106 (B) The opening statement of this provision, while unchanged, should be clarified.

Diagnostic testing ordered as part of an initial evaluation is often subject to objection and delay, and that information may not be available for months.

If a supplemental report issues at that time, based upon review of only these study results, it is sometimes the case that it is only at that point in time that the complex issues of Causation and Apportionment may be addressed.

That report therefore represents bona fide medical-legal analysis, commentary and opinion.

If, on the other hand, this provision is only meant to refer to supplemental reports that consist solely of listing or naming the test results, without any further consideration, analysis, explanation, or opinion, then that makes sense and I have no objection to that.

However, if that is the intention, then this provision should specify this fact, which could be accomplished by adding the word "solely" at the beginning, prior to the phrase "the results of laboratory of diagnostic tests…"

Secondly, and more importantly, the additional language in this provision is entirely arbitrary, unjustified and unworkable, and is completely out of touch with the reality of preparing supplementary medical-legal reports.

The time limit of 3-hours here makes zero sense whatever.

It is routinely the case that the parties request supplemental reports based upon massive, newly available medical records that span years or decades (e.g., a full set of Kaiser records). To address, explain and incorporate this information into an already complex case cannot possibly be universally accomplished in 3-hours (setting aside the time for primary record review, to the degree that the time spent on "review" versus "report preparation" can even be distinguished from report preparation, which is itself highly subject to interpretation).

In my specialty of internal medicine, it is by far the majority of cases where a 3-hour time limit may be adjudged incompatible with providing substantial medical evidence.

In addition, the limit of 2-hours to be billed for medical research is equally arbitrary and unrealistic.

It is often only after supplemental medical records are received that the complex issues of Causation and Apportionment lead to the need for medical research. An arbitrary 2-hour time limit here has no possible rationale, unless the DWC intends to assert that in no situation should any physician ever have to spend more the 2-hours in this category of activity.

Charles McDaniel, MD May 7, 2018
QME Psychiatry

DWC has solicited comments regarding proposed changes to **§ 9794- 9795.**

Let me preface this by noting my concern with retaliation from DWC. It is my understanding that numerous QME's have recently been singled out for audits, without transparency in the method or criteria by which they were selected, based on unpublished and unclear guidelines, that resulted in non-renewal of their QME appointment. My concern is that DWC will retaliate against anyone who has taken the time to question their now-public, proposed changes that are without basis in medicine or medical-legal analysis.

Regarding proposed changes to **§ 9794- 9795**

In instances where the issue applies to ML 103 as well as 104, but I have not specifically called that out, then please note that my comments apply to both.

1. Addressing Code ML103 and proposed changes that read:

"In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation."

As well as Code ML104 (1) and proposed changes that read:

"An evaluation which requires four or more of the complexity factors listed under ML 103. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were actually and necessarily incurred for the production of the medical-legal report and required for the evaluation, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon~~ 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.

The proposed sections, underlined above, place an additional and undue burden on an already arcane system of documentation requirements. To create new, cumbersome documentation requirements while simultaneously limiting the amount of time that may be spent writing the document is non-sensical and will result in perfunctory report writing as clinicians try to fulfill the conflicting requirements from the DWC.

2. With regard to every change noting that no more than 3 hours may be billed for report preparation, this raises a number of concerns:

a. It sets an arbitrary limit on time that can be spent on analysis of injury in the context of historical documentation and testimony and sets an arbitrary time limit on the articulation of the analysis of injury. The basis for 3 hours is arbitrary and whimsical and has no basis in medical evaluation, analysis, or reporting.

b. The arbitrary limit takes no account of the complexity of the injury, complexity of the analysis required, complexity of the documentation surrounding the injury, nor the disciplinary-specific requirements of various areas of expertise that may be called upon for evaluation. The 3-hour limit assumes that every case is equivalent in terms of injury, complexity, and analysis.

c. The 3-hour limit does not take into consideration disciplinary differences. It takes no consideration of the number of issues, complexity of issues, or analytic requirements for various disciplines given the disciplinary-specific requests that may be articulated by either applicant or defense.

d. Via the 3-hour limit, the DWC abridges the applicant's rights to adequate analysis by an expert.

e. Via the 3-hour limit, the DWC abridges the defense's rights to adequate analysis by an expert.

f. Via the 3-hour limit the DWC abridges the applicant's rights to thorough analysis that may reveal facts and issues that were previously undiscovered.

g. Via the 3-hour limit the DWC abridges the defense's rights to thorough analysis that may

reveal facts and issues that were previously undiscovered.

h. Via the 3-hour limit the DWC abridges the applicant's rights to an expert's presentation of material and facts that were newly revealed through record review discovery.

i. Via the 3-hour limit the DWC abridged the defense's rights to an expert's presentation of material and facts that were newly revealed through record review discovery.

3. Addressing Code ML103 (3) (as well as other sections of the proposed changes with analogous requirements) sand proposed changes that read:

"Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;"

The proposed sections, underlined above, requiring that a clinician may not cite sources that the clinician has previously cited in other reports is anti-academic, informationally restrictive, and undermines the idea that clinical knowledge and thoughtful evaluations are based in science. By preventing clinicians from citing articles that have previously been cited, the DWC unfairly compromises the expertise that is made available to an applicant or the defense by forcing the clinician to seek out articles that may not be the most topical, relevant, or up-to-date, merely to satisfy the DWC's billing requirement that the articles may not have been cited for the preceding 12 months.

4. Addressing Code ML 103 (6) and proposed amendment that reads:

"Addressing and providing an analysis of the issue of medical causation, ~~upon written request of the party or parties requesting the report~~ provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

In the proposed sections above, demonstrated by strikethrough and underlining, I note the requirement change from "party or parties" to "parties." This opens the door to having either the applicant or the defense (but not both) request that the examiner address causation, thereby requiring that the examiner perform a causation analysis, but since only one party, and not both parties, has requesting causation, this prohibits the clinician from billing for it. This is an unfair practice that creates inequity scenarios. As well, the same inequity scenarios exist in the requirement that "the parties agree that the physician may use causation as a complexity

factor…"

Requiring that "parties agree…is a disputed medical fact...determination of which is essential to the adjudication of the claim…" is fraught with problems. The defense may easily say they have denied the claim and don't agree that causation is essential, thereby ensuring that a) the parties have not agreed upon the clinician making a causation analysis and b) even if the clinician does any work on this issue, the work will not be compensated, thereby creating a disincentive to any causation analysis, and therefore a disadvantage to the applicant.

5. Finally, the QME system and reporting format is a completely new paradigm to every medical expert that enters it. As a result, the new clinicians are spectacularly inefficient when they are first completing evaluations, and it is categorically impossible for any newly appointed QME physician, at least in the specialty of psychiatry, to complete an evaluation in less than 3 hours. In fact, I know of many clinicians who are so embarrassed by how long it took them to complete their first evaluations (and even some of the later, more complex ones), that they under report the number of hours spent evaluating the issues, analyzing the issues, and crafting the articulation of the entire document. And then, even with under-reporting of the time it required to write the report, they claim more than 3 hours.

To be clear, if it does not make financial sense for evaluators to continue to work in this discipline, with arcane administrative requirements and complex analytic demands, when simpler options compensate more and have less hassle, then evaluators will simply leave the system.

Most importantly, if an evaluator's right to provide thorough, thoughtful, and complete assessments to both applicants and defendants is going to be compromised by a public department that chooses capricious ways in which to undermine an applicant's or a defendant's access to expert evaluation and thereby undermines the applicant's or the defense's ability to fairly and justly present their case, then I (and I suspect others) will not continue to work in such a system that abrogates the rights of an applicant or the defense.

Charise L. Alberti May 7, 2018
Workers' Compensation Specialist
Exam Works

9795 (b) regarding the addition of the words, "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."

What is considered to be a "prior agreement"? Is it something that can be agreed on verbally between the parties? Do the agreement have to be in writing?

Maybe the CCR should state "verbal or written".

Another possible wording clarification - "of the parties" may need to be more defined, "between the employer and employee with the QME" or between the employer and/or employee with the QME". There is the "party" that states they cannot and will not sign anything from a QME with regards to agreements, due to the company policy. Some could consider "of the parties" to mean of all the parties, lien claimants, etc. Does the parties mean one or all, etc.

Research, this is even more difficult to understand. Is a QME truly to retain the knowledge that he used research from 12 months prior, on over 200 to 300 medical legal evaluations later and not to mention his/her normal every day patients. The CCR should be written with some sense of humanly possible conditions. How would this be tracked, not all the reports go to the same place, so how would one know if the QME just used the research on three different cases with 3 different employers.

The details are needed, providers to need to be held accountable for their billing practices without a doubt, however these additions to the regulations are not thought out very well.

Janice Skiljo Harris, RN BSN MSN CNLCP MSCC May 7, 2018
MEDLink CEO

MLFS Proposed Regs for ML103/104: <u>Essentially, the proposed Regs are a wholesale slaughter of ML103/104 billing</u>. The ML103 Regs complexity factors significantly limits the ability of the QME to meet ML103 criteria, let alone ever meet ML104 criteria that would prevent the QME from taking cases with complex medical-legal issues with voluminous bankers boxes of medical records. Any complexity factor used as a stand-alone may not be used in combinations under this subdivision". ML104 (5) language is difficult to apply, e.g. "6 or more hours spent on any combination of 3 complexity factors (1)-(3), which shall count as 3 complexity factors, provided that some portion of time has been devoted to each of the three factors. And if one considers the proposed ML103 (6), this complexity factor will never apply unless it's an AME. Surely, it would be unreasonable not to reimburse the QME for their efforts to throughly address the medical-legal issues when they provide factually supported explanatory why/how rational that are necessary to assist the parties toward settlement.

New Regulation Language: The language in the proposed Regs to meet ML103 criteria is unclear and confusing, e.g. (2) "All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of they code", (4) "Any complexity factor used as a stand-alone may not be used in combination under this subdivision".

MLFS Preparation Time: The limitation of report preparation to 3 hours in the proposed MLFS Regs essentially prevents the QME from having enough time to provide a substantial evidentiary report. The need for extended prep time would especially be necessary when meeting billing criteria set forth in apportionment for claimant's with 3 or more employers, 3 or more DOI to same body part/system, 2 or more DOI involving 2 or more body system/regions. In this instance, apportionment is usually not the only med-legal issues as these claims require detailed discussion of medical causation as well as compensable causation for numerous body parts, dates of injury and employers. Surely, it would be reasonable to allow the QME to take more report prep time to allow discussion supported by substantial medical evidence on complex cases.

Re-Review of Prior Records: Disallowing the QME to re-review prior medical records in ongoing legacy cases whereby a QME hasn't seen the patient or reviewed the case for over 9-12 months, also prevents the QME from refreshing his/her notes on the case to then provide a current substantial report that encompasses past and current medical records. Surely, it would be reasonable to allow at least 1-3 hours of re-review of past records to allow the QME to discuss the issues supported by substantial medical evidence.

Signed Pre-Authorizations: The proposed Regs require both parties (who is referenced here is not clear) to sign a pre-authorization for the QME to be able address medical causation, yet by history, only the Carrier's signature is necessary since applicant attorneys, defense attorneys and claimant's do not pay QME bills. We agree with the need to obtain pre-authorizations from the carrier for diagnostic testing when the QME supports the testing necessity. We are not sure after decades of psychological/neuropsychological testing use in psyche and neuropsych claims, how the status for these tests in these type of claims have changed since they are tools necessary for the QME psych to establish validity/reliability of the psych/neuropsych conditions and impairment as well as identify malingering.

Stagnant MLFS Rates: The MLFS has remained the same since 2006 despite QMEs incurred increases in cost of living, cost of goods payroll, insurance policies, office leases. Surely, it would be reasonable to propose a fee increase for MLFS that is based on amount of records reviewed considering that 200 pages (1 inch) = 1 hour of record review along with complexity factors/extraordinary circumstances. Consider a ML102 increase of $750/AME $937.50 (25% more) with cases that have 1-2 inches of medical records. Consider a ML103 increase of $1,250/AME $1,562.50 (25% more) with cases that have 3-4 inches of medical records. The ML104 time based fees could remain unchanged at $250/hour for QME and $312.50/hour for AME with cases that have >5 inches of medical record.

Distrust of QME Billings: Clearly, it appears that the DWC is distrustful of all QMEs billing for record review and report preparation times. Past Rand/CHSWC studies have not supported such a theoretical concept of most QME billing. Yet if the DWC and shareholders do not believe that QMEs are being accurate with their billing, we recommend an audit by DWC. We suggest that the DWC audit 100 QMEs per quarter and require each QME to provide their entire billing for that month. This would weed out the small percentage of QMEs mostly in SoCal who are

indeed over billing, e.g. Dr who does 40 QMEs/AMEs per month and bills 20 hours per case clearly exceeds the number of hours that are even possible in one month.

QME Provider Decrease: The 10/2017 CHSWC study by Frank Neuhauser on QME Updating Trends in Evaluations Availability and Equity does not bear out that QMEs are all over billing as it's being suggested. The study reveals that QME provider numbers have already declined "from 3,187 in 2007 to 2,649 in 2016, a 17% decrease" yet the number of requests for PQMEs have doubled.

A final question remains as to how will California meet the medical-legal reporting needs for resolution of claims in future? These Regs will certainly have a catastrophic impact on injured workers and employers inability to reach settlement.

Jacquelyn A. Weiss MD PhD May 7, 2018

After having read the proposed changes, I have, some observations.

Regarding Causation: it cannot be assume that the parties can identify all industrial causation that they will agree upon in advance. There are often unanticipated additional symptoms leading to disability that arise as a consequence of the injury. In addition, the patient may be seen for a specific injury, and the evaluator identifies instead cumulative trauma. There is also the issue of unanticipated derivative PD or injury that may not be anticipated. Furthermore, not all injuries lead to the same set of symptoms- e.g. not all head injuries result in headache related PD-thus causation of headache PD is not something that the parties can agree upon in advance of the evaluation.

Report preparation: if patients have multiple injuries involving multiple body parts, or it there are a huge number of medical records for review, report preparation can easily exceed 3 hours. This amount of time may not be reasonable in these extraordinarily complex cases, and to spend only 3 hours would lead to an inadequate assessment.

Research: If i have researched a topic within the last year, I always attempt to find newer material that is pertinent to my case. If I do not find additional information, that does not mean that i have not devoted time to research.

I hope that these observations will be considered. Thank you.

Barry A. Halote May 7, 2018

I am in receipt of your proposed changes to the medical legal billing regulations. There is one issue that is very troubling to people in my field, psychology. The proposed regulations set a limit of three hours report preparation time. It is not unusual when performing an evaluation, especially when there is neuropsychological testing involved, for a report to be as many as 30 to 35 pages long, without reviewing records. In order to address issues of apportionment and causation, a psychological history must be thorough, complete, and well-documented. If this is not done, the report cannot be relied upon and cannot be considered substantial evidence.

I am aware that what you are trying to accomplish is to keep costs down, but as you are aware, doctors are leaving the workers compensation system because of actions such as these. If you were to limit a psychological report to three hours report preparation time, it is not feasible to produce a report of any substance. I would not put my reputation on the line to produce a product that is substandard because of restrictions arrived at arbitrarily and capriciously.

I hope you will reconsider the time limit on report preparation time to a reasonable reimbursement for the work that has to be done to produce a quality product.

Anonymous QME May 7, 2018

The proposed changes do not take into account the concerns of or problems faced by the QME's in the Workers' Compensation system. The Insurance Companies on the other hand clearly had a great deal of influence in the proposed revisions to the Med-Legal, fee schedule. In particular the rule limiting providers to "3 hours of report prep time" is ludicrous on its face. I can only assume it was a "throw-away" designed to distract people from the lack of needed reform provided by the rest of the proposal. There are a number of issues which need to be addressed. I present these in no particular order.

1. A very large part of the problem is that the current Med-Legal fee schedule is woefully inadequate in terms of compensation for the various level of reports below ML104. Since 2006 the RV 5 rate of $12.50 per unit has remained unchanged. During this 12 years, the minimum wage has increased over 60%, and as a result staff wages have increased dramatically, inflation and housing costs have increased tremendously, and costs for rent and office space for providers have increased. During this time the expectations of attorneys to provide a thorough report factoring in any and all factors they can imagine, and requirements as the result of case law (Escobedo, Rolda, Fujimoto, Benson, Larsen, Ferrell, Dawson,) for writing a "substantial medical evidence report", rise every year.

If you look back at the original text of the previous iterations of section 9795 change these regulations you will see that the original text of ML102 and ML103, indicated the reports were expected to take 150 minutes hours and 4 hours respectively (A copy this can be found in the Suzanne Honor-Vangerov declaration in the now settled lawsuit Howard v. DIR). Hence why, when "Four or more hours spent on any combination of two complexity factors face to face time, record review, and medical research required more than 4 hours, it automatically gave you two complexity factors, and when any combination of 1, 2 or 3 of the factors that of the three factors required more than six hours, this counted as 3 complexity factors. ("any combination" in plain english necessitates that one or two of the three could not be used) The point was that an evaluation that takes more than six hours, not including report writing and preparation time, is already considerably more involved that the 4 hours expected for a provider to issue an ML 103 report. The goal should not be to make it harder for QME's to bill at an appropriate level. There is a complete disconnect between the work that QME's are required to perform, and the Med-Legal fee schedule.

2. These days it is not uncommon to receive more than 1,000 pages of records. Attorneys and claims handlers routinely send everything they have, and everything they can subpoena, I have seen cases with over 20,000 pages of records, of course many of which are duplicates, but the doctor still has to read/review and parse through them to know that they are duplicates. The system could save a great deal of money if there was some level of care in not providing the QME with redundant and duplicative records, or otherwise completely irrelevant records. Unfortunately this is a tedious burden that the claims adjusters and attorneys are all too happy to pass off to the QME's. Assume a well educated competent QME can read/comprehend/summarize/sort 180 pages per hour (one page every 20 seconds on average, a feat nobody can actually do), 1000 pages requires 5.5 hours. It can be a single reference to a diagnosis, treatment, accident or medication, on a single page out of thousands that is the key to a forensic case.

   a. Take a sample psychological report with 2.5 hours face to face time(not including testing time), 4 hours to read and review 600 pages of records (which is an unrealistically fast rate of 24 seconds per page), then write/edit/serve a 40-50 page report that probably takes them a solid 8 hours. The applicant is not MMI and Causation is not an issue. The doctor has 14.5 hours into the case and the regulations expect them to bill an ML103 for $937, less than $65 per hour. This does not take into account the doctors overhead, such as staff, rent, utilities, etc….

   b. Another sample would be an internal medicine report with 10,000 pages of records, 1.5 hours face to face, the applicant was not MMI, and causation is not an issue. The provider will easily spend 40 hours just to read through the records assuming they can read 250 pages an hour (a rate of 1 page every 15 seconds), and they are expected to bill $937, that works out to less than $23.50 per hour if all they had to do was read the records.

3. Regarding the new language that "No more than 3 hours may be billed for report preparation under this code.". As previously mentioned, this is such an arbitrary rule it can only be viewed as a throw away bargaining chip meant to discarded in order to say that the DIR/DWC is compromising as they bully QME's into accepting the rest of their proposal. Even proposing this limitation demonstrates the complete lack of understanding the people who drafted these regulations have regarding what it takes to perform a QME evaluation and write a report. You cannot place a limit on the time a physician can bill to prepare a report, while simultaneously allowing the parties to provide unlimited records which the physician must read, and the incorporate a summary thereof into a "substantial medical evidence" report. Good arguments must be supported with the evidence and a good forensic differential diagnosis must also explain why the alternative hypotheses are not correct. Generally speaking; more records = more evidence = longer report = MORE TIME TO WRITE. Even a relatively simple 20 page report takes more than three hours to draft, edit, and finalize.
4. Regarding the issue of Medical Research. The issues surrounding the use of the medical research complexity factor stem directly from the problem that unless QME's can meet the requisite complexity factors there is no way to be adequately compensated for the work, time, expertise, and effort that it requires to generate a "substantial medical evidence" report. Simply put $937 is not enough to compensate a qualified forensic medical expert for the time, resources and expenses it takes to issue a report that requires more the 4 or 5 hours of their own time, let alone the office staff and behind the scenes time spent, scheduling, tracking records and cover letter, printing and serving the reports…….and lets not get started on trying to actually timely collect the payment for the work that was done.
5. Regarding the Causation complexity factor. The responsibility should not be on the QME or AME to determine whether or not causation is an issue. The attorneys/parties should very clearly indicate whether or not causation is at issue, and if the parties cannot agree that no part of causation is at issue……guess what…….it is an issue. I propose that the parties be required to very plainly and concretely, in-writing either in the cover letter(s) or in another letter, inform the evaluator if all parties have agreed that AOE/COE causation is NOT at issue prior to the start of the evaluation.
6. A complexity factor should be available for a PQME/AME evaluation. If the services of an expert forensic evaluator are required because the parties cannot resolve the claim on the basis of other available resources, records, and reports, by its very nature the evaluation has some inherent level complexity. If the report meets three or more other complexity factors it is clearly going to take well over the 4 hours originally intended to be required for an ML103 report.
7. At any time the employer/defense counsel/claims adjuster can contest the reasonableness of a QME/AME providers billing. I have personally stood in front of a judge when defense counsel tried to argue that 40 hours of record review was unreasonable…….The judge looked at me like I was a complete fraud, but when he was informed that defense counsel had provided over 25,000 pages of raw records, and that

the record review portion of the billing was already substantially discounted, in that 40 hours translates roughly to one page every 5.7 seconds, he very rightly turned his disbelief towards defense counsel.

8. ML 100 needs to be revised to provide adequate compensation for the providers.
    a. When applicants do not show up for the evaluation the doctor is required to remain there for one hour, time which cannot be recovered, and a good QME will have spent considerable time reviewing the sometimes thousands of pages of records prior to the evaluation. Not to mention the block of time which was set-aside for the entirety of the appointment, which can be the entire day for complex case, or a case occurring at a satellite office which may be hours away from the doctors' primary office. Many QME's have offices in distant locations where they serve communities that otherwise may not have a QME within many miles.
    b. The same problem occurs when an appointment is cancelled within close proximity (1 to 2 weeks) of the evaluation. This is especially if there are more than a few hundred pages of records, a good QME may have already started reviewing these documents, or their medical transcription company will have already started summarizing the records. Then when the appointment cancels, the provider is left holding the bag for their own time and/or the record transcriptionists time. This issue becomes even more problematic in cases with voluminous records. In order for a provider to be prepared for and perform and comprehensive evaluation they should have read the records prior to the evaluation. Unless you have read the records there is no way for the forensic evaluator to adequately address discrepancies with the applicant, formulate appropriate queries as to the applicants condition(s) before, during and since the injury, address whether the applicants memory and faculties are intact, etc…….
    c. The point is that the QME should not be left holding the bag because the applicant failed to attend, the parties cancelled a few days prior to the evaluation, or one party objected to the panel and nobody notified the QME who reviewed the records provided and appeared at the evaluation.
9. The payment for depositions needs to be clarified for the sake of all parties involved. I propose that the minimum fee for one hour of deposition time be tendered at or prior to the commencement of the evaluation. The doctor can then present an written invoice at the deposition and state on the record an accounting of any applicable preparation time, travel time, and/or time in excess of 60 minutes spent in deposition rounded up to the next quarter hour. The party who requested the deposition then has 30 days to pay the additional amount or contest the reasonableness of the charges in writing through the Non-IBR process. I have been in more than one hearing because an attorney wrongfully believes there is a flat $500.00 fee for expert depositions

The overall point being that we need to simplify the billing system, and fairly compensate QME's and AME's for the service they provide. If the billing system was set up to adequately address the issues concerning the requirements on the doctors time and office resources, not just

checking off complexity factors in order to ensure you are paid more than $937 when you have to read 2000 pages of records, there would not be an incentive for providers to stretch to reach complexity factors. There is already a mechanism through which the parties can contest the billing. Bad providers can be weeded out and appropriately disciplined, but in order for the system to work QME's need to be adequately and fairly compensated for the work they do.

That said I propose the following changes for consideration, my proposed additions are in gold, and deletions are ~~struckout~~:

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

(a) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each evaluation is calculated by multiplying the relative value by $15.00~~$12.50~~, 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 and the time required to review the records provided are ~~is~~ the dominant factors determining the appropriate level of service under this section; the time~~s~~ to perform procedures and testing is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service. 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.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

CODE	*B.R.*	*PROCEDURE DESCRIPTION*

ML100	5	~~*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.~~ *Missed Appointment or Appointment Cancellation within 14 days of the evaluation for a comprehensive or Follow-Up Medical Legal Evaluation.* The physician shall be entitled to bill for missed or late cancelled appointment as 8 units at RV-5, or his or her usual and customary fee, whichever is less, for each quarter hour. In addition the physician is entitled to bill in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour for any time spent reading/reviewing/summarizing records prior to written receipt of the cancellation notification.
ML101	5	*Basic Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation which occurs within nine months of the date on which the prior medical-legal evaluation was performed, entails records consisting less than 100 pages, and only records from treatment provided during the interim nine months. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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. No more than 3 hours may be billed for report preparation under this code.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML102	50	*Basic Initial ~~Comprehensive~~ Medical-Legal Evaluation*. ~~Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.~~ Includes evaluations which require less than 1 hour face to face time, involve fewer than 100 pages of records, in which neither party disputes causation, and the injury involves injury to a single body part or region.
CODE	*RV*	*PROCEDURE DESCRIPTION*

ML103	75	*Comprehensive Initial or Follow-Up Medical-Legal Evaluation*. Includes evaluations which do not meet the requirements to be a ML102 Basic Medical-Legal Evaluation and require three or fewer of the complexity factors set forth below. ~~require three of the complexity factors set forth below.~~
		In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were ~~actually and necessarily incurred for the production of the medical-legal report and were~~ required for the evaluation~~, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation~~. ~~An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon:~~
		(1) Two or more hours of face-to-face time by the physician with the injured worker;
		(2) Two or more hours of record review by the physician. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;
		(3) Two or more hours of medical research by the physician, using sources that are not routinely cited by the evaluator on the basis of diagnosis, treatment, or type of report. ~~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 this complexity factor.~~ An evaluator who specifies this complexity factor must also (A) ~~explain in the~~ incorporate the research into 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~~. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;

		(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors~~, provided that some portion of time has been devoted to each of the three factors.~~ Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(6) Addressing and providing an analysis of the issue of medical causation.~~, upon written request of the party or parties requesting the report~~ Causation is presumed to be in dispute unless all parties agree and stipulate in writing prior the start of the evaluation that medical causation is not in dispute. ~~physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation~~;
		(7) Addressing the issue of apportionment, when one of the following conditions applies: ~~items (A) and (B) below both apply:~~ ~~(A) The~~ ~~determination of this issue requires the physician to evaluate and provide an apportionment analysis of~~ (i) the claimant's employment by three or more employers, (ii) three or more dates of injur~~y~~~~ies~~, whether industrial or non-industrial, to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more ~~or more~~ dates of injur~~y~~~~ies~~, whether industrial or non-industrial~~,~~ involving two or more body systems or body regions as delineated in that Table of Contents. ~~The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.~~

		~~(B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.~~
		(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
		(9) The evaluation is being performed by a Qualified Medical Evaluator or Agreed Medical Evaluator.
		~~(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.~~
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML104	5	*Complex Comprehensive Initial or Follow-Up Medical-Legal Evaluation* The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for face-to-face time, record review, medical research, and report preparation:
		(1) An evaluation which requires four or more of the complexity factors listed under ML 103. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were ~~actually and necessarily incurred for the production of the medical-legal report and~~ required for the evaluation~~, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon 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.~~

		~~(1) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician. 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;~~
		(2) A comprehensive medical-legal evaluation for which the physician and the parties agree in writing within 5 business days of the date of evaluation or the receipt of the applicable records, ~~prior to the start of the evaluation~~, that the evaluation involves extraordinary circumstances. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. The request by the physician may be served on the parties by facsimile. If a party does not respond to the request by 5:00 PM Pacific Time, on the 5th business day following receipt they are deemed to have agreed that the evaluation involves extraordinary circumstances. When billing under this subdivision of the code for extraordinary circumstances, the physician shall include attached to ~~in~~ his or her report either; (i) a ~~clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and~~ copy of the signed agreements from the parties; or (ii) a statement under penalty of perjury that the party or parties failed to respond to the request for agreement that the evaluation required extraordinary circumstances. In either event, the evaluator must also provide verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.
CODE	*RV*	*PROCEDURE DESCRIPTION*

ML105	5	Fees for medical-legal testimony. 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 up 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 one hour for a scheduled deposition.~~ The physician shall be paid the minimum fee of one hour at the rate of RV 5, or his or her usual and customary fee, whichever is less prior to the commencement of the deposition. Prior to closing the deposition record, the doctor can present a written invoice and state for the record an accounting of any applicable preparation time, travel time, and/or time in excess of 60 minutes spent in deposition rounded up to the next quarter hour. Within 30 days following the date of the deposition.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML106	5	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 at least five business days prior to the date of the med-legal evaluation ~~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~~. 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.~~

Shawn M. King, J.D.
SOS Medical-Legal Consultants, Inc.

May 7, 2018

[REDACTED] is either a cynic with a plan, or a cynic without a plan. Either way, it is hard to interpret the proposed Med-Legal Fee Schedules changes without reaching the conclusion that a world class cynic is in charge.

And frankly, maybe that's a good thing. But before getting to why it may be a good thing to have a cynic at the helm of billing changes, let's look at only some of the examples that demonstrate the depth of the cynicism.

The cynic with a plan would be the man who knows the proposed changes will cripple the QME system as we know it. How else to explain provisions in the regulations that make some hours of time more worthy than others? How can it be that two hours of record review time, in concert with two hours of face to face time with a patient and two hours of (genuine, and don't snicker) medical research are a valid six hours' time for triggering the newly designed complexity factor five, but six hours of record review time alone wouldn't be?

Likewise, as another example, how can one not reach the conclusion that **[REDACTED]** is a cynic when on the one hand he says a doctor may not refuse an exam because the parties refused to give pre-authorization for billing under 5307.1 yet on the other hand says the doctor has to have pre-authorization to use causation as a complexity factor? Let's recognize that as a practical matter, pre-authorization for billing from the applicant side is worthless and meaningless. The applicant side doesn't have any responsibility for the bill. So in truth any time the new regulations speak of authorization for any type of payment the actual meaning is that the carrier side is in control and able to exert influence over the doctor. That's both cynical and accepting that one side gets to put a thumb on the scale.

Further still, what's the logic behind a cap on thinking time, which is merely another way of labeling report preparation time? Especially a cap that seems to aggressively ignore the vast differences in the type of QME reports the system demands? Not only does the time it take to review 250 pages of records differ from the time it takes to review 500 pages of records, so too does the time it takes to process and structure a meaningful ordering of those records into a thoughtful report analysis.

A full review of the seemingly inchoate thinking behind the new regulations would go on for many, many, more paragraphs. So now let's instead try and think what the point of the new

regulations could be. **[REDACTED]** is far from an unintelligent man, so there has to be some logic behind this. I propose that one of two designs or goals are behind the proposed regulations. **[REDACTED]** as Utilization Review and Independent Medical Review. It's pretty much the Wild West.

Over time, we add percentage barriers to psychiatric injury claims, insert QMEs into the system and even flirt with the treating physician's presumption of correctness. That gets discarded when everyone realizes what a hopeless mess treating doctors make of the legal end of the case. As we get further away from 1990 and closer to the current time, we tinker with TTD such that in comparison to years ago, the benefit is both smaller and more rigid overall. Those pesky treating doctors who frustrated us by not being able to handle a presumption of correctness are penned in and contained via UR and IMR. Apportionment gets rewritten to allow all manner of previously un-allowed factors into consideration and we engineer a straight on wealth transfer from those greedy, greedy injured workers back to the bank accounts of the poor, misunderstood insurance companies via the Benson decision. And that doesn't even include review of the profound changes wrought by tossing out the old work schedule in favor of the AMA Guides.

So, summarizing, we've greatly reduced carrier worries over TTD, we've done the same with medical care costs, and we've made inroads on controlling permanent disability and the apportionment of that disability. In effect, to borrow from The Treasure of the Sierra Madre, "QMEs? QMEs? We don't need no stinking QMEs!" By reducing carrier exposure to various costs associated with claims, the raison d'etre for complex evaluations has shrunk. Under this logic, it is time to choke the life out of the evaluation system and substitute a one size fits all form.

So that takes care of the cynic with a plan.

But what about the cynic without a plan? Under this view, [**REDACTED]** is artfully inviting alternatives by rendering the current system unworkable. Why would this be a plausible path? **Because [REDACTED] is right, it is high time to blow up the payment system for QMEs.**

The complexity based system is something I have great familiarity with, as I had the dubious pleasure of being a member of the Industrial Medical Council's Medical-Legal Task Force in the 1990s that designed the process. Indeed, at the time I was one of the people championing a system based on complexity. And, while it worked for a time, the system is now an abject failure because it is a system inherently open to being gamed by unscrupulous types and also one that rewards inexperience and/or incompetence.

Unexpected consequences are the rule to almost any new regulation or system, and the complexity system is no exception. How much sense does time make as a measure of effort when in every other venture I can think of experience imparts efficiency and better use of time, i.e., less time spent on the same task, not more?! The current system rewards the inexperienced person by paying more for the same task that an experienced hand can do more quickly, and probably better.

Likewise, why didn't we see that clocks were going to break up and down the great valley of California? How else to explain how differing medical offices can review the same set of records in anything from two hours to fifteen hours?

A system was designed to be inhabited by men illuminated by Diogenes' lamp and instead is populated merely by regular folk. And regular folk are susceptible to all manner of ills. The system should be discarded.

What should take the place of the current system? Look again to the past. When I entered the system we all spoke in terms of the 73rd and 80th percentiles, methods of payment designed to guarantee a level of payment for services rendered. The flaw in that effort was bracket creep, as everything was billed at the top of the bracket, driving the percentage up and up. But, conceptually, it shouldn't take much to use the underlying concept of a scheduled payment.

I suggest a tiered system that uses the amount of records submitted as the chief determining factor, along with the type of specialty evaluation. As part of this, all psych testing would have to be paid under OMFS, not Medical Legal rates. Given the grid that follows, there would be no incentive for anything but such a billing style for psych testing.

Specialty →	Psychiatry/Neuropsychiatry/Psychology	Acupuncture	All Other
Amount of records ↓	XXXX	XXXX	XXXX
0 to 250 pages	$850	$400	$625
251 to 500 pages	$1,050	$550	$750

501-1,000 pages	$1,300	$750	$1,000
Over 1,000 pages	Hourly charges for face to face, review of records and report preparation. Elimination of medical research, though this could be substantiated as necessary as part of records review. Charges to mirror current $250 per hour for QME, $312.50 for AME.	Same	Same

For supplemental reports, the premium given to psych reporting for the expected extra face to face time evaporates. Instead, a uniform set of charges across the board could apply, again tied to record review:

Tier One Supplemental: 0 to 50 pages of records: $175

Tier Two Supplemental: 51 to 150 pages of records: $250

Tier Three, for every additional 150 pages, or part thereof, add $250.

Yes, there is still a dependence on counting pages. But, note that now there is an incentive to stop and correct two areas that have clogged the system and stunted quality. First, insurance companies and law firms have turned many doctors into extremely highly paid file clerks. They do this by sending unchecked and unordered files straight to QMEs and AMEs, who then spend seemingly endless hours putting files into order and removing duplicates – all for $250 or $312.50 an hour. And then carriers decry the cost of evaluations! Here's a radical idea, get someone for minimum wage or even higher to vet a file before it is sent to the doctor's office! You want a doctor to produce a report on time and one that makes sense? Then stop burying the doctor with extraneous paper that does nothing but slow him or her down.

On the flip side, if doctors know that page count is going to govern payment rates, the incentive for complete self review of records is greatly increased. The explosion of record review companies has met the need to address the problem cited in the first paragraph. But, an unintended consequence is that some doctors are succumbing to the temptation to review the record summary alone, and not review the underlying file itself. To be every bit as cynical as **[REDACTED]** the above system would also eliminate the ability to bury the charges from a record review service into the value of a report, because there is no way, save for the most

extreme cases, to recirculate records charges back into the overall bill. And for those extreme cases of greater than 1,000 pages of records, one could monitor charges across time to see if there are any consistent outliers in terms of charges for services rendered.

So, there you have it, a new system that doesn't destroy the incentive to report and instead rewards efficiency. I strongly recommend leaving in place the AME modifier of 25% as further incentive to quality. The new system also has the benefit of adhering to the need for medical reporting to meet a standard to qualify as substantial evidence.

Charges could be reviewed every five years, as is supposed to occur currently.

Steve Ounjian May 7, 2018

We suggest simplifying the QME fee schedule. This will eliminate the confusion and acrimony currently growing in the system.

Eliminate the entire model of using factors to set billing levels. It isn't working and adding more language to this billing model could take us further away from solutions that will attract and retain QMEs to the system. I will assume that the retention of existing QMEs is of critical importance to the DWC. The proposed solutions should appeal to all parties.

Therefore keep it simple and objective:

Going forward QME bills shall have a two part component-

1. One flat fee per report/injury evaluated. Example $1,000 (The basic fee allowed for a QME report by DWC back in the late 1980s was actually above $1,000)

Plus

2. A set record review fee for each page of medical record submitted to the QME.
Example: 100 pages = 1 hour ($250)

Each page of medical record submitted is worth a set dollar amount. This maintains objectivity. It's fair and ALL parties should agree to the pricing.

The QME would charge the flat fee plus any allowed record review time by medical record page received. This maintains transparency and eliminates any unreasonable up-coding but at the same time protects the QME from heavy discounts of his or her time. Fairness and an up front agreement is built in for all parties.

This new system could eliminate the following:

1. Carriers could save time and money by not having to rely on bill review. Ultimately saving on spending countless hours arguing over the proper level of bills.

2. QMEs could save time and money by not needing an army of collectors to argue the usage of factors. Nor would they need staff to obtain pre-authorizations on large files. They would be paid without a cut to their bill. Confusion and concern would be eliminated.

3. DWC would not need to spend as much time and resources enforcing confusing regulations around QME billing. This would free up resources for the DWC to possibly monitor the quality of the reports produced.

Assuming the above suggested fee schedule was implemented the following should also be considered:

1. Medical Research and preparation time on face to face evaluations are entirely eliminated. QMEs could elect to add research but it would not be an add on for time or increase charges.

2. Interpreter modifier stays the same.

3. Supplemental pricing would be based on time as it currently stands. No time restrictions on prep time. Record review would follow same model as outlined above.

4. Psychiatry would need a separate higher flat fee to adjust for added complexity.

The following should be updated regardless of the fee schedule model used:

1. No Show or Late Cancel fee (under 6 days from DOS) would pay the standard flat fee mentioned above to the QME. This brings a definitive fee to the ML100 code. This is fair as the QME could not cancel the appointment and is required to show. Therefore the QME should be compensated for the reserved time and lost opportunity to serve the system.

2. Depositions should be required to be prepaid at the time of SETTING the depositions. Often the deposition gets canceled at the last minute and the parties refuse to pay a late cancel fee. Deposition fees should be set higher than what the current fee schedule allows.

It is critical that the new language being considered and implemented protect ALL participants contributing to the work comp system. This includes the QME too. QMEs have to feel that the fee schedule is fair to them. They should be looked upon as a highly valued participant supporting the system not as just a line item frictional cost. This is critical and they shouldn't be trivialized or ignored on this matter.

In closing, let's immediately move to a QME system where the carriers, QMEs and DWC are aligned through a foundation of objective and fair flat fee plus (+) compensation per page

reviewed model. This will serve all parties and allow each to focus more fully on their highest and best use in the system.

Lawrence Weil, MD May 7, 2018

Lots of problems with proposed new regulations. Main issue is seems as though goal is to prevent examiners from billing 104 even when that would be appropriate billing

Most egregious to this examiner:

1) 'research not used in report authored in last 12 months'
HOW WOULD EVALUATOR RECALL EVERY REPORT IN LAST 12 MONTHS AND WHAT IF ANY RESEARCH CITED??
ALSO, WHAT IF THE SAME RESEARCH IS RELAVENT.. WOULD BE APPROP. TO GIVE SMALLER AMOUNT OF TIME.

NOT ALLOWING IT AT ALL SEEMS TO BE A WAY SIMPLY TO PREVENT QME PHYSICIAN FROM REACHING ML104, EVEN WHEN APPROPRIATE

2) 'causation must be agreed upon in advance by both parties' to be complexity factor THIS ESSENTIALLY MAKES CAUSATION IMPOSSIBLE. TO RECEIVE TIMELY LETTERS FROM BOTH PARTIES IS UNUSUAL, MUCH LESS AN AGREED UPON LETTER.
ALSO WE ARE OFTEN ASKED TO "EVALUATION WHETHER OR NOT WORK CONTRIBUTED TO THE INJURY" OR SOME SIMILAR PRASING BUT THE WORD CAUSATION NOT SPECIFICALLY USED. THIS HAPPENS IN FACT MORE OFTENTHEN NOT, THUS UNDER THIS FLAWED PROPOSAL, CAUSATION WOULD NOT OR AT BEST RARELY BE ATTAINED AS A COMPLEXITY FACTOR, SHOULD WE THERFORE NEVER ADDRESS IT??

Making causation so difficult/impossible to be counted as complexity factor seems to again be making much more difficult to reach ML 104, even when appropriate.

Stewart A. Lonky, M.D., F.A.C.P. May 6, 2018

I have reviewed the proposal and have a number of comments. I will address each in a single e-mail so as not to confuse the issues.

For ML103 and ML 104, there appears to be a consideration of a restriction from using the same articles for research more than once a year. This is not reasonable, and can lead to reports not meeting the standard of being "substantial medical evidence"

Let me explain.

In internal Medicine cases, there are certain "landmark" papers, just as in law there are "landmark cases" that are cited. These articles for the bases for an argument as to whether a particular complication can be expected to occur after a certain injury. Many internal doctors use these "landmark cases" to establish the basis for other articles that will pertain the more specific issues in a given case. If the DWC feels that citing landmark cases is not allowed, then the basis for the entire argument will be missing. I believe this provision would never float in the legal arena...an attorney or judge being restricted from using a landmark case from being used in a brief or judgement more than once a year....so why impose this on physicians completing medical-legal reports (which are, in essence, briefs).

AMEs and QMEs must be allowed to cite these references, attribute minimal time for inclusion, and then ADD additional references that are specific to the case at hand if they are applicable or exist. There should be NO restriction from including these cases in as many cases as is appropriate in a year's time for a particular QME. If this rule remains as stated there will be NO scientific basis for opinions.

I'm afraid the DWC reviewers will have to look at ALL the articles cited, not simply restrict those articles serving as the basis for the argument in the first place

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Rod Melvin May 6, 2018

Below is a copy of the e-mail that I sent to the DWC regarding the proposed rule making changes under ML103(6) for causation:

I have read in the DWC's forum the proposed rule making changes regarding the Medical-Legal Fee Schedule and there remains a significant problem with regard to using *causation* as a 'billing complexity factor' under ML103 factor 6.

The DWC's proposal now states the causation may be used as follows:

(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the

determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

The problem is the proposed mandate that "the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact…".

Unfortunately, applicant and defense attorneys & claims administrators have no legal mandate that requires them to specify prior to the evaluation what medical facts are in dispute that has necessitated the QME evaluation. In fact, there is no legal mandate that requires the parties to even provide the QME with a charge-letter/'letter of instruction' prior to the evaluation. This means that the QME is left with having to communicate with both parties to find out what medical facts are being disputed and, specifically, if causation is in dispute. More often than not, because there is no legal requirement to do so, the parties do not respond to the QME's request, which is typically ignored by the parties. Furthermore, with regard to causation, one party will often ask the QME 'if the biomechanics of the claimed injury are consistent with the claimed injury' or a party may tell the QME in a multi-body part claim that only certain body parts have been accepted but not others being claimed by the other party. Such *DISPUTE* inevitably leaves the QME with having to address an obvious *causation* problem/dispute with regard to the body parts not being accepted by the claims administrator/defense.

In other words, the proposed rule making change requiring pre-evaluation written agreement by both parties that *causation* is in dispute is an unrealistic requirement that will seldom…if ever…be accommodated by written agreement. This places a significant burden upon the QME, who is often stuck with having to make significant *causation* determinations in a claim without any legally required cooperation by the parties.

This proposed language needs to be changed; and I would be happy to provide my draft of more appropriate and realistic language regarding causation's use as a billing factor upon request.

Gary Steward, M.D. May 6, 2018

The most problematic of the proposed revisions to the Medical-Legal Fee Schedule are the various arbitrary time limitations. The reason for the ML-104 billing category is the recognition that workers' compensation claims and the medical-legal issues raised may be exceedingly complex and time-consuming to thoroughly address. As long as the information and analysis in the report is comprehensive, relevant, and constitutes substantial medical evidence, and there is compliance with the additional documentation requirements that these proposed revisions set forth, applying an arbitrary time limit is counterproductive and guaranteed to lead to reporting that is incomplete, even slipshod, and this in turn, will bring about requests for depositions and

supplemental reporting, as well as additional litigation regarding whether these time limits are congenial with the demands that the rules and regulations physicians must comply with can in fact be satisfied. I have been performing workers' compensation evaluations in California since 1981. I have composed uncounted reports, including many reports of great length requiring tens of hours to complete, and I have never once been challenged by any party regarding the time I have spent, as verified under penalty of perjury. Never once. On the contrary, I have been complimented innumerable times that the parties greatly appreciated the comprehensive synthesis of massive data that my analysis provides. The complexity of the case drives the time, and the report itself serves to reflect this.

Douglas Owen, D.C., QME May 5, 2018

My name is Douglas Owen, I am a licensed chiropractor and qualified medical examiner. I have been in practice since 1989 and I have been a qualified medical examiner since 1994. My main concern is that often I have cases where the subject may not have had several jobs or may have only injured one body part, but the injury had occurred sometimes years past, and there are numerous medical records to review. Most of my time in writing a report is spent reviewing medical records. It appears from the proposed changes that there may be a case where I spend well over 10 hours reviewing records, but the case does not meet some of the other criteria regarding complexity factors so I will still only be able to bill an ML 102. It is my *time* spent reviewing records and writing the report that I feel I should be paid for, not for how complex the case is.

Due to my extensive experience, the complexity of the case does not necessarily require more of my time, although sometimes it does require more thought and expertise, and I feel that the amount per hour that I am paid is adequate compensation for my skill, however it is the *time* that I spend reviewing records and writing the report which should be the main criteria for payment. In other words the complexity factors for billing as they stand now do not necessarily reflect how much time it takes me to write a report, and no additional modifications to the present fee schedule will change that. I feel that there should be a provision that accounts for the time that it takes me to review records and write the report, whether the case is more complex (i.e. multiple injured body parts, number of previous jobs, complexity of apportionment etc. etc) or a simple case that may have over a thousand pages of records to review.

I have been in practice for over 25 years and I no longer see patients but perform only qualified medical exams, as I sold my patient practice a couple of years ago. It will not be worth my time to travel sometimes 2 hours to arrive for the exam, 2 hours to perform the exam, then another 5 to 10 hours or more reviewing records and writing a report only to be paid $625 (if the case does not meet all of the other complexity factors). When other overhead expenses are accounted for such as my clerical assistant, payment for the office space, malpractice insurance etc., are figured into the equation, then the value of my expertise is substantially lessened and it will therefore

not be worth it for me to continues as a QME, so I will simply retire fully. Perhaps this is the goal for those who are behind adding more stipulations to the present "complexity factors" of the fee schedule (i.e. forcing the retirement of the systems most qualified medical examiners), but in reality, the complexity factors do not substantially affect the time spent to perform an exam and write a report, and the truth is that the question to be asked is simply.....how much is my time worth for my expertise?

Katalin Bassett May 5, 2018

This will finish the process to totally destroy any decent wc evaluation. Great for insurance companies disastrous for injured workers.

Abuses need to be curtailed but do not throw out the baby with the baby water

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Karen Sanders May 5, 2018
Office Manager for QME

One issue that I forgot to address in my last email, that I need to include:

ML106. No more than three hours may be billed for report preparation under this code. We have received massive amounts of records that arrive after the evaluation has been conducted and the report written. About 20% of the time, the QME I work for conducts evaluations without records. The QME cannot cancel an appointment if no records have been sent. The QME can request records directly from a physician if the physician is known, however, if more records arrive after the QME obtains records, then the QME must absorb the cost of eliminating duplicate records. However, even if the QME obtains records from one physician, there is often more than one physician in a case. It is actually very rare that only one physician is involved and we can therefore expect more records to arrive. The QME I work for has conducted numerous evaluations without records. This billing regulation means that attorneys and adjusters can easily send records after the appointment, request a supplemental report, even in large complex cases that the QME has no prior knowledge as to the complexity, thereby rendering it impossible to be paid for large reports and using this billing regulation to dramatically reduce their costs and causing cost overruns for the QME. This will have the most adverse affect on the more experienced QMEs who are chosen for more complex cases. If the goal of the DWC is to drive the more experienced QMEs who handle the more complex cases out of the system with these type of cost overruns, then the DWC will achieve their goal with this proposed billing rule.

Marc Meth, MD, QME May 5, 2018

After reading the proposed changes to the medical-legal fee schedule, I would like to make a few comments. While changes are certainly needed to limit billing abuses by some med-legal evaluators, this schedule marks such a significant OVER-correction that you will lose many outstanding QME and AMEs in the process. Many of the reports that I and others prepare are quite complex and require numerous hours of medical record review, face-to-face patient time and report preparation. To try and force a low standardized fee for these reports instead of properly paying physicians for their time spent will make it impossible to provide excellent reports that show substantial medical evidence. There must be ways to limit abuse of the system without affecting the quality of reports needed by the DWC to help adjudicate the claims of injured workers.

Karen Sanders May 5, 2018
Office Manager for QME

I am the office manager for a QME provider since 2014 who practices in family medicine and pain medicine. Since I deal with billing issues and the requirements for these "agreements" between the QME and the parties (because the QME is not allowed to communicate directly with them), I feel I have another perspective to offer.

1) **Limit to three hours of report preparation.** Bottom line - the number of records has a direct correlation not only to the amount of time it takes to review records, but also to the amount of time it takes to write the report. More records equals more complexity and more writing time. The typical length of a final report for the QME I work for is about 30 pages. I would say approximately 30% will be 50 pages and I have seen about 5% go beyond 50 pages and reach up to 80 pages. Up until the last two years, I would say the typical number of records would be close to 1,000 pages. As the QME I work for gains more experience, he is being chosen for the bigger the cases and the number of records he receives is growing dramatically. Now, a typical case for my QME is closer to 5,000 pages of records, some cases reaching up to 10,000 pages. There should be a direct correlation between the amount of records and the amount of report preparation time, as well as record review time in order to facilitate a fairer billing schema. Otherwise, it becomes inherently unfair for the most experienced QMEs who are receiving more and more complex and record-heavy cases. In addition, attorneys and adjusters typically will dump massive numbers of records without prior review for duplicates, leaving the cost of the labor to cull-out duplicates to the QME. This is not a small, insignificant problem. It

is highly task-intensive and a time-consuming process. We typically receive the massive duplicate record dumps for subsequent re-evaluations and supplemental reports over and over and over again. It is a cost for labor that must be born by the QME. In addition, for those records that the QME did not examine from a previous report because that had nothing to do with the injury, the QME must spend his or her personal time culling out those records once again. This situation does not occur on just on a few cases here and there, but is the norm. The use of extraordinary circumstances to be paid fairly for the amount hours spent on large complex cases, as written in these draft billing code regulations, may as well not exist and is an unobtainable billing code as explained below.

2) **Two or more hours of medical research by the physician, using 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 this complexity factor.** This is unclear as to the use of words "ANY" or "A" as capitalized in the prior sentence. Does ANY prior medical report refer to any report written in any case or just the case the QME is working on? The use of the word "A claim" does not specify that you are talking about a specific case. How does the DWC intend to interpret and enforce this billing code? QMEs deserve an answer to this question so they are not blindsided by unexplained interpretations of this billing factor.

3) **Addressing and providing an analysis of the issue of medical causation, provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation.** During the period of time over the last couple of years, I have been the one trying to get attorneys and adjusters to "agree" to extraordinary circumstances even in those cases where there were massive numbers of records and complexity. This was an IMPOSSIBLE task. The argument they kept giving me was - "I cannot obligate my company or my client to any billing factor before the evaluation is conducted." I am not a doctor and I am trying to explain why we believe it is an extraordinary circumstances. The QME is not allowed to talk to them directly. Now, the same problem will now exist with proposed rule. This rule will effectively eliminate causation as a billing factor unless you change the regulations to require and compel the adjusters and attorneys to provide a written causation statement. And the only way that can be implemented will be to allow the QME to refuse to set the appointment unless they receive a statement about causation. Another problem with this proposed rule - the parties will often say they want the QME to determine causation because they are unsure about causation until the claimant is medically evaluated. This rule regarding this billing factor requires that the parties must determine the matter of causation for themselves before the evaluation. I've seen reports written by the primary physician who states they think a QME should determine causation. There are some cases where the claimant has not been seen by any physician prior to the evaluation. This rule assumes that the adjusters and attorneys have enough medical knowledge to know ahead of time whether or not there is medical causation and this is an argument that they must have before the evaluation. I'm not an attorney or a doctor and I can see the catch-22 problem of this proposed

rule and that it is ludicrous. And again, this rule will effectively eliminate causation as factor. If that is the goal of the DWC, that goal will effectively be achieved if this rule is implemented.

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. It would appear that this is the only billing code that does not have a three-hour report preparation limit and is intended, on the surface, to provide a billing code for large, complex cases. However, you may as well eliminate this as a usable billing code as written. 1) Adjusters and defense attorneys WILL NOT agree in advance to obligate their company or client to any billing code. I heard this over and over and over again with regard to extraordinary circumstances over the last two years. Again, I am not a doctor who can necessarily use my medical knowledge to persuade and the QME is not allowed to talk to adjusters and attorneys to make the case. 2) The idea that adjusters and attorneys will voluntarily make the effort to determine that a case meets extraordinary circumstances and inform the QME on their own, in advance of the appointment, is a thought process not based in reality. The reality is, the QME and his/her staff will make the determination based on the receipt of records and cover letter that a case will meet extraordinary circumstances. 3) The rules regarding the sending of records make it impossible in many cases to know whether or not a case will meet extraordinary circumstances BEFORE the appointment. We will often receive massive number of records the day before, the day after and later. The rules state that the QME can receive records up to 10 days after the appointment and is required to include those records in the report, as long as the report has not already been written. Therefore, by requiring that agreement must be made for extraordinary circumstances BEFORE the appointment effectively eliminates it as a usable billing code. 4) I doubt that very few QMEs have ever been able to bill under extraordinary circumstances unless they have a staff person who is willing to persistently pursue it. No attorney or adjuster is going to let the QME know in advance that they have an extraordinary circumstances case. In fact, I can tell you that 100% of the attorneys and adjusters I've spoken to about extraordinary circumstances, did not know about it, nor did they care. The response always has been, if it is ML104, just bill ML104. 5) If the DWC really wishes to make this billing code available to QMEs, they need to create a regulation that compels and requires adjusters and attorneys to respond to inquiries about the potential for extraordinary circumstances. 6) There is no regulation regarding the measurement of what constitutes extraordinary circumstances. How many pages or inches of records? How many primary physicians? And so forth. At this point, it is up to the QME to make that determination, which then in-turn has to be explained by the QME staff to attorneys and adjusters that the doctor "believes" that the case will constitute extraordinary circumstances. That is, of course, only if we are lucky enough to receive the records in time BEFORE the appointment to make the request. 6) This billing code may as well not exist as it is written in such a way as to inherently preclude any use of it, thereby forcing QMEs to bill at a much lesser rate with a limit of three hours of report writing time. More experienced QMEs who get the larger more complex cases will be hurt the most and be forced to leave the system due to cost-overruns. If this is the goal of the DWC, then this billing code, as written, will certainly achieve that purpose.

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

D. Sami, MD May 5, 2018

I urge the DWC to come up with a list of recommendations that are practical, and will not result in a mass exodus of Qualified Medical Examiners in California:

A. The expectation / requirement "that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact" is impractical and in contradiction to Labor Code 4664.

As physicians we have to interview / examine the patient and review the records to make an informed decision about percentage of industrial and non-industrial causation.

A doctor cannot get a prior agreement for a pre-existing condition that may be unknown. Therefore, medical causation must be addressed on all cases. Based on Labor Code 4664 the doctor has to address any pre-existing medical condition in order to create an impairment rating, and given that requirement there may be apportionment to a pre-existing condition that is non-occupational or from a prior injury/illness.

Also, In many cases we do not receive communication from one (or both) parties prior to the evaluation

B. The expectation that a physician not utilize a reference that he has used in the past 12 months is unrealistic. It would require an impossible feat of memory. Also, some references are sentinel studies that support the discussion of causation and are the basis of substantial medical evidence.– i.e. differentiate medical opinion from scientific / research based conclusions.

C. The expectation for a physician to consider the facts of the case, type and proof-read a comprehensive med-legal report that includes a discussion of causation, apportionment, MMI, future medical, with appropriate references (i.e. to prepare a report that is well thought out, logical and defensible) in 3 hours or less is absurd. The minimum in most cases should be 6-7 hours. Complex cases require more time to develop substantial medical evidence.

D. 80% of physicians who performed worker's compensation treatment have opted out of the system following revision of the fee schedule. As a result many injured worker's are experiencing sub-standard care and delays in treatment.

The drastic changes now proposed for the Med-Legal fee schedule will create a similar exodus of qualified medical examiners, and will only add to the delays in care and increase the number of days employees are absent from work for disability.

Paul Marsh DC, QME May 5, 2018

In summary:

Some of the proposed changes reflected will restrict evaluators' such as myself the ability to submit reports that constitute substantial medical evidence.

- Also the proposed changes make what one can only describe as a "convoluted fee schedule, even more convoluted!"
- The proposed changes seek to limit what is constituted as "Causation" and "Apportionment" as complexity factors.
- They also limit paid report preparation time to 3 hours when using hourly components.
- There appears to be no adjustment for inflation, and there has been no adjustment for inflation since 2006. Meanwhile, inflation has increased 23.5% from 2006-2018, according to the Bureau of Labor Statistics' consumer price index.
    - How can the DWC claim to be even-handed, when it has allowed medical legal fees to remain static for over 11 years?
- I personally believe that $250/hour is not reasonable reimbursement for a medical expert?
    - Especially when the attorneys that attends depositions in Workers Compensation cases are paid $350 or more per hour.
    - Why should a medical expert who has more education be paid any less than the attorney?

These changes in my opinion are neither fair nor just. I fear that if these changes go into effect the system will lose a lot of "good doctors"…. To support my opinion: We have already seen a trend amongst the more seasoned Orthopedic Surgeons of dropping their QME's and only doing AME's and/or utilization review…

Reina Archuleta, CPC, CPCO, CPC-I May 5, 2018
Business Administrator

Corrected the second paragraph to read claims administrator instead of provider...
(g) If the claims administrator receives a written objection to the denial of the medical legal expense under subdivision (d) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a petition to review of the denial of medical-legal expense and a declaration of readiness to proceed pursuant to section 10228 et. seq.

Section (f) (2) emphatically states that should the provider fail to object to the denial, neither the employer nor the employee shall be liable for the Med Legal expense. However, that same language is not found in (g) should the claims administrator fail to file a Petition to Review along with a DOR.

What is the provider's remedy should the claims administrator fail to file a Petition for Review and DOR?

Section (g) does not indicate a timeline for the claims administrator to do this. How long does the claims administrator have to file the Petition with DOR?

I believe it is important to clarify the timeliness on both ends. The pendulum must swing both ways to maintain the balance.

James T. Platto, MPH DC QME May 5, 2018

With regard to the proposed fee schedule regulations and the issue of *causation*, please consider the following.

On reading CCR10606 and LC4628, please be reminded that there is no statutory instruction in either code that requires a comprehensive medical legal (QME) report to address *causation* in terms of the 'cause of the injury'. The only mandated requirement for inclusion in the report is that the '*cause of disability*' (i.e., impairment) must be addressed and included in the report.

And in this regard, if industrial causation is at issue, LC4060, directs that a comprehensive medical legal (QME) report be obtained to address the disputed issue of causation with regard to industrial causation & liability of the employer. And LC4060 says nothing about both parties having to agree to such an evaluation regarding industrial causation in order for the QME to use causation as a billing complexity factor.

Furthermore, given the proposed fee schedule regulation language regarding causation, the lack of adequate language in the proposal creates a situation in which even in a denied claim situation, the QME cannot use causation as a billing complexity factor if only one party requests in writing that the QME address causation…because the proposed language clearly says that there must be pre-evaluation written requests (or agreement) from *both* parties to address causation as a disputed issue in order to use causation as a billing complexity factor. Therefore, in a denied claim, even if *one* party requests in writing that the issue of industrial causation be addressed, that is not sufficient justification (per the proposed fee schedule language involving causation) for the QME to use causation as a billing complexity factor.

Such contradictions on their face would appear to make no sense and should be given thoughtful & careful review by the DWC prior to implementation of the proposed fee schedule language. Without such careful and thoughtful review and reconsideration of this issue…and clear explanation of same…QMEs will remain both confused and potentially at significant risk because of such confusion & apparent contradiction.

Please correct me if I am wrong, but it would therefore reasonably appear that the QME, unless directed in writing by both parties prior to the evaluation to do so, should not address *causation* in terms of 'cause of the injury', (i.e., what other industrial or non-industrial injuries and/or pathologies have contributed to the claimant's current injury status…which is a separate issue from the *cause of disability/impairment*). Remember, not all *contributory causative factors* with regard to the cause of the claimant's current injury status have necessarily contributed to the cause of the disability/impairment. These are two separate issues.

And, in conjunction with this proposed change involving causation, please be reminded that the parties to a claim, (i.e., attorneys and claims administrator), have no legal requirement to provide the QME, pre-evaluation, with letters of instruction that clearly and specifically delineate and explain what the medical fact or facts are in dispute that necessitated the QME evaluation in the first place, which puts the QME at a distinct disadvantage.

Your thoughtful consideration of the above observations and comments is appreciated.

Gerald Markovitz, MD May 5, 2018

Some cases involve a review of an enormous amount of medical records. Not uncommon might be more than one copy paper size box of records. The ability to bill for reviewing multiple thousands of pages of records should not be burdened by requiring a prior agreement to review the records.

How is a physician to know in advance that causation is "a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits" prior to evaluating the patient and reviewing the medical records? It seems inappropriate to require that both the physician and the parties agree prior to the start of the evaluation to address causation as a disputed fact. The parties should agree to have the physician address this issue and let the physician make such a determination as part of the evaluation.

It does not make medical sense to require that a patient be P&S/MMI before determining apportionment. Why must the patient be P&S/MMI to address apportionment?

May ML101 also include a review of medical research?

ML103 complexity factor 5: as proposed seems to make medical research mandatory if the evaluator spends 6 or more hours on the case. What is the rationale for that?

Mara Tansman, Psy.D., QME May 5, 2018

Paying for no more than 3 hours for report preparation is short-changing both the evaluator and the applicant. There is a lot that goes into preparing a well considered evaluation and the DWC will see a decline in the quality of reports.

Andrew Dean, Ph.D., QME May 5, 2018
UCLA Semel Institute for Neuroscience and Behavior

In the new proposed fee changes to the medical legal rates, it has been proposed that repeat eval report time be capped at three hours. I strongly disagree with this proposal for psychology QMEs. To determine apportionment in psychology the applicant's entire psychosocial history must be considered, and hours of psychological testing scored and reviewed. This is very often not possible in three hours and would result in reports that are not substantial medical evidence.

Annette Swain, Ph.D, ABPP-CN, QME May 5, 2018
Associate Clinical Professor, UCLA Department of Psychology

I am writing to express my thoughts and opinions regarding proposed changes to the QME/AME medical-legal fee schedule. I have read that you propose limiting the amount of report preparation time for ML 104 reports to 3 hours. In my opinion, that paltry number is completely ridiculous and will lead most current QMEs to give up providing these assessments. This is especially true in the mental health area, where discussion in the report of mental health issues and test results can become exceedingly complex. Furthermore, in cases where voluminous records are received, as often is the case by the time a QME is requested, it typically takes a considerable amount of time to document that in one's report, even if the report is being dictated. I understand the need to prevent fraud and abuse; however, such a rule will be counterproductive as it will render QMEs forced either to write insufficient reports so as to keep within the 3 hour preparation time or to give up their status and work as a QME altogether.

Gary Stewart May 4, 2018

The inclusion of time limitations, such as no more than two hours of medical research, or no more then three hours of report preparation, is arbitrary and counterproductive. Case complexity in my specialty of internal medicine routinely involves the need to spend many more hours than this in order to understand, summarize and explicate the case, and provide medical-legal conclusions. I routinely, for years, have received feedback from applicant and defense attorneys and claims administrators that they find my summaries and analysis of cases extremely helpful. I have never been advised by any attorney or claims administrator that my record reviews or medical research or the time spent in report preparation were unwarranted or irrelevant. I therefore find this proposal misguided and arbitrary. Such limitations will commonly lead physicians to submit medical reporting in which opinion that is incomplete, inadequately reasoned, poorly explained and virtually useless to the parties to advance a claim toward resolution.

Richard F. Geist, MD, QME May 4, 2018

I am an Internal Medicine physician. Many of the cases that reach me are for individuals who primarily have orthopedic injuries, but for whom some QME has suggested that an Internal Medicine QME evaluation is in order.

A distressingly high number of these workers have been treated for years by surgeons. Multiple medical problems have been ignored by many of the surgeons as the worker had no primary medical physician. Alternatively many have been treated for their medical illnesses by physicians outside the WC system.

Also, attorneys and Claims Managers have become more and more lazy about getting medical records to me by the time I have my appointment with the worker. Then 2-16 weeks later a thick stack of medical records is forwarded to my office for review. My initial report will have been significantly limited by not having the records in a timely fashion. Lacking appropriate medical records, my initial reports often have to be downgraded to a 102 level.

Your new regulations for Supplemental Reports ML101 and ML106 would limited my billing for more than 3 hours of record review. Those records that should have been sent to me before the initial report was completed (and which would have resulted in appropriate higher levels of service) arrive late requiring a supplemental and some of these records are 4-8” in thickness - requiring way more than 3 hours to review in detail, page by page, line by line looking for pertinent medical information. Or if I have asked for medical records from outside physicians

which were not supplied to me initially by the attorneys or Claims Adjuster, and these can be voluminous and clearly call for more than 3 hours of review time.

I look at all Internal Medicine conditions that the worker might have. Often I am the first person to realize that there are non-orthopedic issues that are resulting in the applicant not getting better under the surgeon's care. Similarly, I may find medical complications arising from WC physician care that are clearly WC related. Through careful record review, I have also found cases that must clearly be denied because problems were pre-existing!

If you're going to build in financial disincentives for us physicians, please consider creating them for attorneys and claims administrators who over a period of months fail to send medical records to the QME prior to the initial evaluation!!!

Dominique Kinney, Ph.D., QME May 4, 2018

I am concerned by the following language in the proposed Reimbursement for Medical-Legal Expenses statement:

"No more than three hours may be billed for report preparation."

This clause does not account for the complexities inherent in the preparation of psychological evaluations. A comprehensive overview of a person's life history is required in DWC psychological evaluations in order to establish issues of causation and apportionment. People's life histories are long and complex and cannot be summed up in three hours or less if they are to hold up to evidentiary standards or the standard of care in the psychological community. Although three hours of report preparation may be adequate to report on the detrimental effects of a wrist injury, it takes much longer than three hours to review an injured person's personal narrative. As such, the proposed three hour billing limit is biased against those who may suffer from a mental condition and does not allow mental health providers the opportunity to practice within the current standard of care. Furthermore, the three hour report preparation billing limit is out of compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Notably, the MHPAEA is a federal law that prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Given the recent legal disputes with the DWC and QMEs regarding billing issues, any changes to the billing statement should not violate any ethical or medical standards. The three hour report preparation limit is posed to become another point of legal contention as it prevents mental health providers from practicing within the current standard of care and it prevents mental health providers from being compensated for their time.

Moving forward, the DWC is encouraged to find billing solutions that encourage high quality evaluations to prevent the sometimes endless cycle of claims. Therefore, it is recommended that there be no limit set on report preparation.

Graham A. Purcell, MD May 4, 2018

I have read in the DWC's forum the proposed rule making changes regarding the Medical-Legal Fee Schedule and there remains a significant problem with regard to using *causation* as a 'billing complexity factor' under ML103 factor 6.

The DWC's proposal now states the causation may be used as follows:
(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

The problem is the proposed mandate that "the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact…".

Unfortunately, applicant and defense attorneys & claims administrators have no legal mandate that requires them to specify prior to the evaluation what medical facts are in dispute that has necessitated the QME evaluation. In fact, there is no legal mandate that requires the parties to even provide the QME with a charge-letter/'letter of instruction' prior to the evaluation. This means that the QME is left with having to communicate with both parties to find out what medical facts are being disputed and, specifically, if causation is in dispute. More often than not, because there is no legal requirement to do so, the parties do not respond to the QME's request, which is typically ignored by the parties. Furthermore, with regard to causation, one party will often ask the QME 'if the biomechanics of the claimed injury are consistent with the claimed injury' or a party may tell the QME in a multi-body part claim that only certain body parts have been accepted but not others being claimed by the other party. Such *DISPUTE* inevitably leaves the QME with having to address an obvious *causation* problem/dispute with regard to the body parts not being accepted by the claims administrator/defense.

In other words, the proposed rule making change requiring pre-evaluation written agreement by both parties that *causation* is in dispute is an unrealistic requirement that will seldom…if ever…be accommodated by written agreement. This places a significant burden upon the QME, who is often stuck with having to make significant *causation* determinations in a claim without any legally required cooperation by the parties.

This proposed language needs to be changed; and I would be happy to provide my draft of more appropriate and realistic language regarding causation's use as a billing factor upon request.

Linda Nakell, PhD May 4, 2018

I am a psychologist who has been performing QME evaluations for about 10 years. I believe that my reports are well received by both applicant and defense attorneys, as evidenced by the infrequency with which I am deposed. I am highly concerned that some of the proposed fee schedule changes will prevent me from continuing to write adequate reports.

The three-hour limit for report preparation is thoroughly inadequate for the quality of reports that I prepare. The cases that I write about generally are very complicated, with multiple industrial and non-industrial factors. As a psychologist, I must provide percentages for all stressors, so that a trier of fact can determine whether "personnel actions" may have been "substantial" causes of injury. I also must present the work stressors in the context of the person's life history, in order to carefully weigh the industrial vs non-industrial factors. These requirements are not present *in any other specialty*. Also, in the course of my evaluations, I often uncover factors or events that were previously unknown to the parties, and I must comprehensively discuss these factors and their contribution to causation. Writing about this clearly and comprehensively, in my opinion, obviates the need for costly depositions and helps the parties come to agreement.

Thus, my concern is that three hours of report preparation time just isn't adequate to organize and weigh the frequently complex evidence and write a clear and convincing report. As an evaluator, I would have two options: first, I could write a shoddy, inadequate report; or second, I could work at an exceedingly low rate of pay (if I am paid for only three hours of work when I actually have work 10-12 hours). Neither of these options, in my opinion, is acceptable to the providers, and would be unfair to the injured parties.

I do believe that many psychologists and psychiatrists would no longer be able to maintain their QME practices under the proposed limitations. The number of available QMEs, which already is declining, would continue to decline, possibly precipitously, and it would become very difficult for injured workers to get fair and adequate evaluations.

For all of the reasons outlined above, I strongly recommend that you not limit the report preparation time. Thank you for considering my comments on this important matter.

Tanya Mesirow, Psy.D. May 4, 2018
Clinical Psychologist

I am writing regarding the proposed changes to the Medical Fee Schedule. As a QME in Psychology, the reports require a great deal of time, effort and expertise. Unfortunately with the new proposed changes, it appears that a QME's ability to adequately and effectively complete an evaluation and report will be compromised.

For example, the fact that Causation will require written agreement from both parties, is near impossible. In most cases, it will not be feasible to get PRIOR written agreement from BOTH parties regarding Causation, yet Causation is a very important aspect of the entire case.

Further, the fact that the "Multiple Hour Complexity Factors for ML 103 and ML 104 codes will require ALL three time components of Face to Face time, Records Review Time AND Medical Research Time" is unreasonable. Specifically, requiring two hours of medical research for each evaluation that cite sources that "have not been cited in any prior medical report authored by the physician in the past 12 months" is unreasonable and unnecessarily arbitrary.

Finally, limiting report writing time to 3 hours is untenable considering the amount of information that must be included in these reports. The DWC is asking for more regulations/stipulations while cutting reimbursement for specialists. If the DWC wants complete reports, 3 hours of report time will not be sufficient.

In summary, these regulations restrict QME's ability to submit reports that constitute substantial medical evidence. In addition these regulations further complicate the QME process. I believe you will lose qualified QMEs who do not want to try to meet the demands of an overly complicated QME system, while getting paid less. In addition, in the end, it will likely cost the state MORE money with the need for additional supplemental reports and depositions, as QME's will not have the time necessary to adequately complete their evaluations the first time around.

Robert Ghatan, MD May 4, 2018

The allowable time for review, preparation and editing of a report must consider the factors of multiple injuries, multiple body parts, the need for an extended deliberation toward apportionment of multiple causation, the age of the involved multiple claims and prior awards, the probing of the prior C&R language and settled body parts, to better develop the most accurate apportionment, that sometimes has been necessary to spend more than 3 hours, though admittedly not very common but necessary.

Thanks for asking comments from QME providers.

David M. Reiss, M.D. May 4, 2018

Placing an arbitrary limit on report preparation is irrational. If people are over-billing, investigate and get rid of the "bad apples". But to expect QME's to work for free is inappropriate.

Psychiatric/Psychological evaluations are different from medical injuries wherein if a claimant had not injured the specific body part before, and does not suffer from a pre-existing illness affecting that body part, there is minimal, if any, past history to consider. But in EVERY psychological/psychiatric evaluation, there must be a comprehensive evaluation of a person's entire psycho-social history as well as their current personal life relationships and circumstances.

It is rarely possible to write a psychiatric report that provides an adequate history and an adequate exploration and discussion of all of the relevant psycho-social issues in three hours.

A three-hour limit would be asking me to write an inadequate/incomplete report that would be unethical and damage my reputation, or to work for free.

I will do neither.

Nor would I respect any mental health professional who would.

Suresh Mahawar, MD May 4, 2018

The proposed changes for ML 103 an ML 104 billing will seriously jeopardize the quality of reports. This will mean increasing the frequency of supplemental reports. We do not understand that why the states & nation has been always against physicians seriously limiting their earnings. But when physicians seek any services or products, they have to pay the full market PRICE. The nation as a whole has been against doctors for nearly 40 years & it has come to the point that practicing medicine is not a profession to seek. I hope that division of Worker's Compensation, California resources such drastic measures to limit the income out of proportion to the services being sought.

Thomas Payne May 4, 2018

MEDICAL-LEGAL FEE SCHEDULE FORUM COMMENTS

I have read in the DWC's forum the proposed rule making changes regarding the Medical-Legal Fee Schedule and there remains a significant problem with regard to using *causation* as a 'billing complexity factor' under ML103 factor 6.

The DWC's proposal now states the causation may be used as follows:
(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;
The problem is the proposed mandate that "the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact…".

Unfortunately, applicant and defense attorneys & claims administrators have no legal mandate that requires them to specify prior to the evaluation what medical facts are in dispute that has necessitated the QME evaluation. In fact, there is no legal mandate that requires the parties to even provide the QME with a charge-letter/'letter of instruction' prior to the evaluation. This means that the QME is left with having to communicate with both parties to find out what medical facts are being disputed and, specifically, if causation is in dispute. More often than not, because there is no legal requirement to do so, the parties do not respond to the QME's request, which is typically ignored by the parties. Furthermore, with regard to causation, one party will often ask the QME 'if the biomechanics of the claimed injury are consistent with the claimed injury' or a party may tell the QME in a multi-body part claim that only certain body parts have been accepted but not others being claimed by the other party. Such *DISPUTE* inevitably leaves the QME with having to address an obvious *causation* problem/dispute with regard to the body parts not being accepted by the claims administrator/defense.

In other words, the proposed rule making change requiring pre-evaluation written agreement by both parties that *causation* is in dispute is an unrealistic requirement that will seldom…if ever…be accommodated by written agreement. This places a significant burden upon the QME, who is often stuck with having to make significant *causation* determinations in a claim without any legally required cooperation by the parties

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James T. Platto, MPH DC QME May 4, 2018

With regard to proposed rule making changes for the *Official Medical Legal Fee Schedule*, please consider the following with regard to 'review of records'.

Currently, no matter how many records a QME must review, ML103(2) limits the *complexity factor* to one (1) factor for billing purposes. Unfortunately, QMEs often evaluate claims with no billable factors under *causation* or *apportionment*, but the records sent are many times excessive in volume. For example, I have done many such cases that were limited to an ML102 billing even though the medical records involved well over 1,000 pages…and at times an entire file box full of records…which requires a significant number of hours to review and analyze.

Unfortunately, when the claims administrator is asked in writing to authorize a higher level of billing given such *extraordinary* circumstance involving an excessive record volume, (referencing LC5307.6(b)), the typical response is either that the written request is ignored or denied. This results in the QME investing a very significant number of hours in the review of records with compensation being limited under ML102 to $625.00.

Recognition of this frequent dilemma should be recognized and changes made in the fee schedule to accommodate such situations. Please remember that the claims administrator is not a neutral party to the case and it is obviously in the claims administrator's financial interest not to authorize such a request.

I would therefore propose that when no other billable *complexity factors* are applicable but the volume of records requires substantially more than two (2) hours for review, that the QME be permitted to count every two (2) hours of record review as a billing *complexity factor* if no other complexity factor criteria under ML103 or ML104 have been met.

And I can assure you that this situation involving substantial volumes of medical records with no other complexity factors…thus limiting the QME to an ML102 charge…is the reason why many QMEs continue to non-renew their certification and to drop out of the system. It is simply not worth the QME's time to invest many hours of his or her time, (above and beyond face-to-face and report preparation time), to be limited to the ML102 billing level.

As an example, I had a case involving well over 1,000 pages of records that required no less than six (6) hours to review. This six hours in conjunction with over two hours of face-to-face time, no other complexity factors, and over two hours of report preparation time that could not be used for billing purposes, resulted in a minimum 10 hour investment of my time. Therefore, because the claims administrator ignored my request to bill at a higher level, I was limited to charge at the ML102 level for $625.00, which breaks down to $62.50 per hour for my time. Again, this is why many QMEs are deciding to opt out.

The favor of your anticipated consideration and feedback are appreciated.

Nicholas Thaler, Ph.D. ABPP-CN May 4, 2018

Board Certified in Clinical Neuropsychology
Neuroscience Associates Inc.
UCLA Semel Institute for Neuroscience & Human Behavior

As a clinical neuropsychologist, I have significant concerns about the DWC amendment proposals. Limiting the number of hours for report writing to no more than three puts me in an impossible position. Comprehensive neuropsychological evaluations typically result in 20-40 page reports, including tabulated score data, that at minimum takes 8 hours to complete and in some circumstances can take more then 15 hours. Neuropsychological evaluations take into account both medical and psychological factors that may affect the central nervous system. Given the complexity underlying diagnosing a traumatic brain injury (particularly those that are milder in nature), reports must be carefully prepared and reviewed in a manner that can clearly convey results without misinterpretation. Such reports include a thorough overview of the patient's past and current clinical history, interviews, behavioral observations, and a review of individual neurocognitive domains (e.g. attention, language, executive functionings) as well as emotional and personality characteristics. It is simply impossible to produce an adequate report within the proposed three hour cap. Such an amendment is unsustainable for psychologists and neuropsychologists alike.

Reina Archuleta, CPC, CPCO, CPC-I May 4, 2018
Business Administrator

What happens if the Claims Administrator fails to file a Petition with DOR per CCR 9794(g)?

(g) If the claims administrator receives a written objection to the denial of the medical legal expense under subdivision (d) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a petition to review of the denial of medical-legal expense and a declaration of readiness to proceed pursuant to section 10228 et. seq.

Section (f) (2) emphatically states that should the provider fail to object to the denial, neither the employer nor the employee shall be liable for the Med Legal expense. However, that same language is not found in (g) should the provider fail to file a Petition to Review along with a DOR.

What is the provider's remedy should the claims administrator fail to file a Petition for Review and DOR?

Section (g) does not indicate a timeline for the claims administrator to do this. How long does the claims administrator have to file the Petition with DOR?

I believe it is important to clarify the timeliness on both ends. The pendulum must swing both ways to maintain the balance.

Daniel Buch, B.S., D.C., QME May 4, 2018

I am very concerned about a number of the proposed alterations and amendments to the Medical Legal Fee Schedule (MLFS). The proposed changes are in my opinion punitive and a serious underestimation of the time and professional expertise QME's devote to the medical legal evaluation and report writing process.

I will focus this comment however on just one of my concerns. Overall the proposed alterations impose conditions which make it highly unlikely that a physician, acting in the capacity of a Qualified Medical Evaluator, will be justly compensated completing reports requiring extensive medical record review and face to face examination time.

My primary concerns regard the complexity factor modifications which, if codified, would make it nearly impossible for a physician to qualify for ML 103 or ML 104 billing codes. By imposing additional requirements on the ML 103 and ML 104 codes, the physician will no longer be able to be properly compensated for the performance of evaluations which require the review of voluminous medical records and face to face examination time.

- Prior to the proposed alterations, under the MLFS the physician could qualify for an ML 103 if
  "(5) Six or more hours spent on **any** combination of three complexity factors (1)-(3), which shall count as three complexity factors." *(Emphasis added. MLFS prior to proposed alteration)*

As an example, if a voluminous amount of medical records were reviewed by the physician requiring 8 hours of record review time. If the physician spent 2 hours of Face to Face examination with the applicant, the 8 hours of record review time count be combined with the 2 hours of Face to Face Time, to equal 10 hours total. Under the current MLFS, this would properly qualify as an ML 103.

- The proposed alterations and amendments include the following:
  "(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, **provided that some portion of time has been devoted to each of the three factors.** Any complexity factor used as a stand-alone may not be used in combination under this subdivision;" *(Emphasis added. Proposed alteration to the MLFS)*

Under the proposed changes, an evaluation under the same circumstances would NOT qualify as an ML 103 because the proposed changes state, **"provided that some portion of time has been devoted to each of the three factors."** This is specifying that time must have been spent not only in Face to Face Time and Record Review Time, **but also must include some time devoted to Medical Research.**
The proposed alteration to the MLFS, inserting the additional condition that, "some portion of time has been devoted to each of the three factors" represents a near total disregard for the time devoted to a case involving voluminous medical record review and face to face patient examination time. To not allow the qualification of an ML 103, as in the example discussed above, would constitute a gross underestimation of the services rendered.

It is my sincere opinion that the proposed alterations to the MLFS will do harm to not only the physicians serving as QME's but also to the community at large. How is an applicant, represented or otherwise, to be sure of a fair and complete QME examination if the physician will be so severely under compensated to perform the services required?

Record review is much more than merely a simple listing of the records made available. Record review involves the assimilation of the information and bringing that information together with the examination findings and clinical experience to form an *accurate and unbiased* opinion of medical legal issues involved. By making it virtually impossible for the physician to bill for medical records review time, the proposed changes to the MLFS will impose hardship and bias into the California Workers' Compensation system.

I hope that the example provided here will help those who do not serve as QME's understand some of the shortcomings of the proposed changes. Yes, we need clarity to the MLFS, but we also MUST ensure that physicians are fairly compensated for the time devoted to difficult cases.

Henry A. (Hank) Sigal, Psychiatrist May 4, 2018

As a psychiatrist, I have performed AME and QME evaluations for many years. I believe my reports are well-regarded by all sides. I am deeply concerned that some of the proposed fee schedule changes will prevent me from writing adequate reports.

My greatest concern is the proposal to limit report preparation time to 3 hours. At least in psychiatry, often this isn't adequate. Psychiatric cases can be very complicated. Just on the causation issue, for example, psychiatrists must discuss *all* the stresses that contribute to psychiatric injury. We must then compare industrial to non-industrial problems, to see if industrial factors were predominant. We must then provide percentages for each stress, so a trier of fact can determine whether "personnel actions" may have been "substantial" causes of injury. These requirements are present *in no other specialty*.

Moreover, in my experience "pure stress" claims are fairly uncommon. Most of the applicants I see also allege physical injuries. Questions then arise as to whether psychiatric factors might be contributing to pain complaints (i.e., whether an underlying orthopedic claim might be "psychosomatic" to some degree); whether such factors might affect surgical results; whether psychiatric factors are limiting orthopedic treatment or improvement; and so on.

Even in a "pure stress" claim, I sometimes discover other issues that should be brought to the parties' attention. Such issues should be discussed, but in a complicated case 3 hours won't be enough time. Moreover the applicant and defense attorneys are unlikely to agree causation was a factor in such cases, as they won't be aware of the issue until I raise it.

Of course, even some psychiatric cases are quite straightforward. Sometimes 3 hours is enough. In many psychiatric cases, though, the actual time needed to organize evidence, prepare and dictate a report, and edit the transcription vastly exceeds 3 hours. If I am limited to 3 hours of report preparation in such cases, my report simply could not constitute substantial medical evidence. This means I'd have to choose between producing an inadequate report, or working without pay. Neither choice is reasonable, in my view.

It is my sincerely held belief that limiting an evaluating psychiatrist to 3 hours of report preparation time would make it impossible to maintain a psychiatric QME practice, particularly in underserved locations. According to the CWCI, the number of QMEs fell 20% between January 2012 and September 2017. Adoption of this proposal would likely hasten this decline. It's hard to see how this could benefit anyone.

I urge you to consider dropping the limit on report preparation time - or at least consider making an exception in psychiatric cases.

James T. Platto, MPH DC QME May 4, 2018

I have read in the DWC's forum the proposed rule making changes regarding the Medical-Legal Fee Schedule and there remains a significant problem with regard to using *causation* as a 'billing complexity factor' under ML103 factor 6.

The DWC's proposal now states the causation may be used as follows:

(6) Addressing and providing an analysis of the issue of medical causation, upon written request of the party or parties requesting the report provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

The problem is the proposed mandate that "the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact…".

Unfortunately, applicant and defense attorneys & claims administrators have no legal mandate that requires them to specify prior to the evaluation what medical facts are in dispute that has necessitated the QME evaluation. In fact, there is no legal mandate that requires the parties to even provide the QME with a charge-letter/'letter of instruction' prior to the evaluation. This means that the QME is left with having to communicate with both parties to find out what medical facts are being disputed and, specifically, if causation is in dispute. More often than not, because there is no legal requirement to do so, the parties do not respond to the QME's request, which is typically ignored by the parties. Furthermore, with regard to causation, one party will often ask the QME 'if the biomechanics of the claimed injury are consistent with the claimed injury' or a party may tell the QME in a multi-body part claim that only certain body parts have been accepted but not others being claimed by the other party. Such *DISPUTE* inevitably leaves the QME with having to address an obvious *causation* problem/dispute with regard to the body parts not being accepted by the claims administrator/defense.

In other words, the proposed rule making change requiring pre-evaluation written agreement by both parties that *causation* is in dispute is an unrealistic requirement that will seldom…if ever…be accommodated by written agreement. This places a significant burden upon the QME, who is often stuck with having to make significant *causation* determinations in a claim without any legally required cooperation by the parties.

This proposed language needs to be changed; and I would be happy to provide my draft of more appropriate and realistic language regarding causation's use as a billing factor upon request.

Christina Averill Ph.D. May 4, 2018

I am assuming that the proposed limitations of 3 hours of report preparation time will not apply to psychological reports and that a carve out will be implemented to allow psychologists and psychiatrists to produce a comprehensive and accurately detailed report. Such a limitation on psychological reports would result in poorly written and templated reports which could not possible illuminate the necessary and required medical legal determinations required of a QME psychological evaluation. Psychological and psychiatric reports are considered Complex Comprehensive Medical Legal Evaluations at this time and are billed differently because of the amount of time and report writing required and I would certainly assume that this carve out would be extended and taken into account in any discussion of report writing limits. To do otherwise would jeopardize the objectivity and necessary complexity of the QME report.

I have been a QME psychologist for many years and, in my opinion, this proposal borders on the

unethical as it will force psychologists to severely curb time spent on writing and editing reports which will then directly impact upon the quality and detail of medical legal determinations and reports. These reports have a clear and strict criteria that must be met and to limit the amount of report preparation time would immediately detract from the quality and usability of the document.

I would therefore ask that a carve out for psychological reports be extended in any proposed changes for limitations on report writing time to ensure that QME psychologists can continue to provide the complicated and comprehensive reports that are required of us.

Brian VanFossen, Ph.D., QME May 4, 2018
Forensic Neuropsychologist
Greater Los Angeles and San Diego Regions

After reviewing the DWC amendment proposals, I strongly object to the sections that limit report preparations to three hours. In psychiatric AME/PQME cases, a thorough review of all of the data can take many, many hours, and this level of analysis is required to stand up to a careful scrutiny by the Trier of Fact and certainly to avoid unnecessary deposition. Discussion with many defense and applicant attorneys over the years confirms that this careful level of analysis, which is time-consuming, is now the expectation.

Indeed, I expect that artificially limiting the number of hours for report preparation in psychiatric cases will result in a drastic reduction in quality of medical-legal reports. Please re-consider.

Micheal D. Zeger, D.C., QME May 4, 2018

I am a sole proprietor Chiropractor and Qualified Medical Evaluator. I perform a modest amount of qualified medical exams (1-2 per month) and I do not have a staff that can help with the logistical production of QME reports. Meaning that, it sometimes takes me over a half hour just to prepare and send the required appointment notification letters in order to simply schedule an applicant. It easily takes over an hour to assemble, print and mail the final report. That's around 1.5 hours of my time that I do not get reimbursed for. That does not include the time it takes to write the actual report.

Now you propose to limit the report writing time to three hours. This is completely unreasonable. It takes much longer than three hours to make coherent and thoughtful recommendations regarding the multitude of disputed issues in a workers' compensation case. I take every

evaluation as a unique and individualized entity. I try to let the facts of the case dictate my decisions regarding disputed issues. The proposals you are making will mean that only 'cookie-cutter' evaluations performed by medical assistants and written by a team of ghost writers will be economically feasible. Most if not all med-legal reports, cannot be written in less than three hours and it is ridiculous to think otherwise.

Furthermore, not only are you reducing the amount of time an evaluator can bill for report writing, but you are also adding requirements to the report, with redundant and unnecessary justification billing complexity factors. I have recurrently had difficulty getting paid for my reports, by claims administrators, who often do not pay med legal fees within the required timeline and are never held accountable for late fees or interest. I'm not understanding why QME's are being put under such extreme scrutiny for their billing practices when the payers are not.

In conclusion, the constant change of rules and regulations within the workers compensation system is bad for both applicants and doctors who have to keep chasing a moving target. It is a shame that the insurance company's influence holds so much sway over a system that is supposed to protect injured workers not protect insurance companies' interests.

Christopher Simonet May 3, 2018

I reviewed your proposed changed to§9794 and §9795. I am a QME who performs psychological evaluations. My comment regards the limit of 3 hours preparation time for all medical/legal codes in the absence of a signed agreement for ML104(3) prior to the evaluation. Based on my discussion with other QME's, it is my impression attorneys almost never respond to requests to sign such documents-- and it has been my personal experience NO attorney has ever responded to such requests from me-- in advance of an evaluation, despite such requests being very common. Thus, in the absence of such signatures, under your proposed guidelines, all of my evaluations would be subject to a cap of 3 hours report preparation time. Such a limit is absolutely unrealistic and I could never justify the hours actually required to produce an adequate report for the 3 hours of pay only. I would not be able to continue providing my services as a QME, and I suspect this would be the case for most QME psychologists. I believe those who would work under such a cap would produce hurried, careless, low quality reports that would be inadequate to the needs of the parties involved. I believe the proposed wording limiting the hours should be deleted entirely and, given the varying amount of time required to complete reports, the hours be determined by the actual hours spent by the QME completing the reports.

Vladimir Lipovestsky, MD, FIPA May 3, 2018

There is nothing in the text of the proposed evaluation to indicate why a revision of the ML fee schedule was felt to be warranted. If the purpose is to implement the process the court recently halted, this should be made explicit.

Now all complexity factors have to be explicitly justified. There is no articulation of what that looks like for the face to face time with the applicant or the review of records. The carrier is given instruction to pay for the service they deem justified and to offer documentation of their reasoning in the EOR. This will most definitely be abused by the carrier. All they need to do is routinely deny anything over ML102 and let the rest of the process decide what they have to pay.

Causation: agreement of both parties in advance of the evaluation about causation being an issue and agreement on QME using it as complexity criteria. 30% of the time I don't even get any advocacy letter at the time of the evaluation and in half of the rest of the cases only one side provides the letter. So this is clearly meant at elimination of causation as a complexity factor in most cases. Since this is not a complex matter, the QME could be advised to accept causation arguments from the advocacy letter they receive in advance of seeing the applicant. Or simply make a random decision at the time they see the applicant.

Apportionment is almost never a complexity factor even when a patient is MMI. Interestingly enough, what concerns the parties most of the time is a discussion of non-industrial factors, which…..are not a complexity criteria.

Then there is the three hour requirement for completion of the report. An average report takes me 6-7 hours to complete. I guess I am too slow, or maybe I don't need to take the questions so seriously.

What is most interesting is the report still needs to have enough understanding of the findings of the case and of the history of the claimant to articulately state the medical legal conclusions so that they constitute substantial evidence at ML102 or ML103 fees. And the goal is what? to attract a volunteer force committed to serving the great cause of the justice system? Speaking of the justice system, California jails and prisons are paying psychiatrists around the same hourly wage as ML104 but with all the overhead covered and no threat of disciplinary or other proceedings. HMMM…….

It is clear that the QMEs are meant to disappear. What comes instead, we will not be told until it comes.

Robert F. Meth, M.D. May 3, 2018

These new rules do not take into consideration the voluminous records I get to review with the complex internal medicine evaluations that I perform. I have been doing QME and AME evaluations since 1986 in addition to seeing my regular internal medicine patients. If these changes go through it will be impossible to spend the time to review the voluminous medical records and not be reimbursed for all the time spent. You will be losing many very qualified AME and QME evaluators.

Dr. QME May 3, 2018

Hi, as a current QME evaluator, I'm writing to comment on the reasonability of the proposed change of Reimbursement of Medical-Legal Expenses Regulations and the detrimental consequence of these new proposals if adopted.

With regard to medical research by QME physician, the new proposed regulation include the following requirements:

(3) Two or more hours of medical research by the physician, using 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 this complexity factor. An evaluator who specifies this complexity factor 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. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;

While I agree with the requirement listed in (A), (B) and (C), I disagree the requirement that physicians using sources that have not been cited in any prior medical report in the preceding 12 months. This requirement seems arbitrary and irrational. How can a QME physician substantiate a determination as substantial evidence? Sure we can all say, "based on my experience". In reality, it is not considered substantive medical evidence because experience is subjective, regardless how many times one keep repeating it. The only way to substantiate a medical determination is to cite, refer, quote, etc, from robust studies. What sets a bad med-legal evaluator from a good one is basically how much evidence-based medicine a good one has to read ferociously and remember cumulatively through years of med-legal forensic work. To place this 12 month of arbitrary exclusion on forensic med-legal work is analogous of restricting a surgeon to operate a complex surgical case without referring to his/her surgical experience cumulated from previous 12 months of surgical cases.

How absurd is it? This new proposed regulation seems to simply discouraging medical research in writing a strong QME report. This would inevitably degrade the quality of QME report, leads to more requests for supplemental reports and cross-examinations. Not only is this not reasonable requirement, it does not even make prudent financial sense.

With regard to the analysis of medical causation, the new proposed regulation suggests that,

*(6) Addressing and providing an analysis of the issue of medical causation, **(upon written request of the party or parties requesting the report, deleted)**, provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;*

The new proposed rule requires both QME evaluator and the parties to agree PRIOR to the start of the evaluation. It removes the existing regulation that states "upon written request of the party or parties requesting the report". So what exactly did the drafter of this new proposal have in mind? As a QME evaluator, it has been difficult to simply request all necessary medical records from defense, application attorneys and from adjusters. Now you want QME evaluator to chase after these parties to "AGREE" medical causation needs to be addressed despite of the fact the requesting party has already requested QME evaluator to address medical causation?

Realistically and logistically this is not possible as QME evaluators would not be able to get hold necessary parties to particularly AGREE in writing on a timely fashion.

In addition, the new proposed regulation also states,

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.

So what will happen realistically is this: QME will do the evaluation and report a QME report, not addressing medical causation, when in fact there are inherent disputes in medical causation. Again more time will be wasted on seeking supplemental report and cross-examination. More financial burden will be placed on insurance carrier to pay for these additional and completely avoidable expenses IF and ONLY IF, the original QME evaluation and report are done with thorough consideration to every details, including the analysis of medical causation.

With regard to the time of report preparation, the proposed new regulation states,

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.*

Again this new proposal continue to use arbitrary rationing to undermine the quality expected from QME physician evaluators. A detailed discussion and analysis of a complex case, including medical causation, apportionment, disability status, future medical, for example will take more 3 hours. This is only one part of the QME report. Why restrict report preparation to three hours? Why not 10 hours or 2 hours? This is a completely bizarre requirement! So the drafter of this proposal basically says, "I don't care if you do a good job or not in writing your report, I won't pay you for over 3 hours of work that can take 10 hours".

Guess what will happen, the report quality again will go down the drain. You will end up with more supplemental reports and deposition request. In turn, this new proposed rule, if accepted, will lead to more cases stuck in the WCAB pending more supplemental reports and deposition.

Overall, the new proposed regulation tries to absentmindedly reduce reimbursement for quality QME evaluation. However, for the reasons I have pointed above, these arbitrary measures will not produce quality QME work. It will not save the cost. It will in fact cost more headache to produce less result, which in turn, to be more costly.

Dr. Julie Armstrong, QME and
QME Continuing Education Provider

May 3, 2018

I am a Psychologist QME and have performed hundreds of QME evaluations since my initial certification in 2003.

I am responding to the amended limitation in the fee schedule that proposes:

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 oppose this change for the following reasons:

For a Psychology or Psychiatry evaluation, the limit of 3 hours for report preparation is untenable. In looking at the last 5 QME reports prepared, the length of the report ranges from 19-22 pages. These are unusually short reports. 3 of them are re-evaluations and all of them had few or no records for review. My usual reports run 28-35 pages.

On the other end, I have had cases with a box or more of records, and final reports that total more than 50 pages. My longest report was 97 pages for an injury that was an extended CT injury over many years.

A Psychology evaluation, by its very nature, must explore all corners of the applicant's mind and experience. The DWC recommends we use the Method of Measurement Evaluation of Psychiatric Disability as a guide to what information must be obtained and reported on in the analysis of every Psychology and Psychiatry case. Here is what is required according to this document:

Taken from:

Title 8: California Code of Regulations
Division 1: Department of Industrial Relations
Chapter 1: Industrial Medical Council
Article 4: Evaluation Methodology
Section 43: Method of Measurement of Psychiatric Disability

"To complete the interview almost always will require at least one to three hours of direct contact with the applicant by the examiner."

And specifically, "The suggested headings are not required, but a systematic, quasistandardized report *including all the relevant facts* is likely to be most useful to judges."**(emphasis mine - JA)**

A. Evaluation report for psychiatry disability
(To be used by psychiatrist and psychologist examiners.)

1. Identifying information
- Date, place, and duration of examination
- Reason for referral and referral questions
- Names and functions of others taking part in the examination, including use of interpreter
- Applicant (patient/client)
    1. Date of birth
    2. Date of alleged industrial injury
    3. Date last worked
- Sources of facts (include collaterals, if interviewed)

2. Description of applicant at interview
    - Appearance (do not omit obvious physical aberrations)
    - Demeanor, general behavior
    - Apparent effective state, based on observation
    - Stream of speech
    - Interaction with interviewer
3. Description of applicant's current complaints

- Subjective complaints
- Applicant's view of the impairment created by the complaints

4. History of present illness
    - Applicant's description of industrial stressors, onset of complaints, and alleged injuries or illness associated with onset
    - Psychological response to alleged injury situation
    - History of mental health problems since alleged injury
    - History of treatment since alleged injury
    - Current treatment and medication, including medication taken on day of interview
5. Occupational history (Distinguish baseline, injury concurrent, and post-injury events)
    - Educational level and professional, technical, or vocational training
    - Sequential description of occupations pursued (including military service)
        1. Training and skills required
        2. Supervisory responsibilities
        3. Career mobility (upward, downward, lateral)

    - Difficulties and/or accomplishments in each occupational setting Previous occupational injuries, time lost, and outcome

6. Past mental health history and relevant medical history
7. Family history

a. Family of origin

1. Parent's age, education, occupational history
2. Sibling's age, education, occupational history
3. Composition of family during applicant's childhood and youth
4. Mental health history and relevant medical history of family members
5. Family response to illness
6. Relevant social history of family members
7. Quality of family relations

b. Family of procreation

1. Present marital status
2. Spouse's age, education, occupational history
3. Number of offspring (Obtain same data for adult offspring as for spouse)
4. Mental health history and relevant medical history of family members
5. Relevant social history of family members
6. Quality of family relations

c. History of previous marriages

8. Development history
9. Social history (Distinguish baseline, injury concurrent, and post-injury findings)
    - Interpersonal relationships
    - Previous life changes (external stresses and losses) and response to these
    - Educational history
    - Legal history, when applicable (Include previous workers' compensation and personal injury claims, with the circumstances and outcome)
    - Criminal history which is relevant to diagnosis and/or disability
    - Substance use and abuse
    - Applicant's description of a typical day
    -
10. Mental status examination (Include relevant negative findings)
    - Level of consciousness
    - Mood, e.g.:
        1. Depression
        2. Liability
        3. Elation
        4. Anxiety
        5. Inappropriateness
    - Cognition/thinking
        1. Orientation
        2. Estimation of intelligence
        3. Memory dysfunction
            a. Recall/short-term memory
            b. Remote memory
        4. Perceptual and communication disorders (agnosias and aphasias)
        5. Thought content
        6. Thought disorder, e.g.:
            a. Ideas of reference
            b. Looseness of associations

c. Delusions
d. Perceptual disorders, including hallucinations e. Intrusive thought/obsessive thinking

7. Evidence of deficit in
    a. Learning
    b. Problem solving
    c. Judgment

8. Insight (Include applicant's perception of relationship between injury and psychological condition.

d. Behavior

1. Motor: retardation or hyperactivity
2. Appropriateness in interview

e. Evidence of physiologic disturbance
1. Skeletal muscle system
2. Autonomic
3. Somatoform or conversion symptom

11. 11.Findings from psychological assessment (Attach complete psychological report)

12. 12.Review of medical record

13. 13.Interviews with collateral sources and review of employment or personnel records (Compare description of industrial stressor with applicant's account)

14. 14.Diagnosis using DSM-IV terminology and criteria

15. 15.Summary and conclusions (Provide sources for all information cited as evidence.)
    - Brief summary of relevant history and findings
    - If any disability, present and justify an opinion concerning the current cause(s), whether or not they are related to the work place. Consider:

2. The relationship of work exposure to disability
3. Nonindustrial causes of disability, including pre-existing causal factors
4. Aggravating or accelerating factors (industrial and non-industrial)
5. Natural progression of pre-existing disorder
6. Active or passive contribution of the workplace to the disability. (See Twentieth Century Fox Film Corporation v. W.C.A.B. and Kevin Conway (1983) C.A. 3rd 778, 190 CA: Rptr 560, 48 C.C.C. 275 and also Georgia Pacific Corporation v. W.C.A.B. and Robert H. Byrne (1983) 144 C.A. 3rd 72, 192 Rptr. 643, 48 C.C.C. 443.)

6. Applicant's subjective reaction to stress at work, if relevant. (See Albertson's Inc. v. W.C.A.B. (Bradley) (1982) 131 Cal.App.3d 308, 182 Cal. Rptr. 304, 47 C.C.C.460.)

Indicate whether actual events of employment (for injuries on or after 1/1/90) were at least 10% or (for injuries on or after 7/16/93) were predominant as to all causes combined of the psychiatric injury (see Labor Code Section 3208.3(b)(1) or, if applicable, whether they were a substantial cause (see Labor Code Section 3208.3(b)(2)(3)).

c. Indicate diagnostic entities which were work-disabling prior to the alleged industrial injury and provide evidence.

- State whether the disability is temporary or has reached a permanent and stationary status and cite evidence. If the condition is permanent and stationary, state on what date it became so and cite evidence. Consider the natural history of the disorder, the response to treatment. If the condition is not yet permanent and stationary, state when you expect it

will be so. If you think further reasonable medical treatment will improve the condition, describe the treatment and its expected benefits.

- If the disability is permanent and stationary, present an opinion regarding the nature and severity of the disability. Describe the disabling symptoms (subjective and objective factors in disability) according to Chapter II. Complete the Work Function Impairment Form (Exhibit "A") citing symptoms, mental status findings, psychological test data, and history as supporting data. (Descriptions of work functions in Exhibit "B") If there is a non-psychiatric disability, a specialist in the area affected.
- Make an advisory apportionment of disability. In order to do this, describe the disability that would exist at this time in the absence of the work place injury. Cite the evidence on which the estimated preinjury level is based. Use a separate Work Function Impairment Form. (Exhibit "A")
- Indicate recommended treatment and/or rehabilitation, if any. State whether the employee, the effects of whose injury, whether or not combined with the effects of a prior injury, whether or disability, if any, is permanently precluded or likely to be precluded from engaging in this or her usual and customary occupation or the position in which he or she was engaged at the time of injury.
- Respond to all referral question and/or to questions and issues raised in referral reports.

Because of the nature of a Psychological evaluation, we are required to report on negative findings, in order to document that an area of inquiry was done.

The above information, **required in each report**, does not include the discussion and description of any current impairment or disability, and does not include the discussion of psychological testing administered, and the results of those tests.

There is no way that a report of this depth and thoroughness can be prepared in 3 hours. It is unreasonable and untenable to impose a limit of 3 hours on report preparation for any ML 104 report in psychology. I recommend that Psychology and Psychiatry evaluations be excluded from the 3-hour limit on report preparation. If the DWC insists on mandating a number, it is my experience that these evaluations take upwards of about 12-15 hours to write, edit and finalize.

I would be happy to testify to this or answer any questions the DWC may have regarding this opinion or about the process and nature of a psychology Qualified Medical Evaluation.

David Sones May 3, 2018

What code do we use when Supplemental Reports or Follow-up reports take more than 3 hours? There have been occasions when I have been send more than 10,000 pages of records, and there is no way I can review this in less than 3 hours.