SECTION NO.	QME REGULATIONS RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	ID NO. OF COMMENT	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comments are listed at the end of this chart	**Comment Period was open from November 30, 2007 through January 17, 2008**				
1(e)	**Recommendation** Clarify the language in the proposed modified regulations wherever necessary so that an agreed panel qualified medical evaluator (agreed panel QME) cannot be confused with an agreed medical evaluator (AME). **Discussion** As currently written, the definitions of AME and evaluator and other language in the proposed modified regulations may be interpreted by some to allow agreed panel QMEs to be considered AMEs entitled to the 25% AME reimbursement. CWCI urges the Division to revise the language where necessary to avoid disputes over this issue. The language in the attachment to Form 106 under the heading "The AME or QME selection process in represented cases" is a case in point. Here the agreed panel QME is incorrectly referred to as an "Agreed Medical Evaluator" instead of as an "evaluator."	**39A**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part. Two new definitions, "Agreed Panel Qualified Medical Evaluator" and "Panel Qualified Medical Evaluator" have been added. The Agreed Panel Qualified Medical Evaluator definition section makes clear that such physicians are entitled to bill as an Agreed Medical Evaluator under the medical/legal fee schedule for evaluation reports and deposition testimony.	New definitions have been added to section 1, as follows: ***(d) "Agreed Panel QME" means the Qualified Medical Evaluator described in Labor Code section 4062.2(c), that the claims administrator, or if none the employer, and a represented employee agree upon and select from a QME panel list issued by the Medical Director. Such an Agreed Panel QME shall be entitled to use modifier "-94" as defined in subdivision 9795(d) of Title 8 of the California Code of Regulations for medical/legal evaluation services.*** ***(y) "Panel QME" means the physician, from a QME panel list provided by the Medical Director, who is selected under Labor Code section 4062.1(c) when the employee is not represented by an attorney, and when the injured employee is represented by an attorney, the physician whose name remains after completion of the striking process or who is otherwise selected as provided in Labor Code section 4062.2(c).***
1(e) and 1(s)	LC 4602.2(b) states that the 'agreed medical evaluator' (AME) does not need to be a qualified medical evaluator (QME). The AME proposal by either party occurs prior to the panel of medical evaluators issued by the Division of	**38A**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund	Accepted in part. See response Ramirez, directly above.	See action directly above.

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	Workers' Compensation. LC §4602.2(c) also requires the parties to agree upon an agreed medical evaluator. However, subsection (c) goes onto say that if the parties have not agreed on a 'medical evaluator' from the panel by the 10th day, each party may strike one from the panel. The remaining qualified medical evaluator [QME] shall serve as the medical evaluator. It goes on to allow one party to select who remains on the panel when the other does not exercise the strike-through to serve as the 'medical evaluator'. While the term AME is defined by these QME regulations as a physician agreed to by the two parties on represented claims, the role of the panel QME physician who is agreed to as the 'medical evaluator' from the panel list is best described as the agreed Panel QME or agreed qualified medical evaluator. There is a clear distinction being made between an AME and a QME in the benefit notice regulations (§9812) recently promulgated by the Division. DWC's Fact Sheet E "Answers to your questions about qualified medical evaluators and agreed medical evaluators" is also required to be sent with required benefit notices and states the following: **"Q: What's the difference between a QME and an AME?** A: If you have an attorney, your attorney and the claims administrator may agree on a doctor without going through the state system used to pick a QME. The doctor your attorney and the claims administrator agree on is called an agreed medical evaluator (AME). A QME is picked from a list of state-certified doctors issued by the DWC Medical Unit. QME lists are generated randomly." In addition, absent a clear distinction between a QME (agreed or by strike-through) and an AME, the Panel QME may start billing with AME Med/Legal Fee Schedule modifier 94 [*Evaluation and Med-Legal testimony performed by AME- Multiply value* ***x 1.25*** *& If modifier 93 is also applicable to ML 102 or ML 103, then multiply value x 1.35*] and discontinue including the modifier 95 [*Evaluation performed by a panel selected Qualified Medical Evaluator - For identification purposes and does not change the normal value of any procedure*]. Statistical data of QME and AME evaluations collected by the various regulatory and rating agencies will be		January 17, 2008 Written Comment		

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	impacted by the changes in the proposed regulations. If these QME regulations cannot resolve this issue, the Medical/Legal Fee Schedule regulations may need to be adjusted. **Recommendation:** Commenter recommends differentiating between the AME prior to the panel of QMEs issued by the DWC and the agreed evaluator from the panel of QMEs. Subsequent to the differentiation, the labels and references to AME in these proposed regulations and forms need to be evaluated for change consistent with a revised "AME" definition. For example, recommended revisions to 'Attachment to Form 106 (Rev. Mar. 2007)' page 2 are as follows: After the panel is issued, represented parties have ten (10) days to communicate and to agree on one QME from the list to serve as the ~~A~~agreed panel qualified ~~M~~medical ~~E~~evaluator. If the parties have not agreed on a medical evaluator ~~AME~~ by the 10th day after assignment of the panel, each party may then strike one name from the panel….(LC §4602.2(c)).				
1(j)	**Recommendation** "Claims Administrator" means the person or entity responsible for the payment of compensation for a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF), and the Subsequent Injuries Fund, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority, or the California Insurance Guarantee Association. **Discussion** The recommended additional entities fall within the definition of claims administrators and should be	**39B**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	The wording in subdivision 1 that defines "Claims Administrator" has been changed to: "Claims Administrator" means the person or entity responsible for the payment of compensation for ***any of the following:*** a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, ***an insured employer***, the director of the Department of Industrial Relations as

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	specifically included here. Particularly with regard to CIGA, no other definitional element applies, as CIGA is a creature of statute.				administrator for the Uninsured Employers Benefits Trust Fund (UEBTF) ***and for the Subsequent Injuries Benefit Trust Fund (SIBTF)***, ~~or~~ a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority, ***and the California Insurance Guarantee Association (CIGA)***. The UEBTF shall only be subject to these regulations after proper service has been made on the uninsured employer and the Appeals Board has obtained jurisdiction over the UEBTF by joinder as a party.
1(j) 30(d)(2), (3) and (4) 31.5(a)(7) 34(a) 35(a) 36(c)	The self-insured/self administered employer is a "Claims Administrator", as provided in the definition in new Subdivision (j) of Section 1. This correction should also be made in the other referenced subsections.	**37O**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part. See response to Ramirez, directly above. The punctuation in the phrase "claims administrator, or if none the employer, …" will be used consistently throughout the regulations.	See action directly above.
1(l)	Commenter recommends increasing hours from 12 to 32.	**28D**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Rejected. The Administrative Director is satisfied that the 12 hour course is sufficient at the current time.	No change.
1(x)	Commenter points out that the proposed definition creates a host of issues: (1) although the proposed regulations do not require any physician to have a "primary practice location" a physician who does not have one will be placed at a distinct disadvantage in the QME panel selection process (cf. Reg. Section 30(f)); (2) The definition requires a physician to spend "at least five (5) or more hours per week" in the "primary practice location." Many senior physicians work full-time for two weeks and then take off the next two weeks. In this case, the physicians could not have a primary practice location."; (3) Commenter believes that this definition is interrelated to the revisions to Section 30 and may be	**30A**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation	Rejected.	The Administrative Director decided to withdraw the proposed language regarding 'primary practice location' and the 1.5 reference in subdivision 30(f), for other reasons.

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	unfair to competent, qualified physicians. Accordingly, commenter feels the definition of "primary practice location" is too restrictive and will operate to keep many qualified evaluators, particularly AMEs, from participating fully in the comp system. Commenter believes that giving extra weight to primary practice locations is contrary to law and the entire discussion of these locations should be removed from the proposed regulations. If the Division desires to move forward, commenter recommends that the definition be revised to describe a "primary practice location" as one where the physician spends, over a 12-month period, an average of five or more hours a month engaged in any combination of direct patient care or performing examinations for AME or QME evaluations.		January 17, 2008 Written and Oral Comment		
1(x)	**Recommendation** "Primary practice location" means any office location at which the physician spends ~~at least five~~ eight (~~5~~ 8) or more hours per week engaged in direct medical treatment. For physicians appointed as QMEs pursuant to Labor Code section 139.2(b)(2) (AME qualification) 'primary practice location' means any office location at which the physician spends ~~at least five~~ eight (~~5~~ 8) or more hours per week performing examinations for AME evaluations. For physicians appointed as QMEs pursuant to Labor Code section 139.2(c) and section 15 of Title 8 of the California Code of Regulations, 'primary practice location' means location at which the physician spends ~~at least five~~ eight (~~5~~ 8) or more hours per week engaged in direct medical treatment or performing examinations for AME or QME evaluations. **Discussion** Five hours per week are too few to be considered a "primary practice location" and the minimum time should be at least 8 hours.	**39C**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected.	The Administrative Director decided to withdraw the proposed definition in § 1(x) and the proposed change in § 30(f) referring to 1.5, for other reasons.
10	This section provides that "an applicant who is currently serving a period of probation imposed by the applicant's professional licensing agency shall be denied appointment as a QME until the applicant's professional license is unrestricted." Commenter opposes this prohibition. Conditions of probation are adopted to permit an applicant to practice under certain restrictions. As long as those restrictions are not inconsistent with the proper	**30B**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial	Accepted in part. The sentence in subdivision 10(c) objected to by the commenter has been withdrawn. However, Labor Code section 139.2(m) provides, in pertinent part: "The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the	The sentence objected to is now shown in strikeout. A new sentence is proposed in 10(c), as follows: ***Applications for appointment or reappointment from physicians who are on probationary license status with***

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	duties of an evaluating physician, a doctor on probation should not be denied the opportunity to earn a living. For example, if a male physician is on probation and must have a female assistant present before examining a female patient, the physician should not be denied QME status if he will be examining a male injured worker or a female injured worker with a female assistant present. The proposed language of subdivision is too broad. A physician on probation ought to be granted QME status as long as he/she complies with the terms of the probation.		Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	relevant licensing board." Therefore, new language is proposed that enables the administrative director to review such applications on a case-by-case basis to determine the appropriate action in each case.	***a California licensing board while the application is pending shall be reviewed by the Medical Director on a case-by-case basis consistent with the provisions of Labor Code section 139.2(m).***
10(c)	This addition would appear to allow a physician on probation to become a QME if they passed the exam and begin in the QME capacity before completing probation. Commenter does not believe that this should be allowed. Commenter recommends that an applicant on probation not be allowed to take the test until the probation is ended. Alternatively, an applicant could take the test but not be placed on a panel until the probation has been successfully completed.	**37A**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. The Administrative Director is aware that physicians on probationary status with a California licensing board are permitted to practice as long as they are compliant with the terms of probation of the licensing board. Labor Code section 139.2(m) directs the Administrative Director to suspend or terminate an evaluator who is suspended or placed on probation by a licensing board. Therefore, the Administrative Director will review such applications on a case-by-case basis to determine the appropriate action to take, consistent with the provisions of Labor Code section 139.2(m).	The proposed wording in section 10 (c) that would preclude appointment or reappointment of such physician applicants is being withdrawn. New wording is proposed as follows: ***Applications for appointment or reappointment from physicians who are on probationary license status with a California licensing board while the application is pending shall be reviewed by the Medical Director on a case-by-case basis consistent with the provisions of Labor Code section 139.2(m).***
10(e)	**Recommendation** Any physician who, while under investigation or following the service of a statement of issues or accusation for alleged violations of these regulations, either resigned from or failed to renew his or her appointment as a QME, shall be subject to having ~~that action~~ the disciplinary process reactivated upon re-application or application for renewal of QME status. In the event any of the alleged violations are found to have occurred, the physician's application for appointment or reappointment may be denied by the Administrative Director. **Discussion** The modifications are suggested for clarity.	**39D**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	Changed to: Any physician who, while under investigation or ~~following the~~ after service of a statement of issues or accusation for alleged violations of these regulations ***or the Labor Code***, ~~either resigned from or failed to renew~~ ***withdraws*** his or her application for appointment or reappointment ***, resigns or fails to seek reappointment*** as a QME, shall be subject to having ~~that action~~ the disciplinary process reactivated ***whenever an application for appointment or reappointment as a QME is***

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					subsequently filed. In the event any of the alleged violations are found to have occurred, the physician's application for appointment or reappointment may be denied by the Administrative Director.
10(e)	Commenter states this subsection requires clarification and suggests the following language: Any physician who, while under investigation or following the service of a statement of issues or accusation for alleged violations of these regulations, either resigneds from or faileds to renew his or her appointment as a QME, shall be subject to having that action reactivated should he/she re-apply for QME status. In the event any of the alleged violations are found to have occurred, the physician's application for appointment or reappointment may be denied by the Administrative Director.	**37B**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. Used alternate clarifying language.	See proposed language directly above.
11(a)(2)(C)	Commenter asks criteria are equivalent to board certification for a QME having a specialty in medical toxicology, for example.	**4A**	Nachman Brautbar, M.D. brautbar@aol.com Email of December 27, 2007	Certification from an American Board of Medical Specialties specialty program of completion of a subspecialty in medical toxicology, or completion of subspecialty training that such an ABMS board would deem equivalent to their certified sub-specialty program.	None required in the regulation text.
11(b)	Commenter states that the complexity of preparing a disability evaluation report has greatly increased due to legislative changes and that the 12 hour course requirement is no longer adequate.	**28E**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Rejected. The Administrative Director is satisfied that the minimum of 12 hours for this course is sufficient at the present time.	No action taken.
11(e)(1)	This paragraph provides that a QME applicant must declare that he or she "Has an unrestricted license..." In order to conform this provision to the definition of a "Qualified Medical Evaluator" in Section 1(y), commenter recommends that this language be amended to "Has an unrestricted California license...."	**29A**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted.	'California' has been inserted as appropriate to section 11(e)(1) and to declaration boxes on form 100 and form 104.
11(e)(1)	Commenter suggests that the division clarify that "California" be inserted before license as it appears elsewhere throughout the code.	**T1**	Linda Atcherley, Legislative Chair California Applicant's	Accepted.	Same as above.

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11(f)(8)	**Recommendation** Any applicant, who upon good cause shown by the test administrator, is suspected of cheating may be disqualified from the examination and, upon a finding that the applicant did cheat in that exam, the applicant will be denied further admittance to any QME examination ~~for a period of at least two years thereafter~~. **Discussion** An applicant, who is found to be cheating, should forfeit his or her opportunity to conduct evaluations in the workers' compensation system.	**39E**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part..	Changed 'two' to 'five' years.
11(f)(8)	Commenter is concerned that the penalty for cheating on the QME examination is not sufficiently stringent. As cheating on an examination could indicate some basic integrity problems, commenter prefers that such an individual never be eligible to take the examination again. Commenter suggests that the penalty must be at least five years and perhaps passage of a required ethics class prior to re-taking the exam.	**37C**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected.	None.
11.5(h)	Commenter opines that the curriculum needs to be re-examined to focus on apportionment -- how it is considered and how it is expressed within the context of the current case law and Labor Code.	**28F**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Rejected. The text of subdivision 11.5(h) has been revised to refer to the amendments made by SB 899 to the Labor Code pertaining to apportionment. However, the Administrative Director is concerned that focusing the report writing course curriculum solely on the discussion of apportionment will be too restrictive. The reports written by QMEs must address the broad range of issues that arise in determining all benefits an injured worker may be entitled to receive.	None.
11.5(h)(i)(1)	Commenter is concerned about the continued use of the terms, "work restrictions", "pre-injury capacity" and "vocational rehabilitation" in the curricula. Commenter states that DWC needs to make certain that some of the formalities are observed as it relates to the AMA Guidelines and get away from the work restrictions as there are no State definitions of "heavy", etc. It would be best if the restrictions were removed completely and the AMA Guides used exclusively. Commenter recommends defining these terms and what constitutes a complete	**15C**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The commenter is incorrect. The 1997 PDRS includes definitions of factors of disability including 'heavy lifting' and 'very heavy lifting' at page 2-19 of the PDRS. Cases with dates of injury prior to 1/1/2005 and some cases with dates of injury after that date will have the 1997 PDRS applied to the discussion and rating of permanent disability.	None.

	report, which would affect its admissibility if it is delayed or incomplete.				
11.5(i)(3)	Commenter recommends omitting the comma as follows: American Medical Association, Guides to the Evaluation…"	**38B**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Rejected. The notation already used is consistent with the publication itself.	None.
11.5(i)(3)	Commenter states that there is some ambiguity in the following: Factors of disability, including subjective and objective factors, for cases involving dates of injury not subject to the AMA guide-based impairment rating system. It would appear that this language is intended to continue educating evaluators on the criteria of the Permanent Disability Rating Schedule as it existed after the 1997 revisions to injuries not subject to rating under the 2005 revisions to the PDRS, as further defined in Labor Code § 4660(d). There is, however, the opportunity for the Division to adopt provisions in the PDRS on a going forward basis that are not covered by the AMA Guides, 5th Edition, assuming that the term "AMA guide-based impairment rating system" means the same as "AMA Guides" as defined in proposed 8 CCR § 1(d). This could, consequently, suggest that subjective and objective factors are relevant to the determination of disability for injuries occurring after January 1, 2005 where the determination of the nature and extent of disability is not predicated on the use of the AMA Guides, 5th Edition. **Recommendation:** The use of the 1997 PDRS, and the training on its use, should be expressly limited to cases ratable under the old schedule as set forth in Labor Code § 4660(d) as most recently affirmed in *Genlyte Group, LLC v. WCAB (Zavala).*	**31A**	Mark Webb, Vice President Governmental Relations Employers Direct Ins. Co. January 16, 2008 Written and Oral Comment	Rejected. The 'opportunity to adopt provisions in the PDRS on a going forward basis' is beyond the scope of this rulemaking because it would require amendments to the Permanent Disability Rating Schedule, adopted pursuant to Labor Code § 4660(d) and found at § 9805 of Title 8 of the California Code of Regulations. Moreover, the proposed regulatory wording is consistent with the holdings in both *Genlyte Group, LLC v. WCAB (Zavala)*[hereafter, *Zavala*] and *Costa v. Hardy Diagnostic (SCIF)* [hereafter, *Costa*] because the proposed wording requires QMEs to be trained on describing disability under both the pre-1/1/2005 PDRS and the PDRS adopted to be effective 1/1/2005.	None.
11.5(i)(3)	"The occupational history"; "Work restrictions"; "Loss of pre-injury capacity"; and "Vocational rehabilitation" **Comment:**: These elements of measuring permanent disability remain unchanged from the current regulations.	**31B**	Mark Webb, Vice President Governmental Relations Employers Direct Ins. Co. January 16, 2008 Written Comment and Oral	Accept in part. Section 11.5(i)(3) The Language of Reports will be amended by adding, after the topic of Vocational Rehabilitation: "(for claims with dates of injury prior to January 1, 2004)".	Section 11.5(i)(3) The Language of Reports will be amended by adding, after the topic of Vocational Rehabilitation: "(for claims with dates of injury

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	Clearly, prior to the enactment of AB 227 (Vargas) and SB 899 (Poochigian), they were relevant criteria for measurement of the worker's diminished ability to compete in an open labor market and to resolve disputes over the eligibility for vocational rehabilitation benefits. As cited recently in *Costa v. Hardy Diagnostic (SCIF),* (2007) Case No. GRO 0031810, relying upon *LeBoeuf v. Workers' Comp. Appeals Bd.* (1983) 34 Cal.3d 234, 242-243, the Appeals Board has clearly left the door open for the rebuttal of the prima facie evidence of disability established by the PDRS by using, in part, vocational assessments of the injured worker. What is before the Division, in this case, however, is not a legal challenge to the PDRS, but rather what should QMEs receive training on as it relates to injuries clearly falling under the 2005 PDRS? *Costa* fails to acknowledge that vocational rehabilitation was eliminated from the definition of "compensation" in Labor Code § 3207 when SB 899 was enacted. The existence of vocational rehabilitation as a benefit, and after 1974 as a mandatory benefit, was central to the Court's decision in *LeBoeuf*: "The statutory scheme envisions that vocational rehabilitation will be provided an injured worker before a final decision is reached on the nature and extent of his or her permanent disability. As this court stated in *Webb*, "'[i]t seems clear that [the Legislature] intended a worker's disability should not be permanent and stationary until he was both vocationally and medically rehabilitated.'" (*Webb v. Workers' Comp. Appeals Bd.,* supra, 28 Cal.3d at p. 627, quoting from *Ponce De Leon v. Glaser Bros. (1977)* 42 Cal.Comp.Cases 962, 968; see also *Tangye v. Henry C. Beck and Co.* (1978) 43 Cal.Comp.Cases 3, 7.) This is to ensure that the permanent disability rating upon which an award is based accurately reflects both the permanent medical and vocational disabilities." 34 Cal. 3d at 242, 243. In essence, the Appeals Board in *Costa* has come		comment	This change is consistent with the statutory amendments of AB 227 and SB 899 to section 139.5 of the Labor Code. AB 227 repealed the existing section (which provided for vocational rehabilitation benefits and the agency unit to administer the benefits) and replaced it with a new section 139.5 that provided for "Supplemental Job Displacement Benefits". SB 899 repealed that version of Labor Code section 139.5 and added wording that effectively restored, for claims with dates of injury prior to 1/1/2004, vocational rehabilitation benefits and the agency to administer the benefit. SB 899 also added a sunset date for the section of 1/1/2009, unless reenacted prior to that date. Commenter's other remarks speculate that by listing 'occupational history', 'loss of pre-injury capacity', 'work restrictions' and 'vocational rehabilitation' as topics in QME courses, the Administrative Director is trying to teach QMEs to rebut the PDRS adopted effective 1/1/2005. It is necessary to include these topics in QME disability report writing and continuing education courses because: a) 'occupational history' is necessary background, regardless of the date of injury', for use in determining the mechanism and dates of injury; b) 'loss of pre-injury capacity' is necessary for cases to be rated under the 1997 PDRS; c) 'work restrictions' are necessary, regardless of the date of injury, because the information is used for cases rated under the 1997 PDRS and, for claims with dates of injury after 1/1/2004, to assess the functional capacity for the injured workers' return to work and eligibility for supplemental job displacement benefits. Moreover, the court in *Genlyte Group, LLC v. WCAB (Zavala)*[hereafter, *Zavala*], expressly rejected the defendants' argument there (like Mr. Webb's here) that it is not necessary for the injured worker to reach permanent and stationary status to	prior to January 1, 2004)".

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	perilously close to finding that a rating under the old PD system is sufficient to rebut the new schedule. Considerations that were relevant to the determination of the diminished ability to compete in an open labor market are no longer relevant now that vocational rehabilitation has been eliminated as compensation to an injured worker and now that the definition of permanent disability has been changed. This is not to suggest that the PDRS is not rebuttable, but rather only to comment that it should not be up to the Division to train QMEs on every possible way to rebut the schedule. **Recommendation:** Training in the areas of vocational rehabilitation should be limited to injuries to which Labor Code § 139.5 applies, or more specifically to dates of injury prior to January 1, 2004 by operation of AB 227. Work restrictions and occupational history are relevant to injuries to which the 1997 PDRS applies and are appropriate to take into consideration when there is a dispute over whether a return to work offer meets the necessary criteria in Labor Code §§ 4658(d) and 4658.6, but not to the determination of permanent disability under the 2005 PDRS and future revisions thereof.			trigger the determination regarding the existence of permanent disability. Further, regardless of the absence of discussion in *Costa* by the WCAB about the repeal of wording referring to vocational rehabilitation in Labor Code 3207, QMEs need to be trained on evaluating permanent disability under both the 1997 PDRS and the 2005 PDRS because there are still disputed cases in the workers' compensation system that apply one of these two schedules.[i]	
11.5(i)(3)	**Recommendation** Factors of disability, including subjective and objective factors, and loss of pre-injury capacity for cases involving dates of injury not subject to the AMA guide-based impairment rating system Work restrictions Work Capabilities ~~Loss of pre-injury capacity~~ American Medical Association, Guides to the Evaluation of Permanent Impairment, [Fifth Edition] (AMA Guides) and its use in determining permanent disability in accordance with the Schedule for Rating Permanent Disabilities [effective January 1, 2005] (for all claims with dates of injury on or after January 1, 2005, and for those compensable claims arising before January 1, 2005, in which either there is no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent	**39F**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	Subdivision 11.5(i)(3) has amended to read: Factors of disability, including subjective and objective factors***, loss of pre-injury capacity and work restrictions***, for cases involving dates of injury not subject to the AMA guide-based impairment rating system ~~Subjective~~ ~~Objective~~ ***Activities of Daily Living, for cases subject to the AMA Guides*** Work restrictions ~~**Loss of pre-injury capacity**~~ ***Work Capabilities***

	disability, or when the employer is not required to provide the notice to the injured worker required by Labor Code section 4061) … **Discussion** In the list of topics included for instruction in the disability evaluation report writing section, "Work capabilities" should be added since work capabilities and/or work restrictions are useful when addressing return to work issues. It is necessary to move "loss of pre-injury work capacity" to associate it only with cases involving dates of injury not subject to the AMA guide-based impairment rating system since it is now an obsolete term of art relating to the former permanent disability evaluation system.				
11.5(i)(4)	In order to ensure that the QME understands what set of rules and calculations are to be used in making medial determinations, commenter recommends the following amendment: An overview of... an in-depth discussion of measurement of impairment – including the calculation used and rationale for rating -- under the AMA Guides (5th), as relevant.	**38B**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Accepted in part.	Subdivision 11.5.(i)(4) has been amended to read: An overview of ~~the protocols and an in-depth discussion of one or more of~~ the Neuromusculoskeletal, Pulmonary, Cardiac, Immunologic, or Psychiatric protocols, and an in-depth discussion of measurement of impairment***, calculations and rationale for rating*** under the AMA Guides, as relevant.
11.5(i)(6)	Commenter believes that it is important that an individual taking this course be required to actually write a QME report that is evaluated and commented on by the entity putting on the course. The regulations currently only say, "if feasible, physician should have the opportunity to write a report." Commenter recommends deleting this language and mandating that a practice report be written.	**30C**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Accepted.	Subdivision 11.5(i)(6) has been amended to read: ***(8) Submission and Critique of Written Medical/legal Report. As a condition of completion of the course taken to satisfy the requirements of this section, each physician enrollee shall draft at least one practice written medical/legal report, based on a sample case library of materials, which written report shall be critiqued with notations by either another course enrollee or by the***

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					course education provider.
11.5(j)	Commenter supports the proposed language which would allow the entire 12 hour report writing course to be taken through a distance learning course. This will allow more entities to offer the report writing course throughout the year.	**T2**	Frank Navarro, California Medical Association Diane Przepiorski California Orthopaedic Association January 17, 2008 Oakland Public Hearing - Oral Comment – Page 23	Accepted.	No change needed.
12	Commenter requests that board certification in Rheumatology be included in the appropriate qualification for pain medicine. He opines that the vast majority of acute and chronic pain is musculoskeletal (75-80%) and that rheumatology has been excluded from the list of pain physicians. He states that a rheumatologist is the specialist with the broadest and most extensive exposure to non-fracture musculoskeletal problems in medicine.	**1A**	Franklin Kozin, MD December 8, 2007 Written Response	Rejected. The California Medical Board, as the California licensing agency for medical doctors, not the Division of Workers' Compensation, has the authority to recognize board certification of medical specialties and subspecialties. Pursuant to Business and Professions Code § 651, the specialties certified by the American Board of Medical Specialties (ABMS), and its member boards, are recognized. Further, pursuant to its authority under section 651, the Medical Board has recognized four additional specialty organizations in other specialties. While Rheumatology is a certified sub-specialty of the American Board of Internal Medicine, which is itself a member board of the ABMS, there is no evidence that any ABMS board has recognized subspecialty certification in Rheumatology as equivalent to or as meeting the qualifications for the subspecialty certification in Pain Medicine. The Division will consider this request upon receipt of evidence that an ABMS board will accept sub-specialty certification in Rheumatology for this purpose, or upon receipt of evidence that the California Medical Board has recognized board certification in Rheumatology for this purpose.	None.
12 and 13	Commenter asks why Chiropractic QME specialty panels that have been in place are now 'illegal' and whether DWC has contacted the Board of Chiropractic Examiners. Commenter will contact the Board of Chiropractic Examiners.	**2A**	Robert White, D.C. President, Ventura County Chiropractic District robertwhitedc@verizon.net email of December 17, 2007	Rejected. The Administrative Director has amended the QME regulations to be consistent with provisions of Business and Professions Code 651. The Administrative Director also contacted the Executive Officer of the Board of Chiropractic Examiners, Brian Stiger, by letter dated March 11, 2008, for clarification of that Board's position in regard to recognizing post graduate diplomate specialty boards. However, no answer has been	No change.

				received from the Board to date.	
12 and 13	Commenter supports the proposed revisions to these sections which will clarify that the Division may only recognize specialty boards that are recognized by the respective licensing boards for the physicians and that physicians may only list specialties recognized by their licensure board.	**T3**	Frank Navarro, California Medical Association Diane Przepiorski California Orthopaedic Association January 17, 2008 Oakland Public Hearing - Oral Comment – Page 24	Accepted.	None required.
12 and 13	Commenter opines that the Division lacks the authority to adopt a regulation to preclude a doctor of chiropractic from serving as a QME in a specialty area unless the BCE recognizes the board that conferred the specialty designation. Commenter adds that a chiropractor's right to advertise specialty designations is constitutionally protected commercial speech. Thus, commenter contends that the Division should keep Sections 12 and 13 as they currently exist in regulation.	**34A**	William F. Updyke, DC President California Chiropractic Assoc. January 17, 2008 Written Comment Kristine Shultz California Chiropractic Assoc. January 17, 2008 Oral Comment	Rejected. Section 651(i) of the Business and Professions Code requires each of the healing arts boards and examining committees within Division 2 of that code to adopt regulations, in compliance with the Administrative Practices Act in the Government Code, in order to enforce section 651. Section 651 governs persons licensed under "any initiative act referred to in this division" (Bus. Prof. Act § 651(a)), which would include doctors of chiropractic. Further, the Board of Chiropractic Examiners is referenced in Chapter 2 of Division 2 (Healing Arts) of the Business and Professions Code. Accordingly, the wording proposed by the Administrative Director in section 12, to recognize only those specialty boards recognized by a physician's licensing board, and in section 13, to allow a QME to be listed only in those specialties recognized by the physician's licensing board, is entirely consistent with the wording and intent of Business and Professions Code 651. Nothing in the Constitution requires a state agency, including the Administrative Director, to adopt in the QME regulations the wording that an individual chiropractor prefers but which the doctor's California licensing board has not sanctioned as a specialty category. Regulations 12 and 13 as proposed provide that the Administrative Director will accept the specialty designations recognized by the physician's California licensing board consistent with Business and Professions Code section 651(i)..	None.
12 and 13	Commenter states that there has been a misrepresentation of facts regarding the Board of Chiropractic Examiners not recognizing specialty boards such as the Dipolomate of the American Board of Chiropractic Orthopedics and		Richard Fink, DC Erickson Chiropractic Clinic January 17, 2008 Written Comment	Rejected. As stated in a letter dated March 11, 2008, written on behalf of the Administrative Director to the Executive Officer of the Board of Chiropractic Examiners, Brian Stiger, the Board	None.

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	Diplomate of Chiropractic Neurology. There have been B.C.E. members who were adverse to the chiropractic profession voicing opinions that the board did not recognize these specialties, but this was not a legal determination. There is no legal requirement in the California Labor Code, California Code of Regulations, or the Business and Profession Codes that mandates that a state board recognize a specialty course of training in order for that specialty to be separately listed on the panel QME list of doctors. The attempt to remove the DCO/DCN specialties from the QME list would only result in more QME evaluations by chiropractic doctors who are without any postgraduate specialty training in orthopedics or neurology. Commenter believes that this would impair rather than benefit the QME evaluations of injured workers.			representatives have provided conflicting statements at different times on the issues of whether the Board recognizes the American Board of Chiropractic Orthopedists, whether a licensed chiropractor with a postgraduate diplomate from the American Board of Chiroprractric Orthopedics may advertise as a 'board certified chiropractic orthopedist' and whether the Board recognizes any other specialty board in a manner that would allow the doctor of chiropractic licensed in California with such a certification to advertise as a 'board certified' chiropractor without being subject to discipline under Business and Professions Code section 651 or any of the Board's regulations. Moreover, the commentor's statements are incorrect. Business and Professions Code section 651 provides, in pertinent part: "(a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed…. (g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action…. (i) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code." The Board of Chiropractic Examiners is referenced in Division 2 (Healing Arts), Chapter 2 (Chiropractors), sections 1000 through 1058, of the California Business and Professions Code. As stated in section 1000 of the Business and Professions Code, practitioners of chiropractic are	

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				licensed by the Board of Chiropractic Examiners pursuant to an initiative act adopted by electors on November 7, 1922. Moreover, the additional post graduate diplomate education and training received by any doctor of chiropractic who is appointed as a QME will be identified and described on the QME panel letter sent to the parties under the QME's name, contact information, profession education and professional training.. Therefore those QME chiropractors holding such certification will be identified as such.	
12 and 13	Commenter opposes and questions the division's authority to eliminate section 12 which recognizes Specialty Boards and points out that the state legislature places no conditions on the ability of chiropractors to use specialty designations. The California Board of Chiropractic Examiners does not specifically "recognize" chiropractic specialties, but the board specifically does not prohibit or preclude chiropractic specialties. Commenter states that the California Medical Practices Act and the California Board of Medical Examiners has no current codified policy "recognizing" any designated specialty board. It appears that they take their specialty designation regulations from the Business and Professions Code 651(h)(5). Commenter opines that the Business and Professions Code allows for recognition of a nongovernmental federation of specialty boards.	**T4**	Steven G. Becker, D.C. January 14, 2008 LA Public Hearing - Oral Comments – Page 14	Rejected for the reasons stated above.	None.
13	**Recommendation** A physician's specialty(ies) is one for which ~~the physician is board certified or, one for which a~~ medical doctor or doctor of osteopathy is board certified ~~has completed a postgraduate specialty training~~ as defined in Section 11(a)(2)(A), or held an appointment as a QME in that specialty on June 30, 2000, pursuant to Labor Code Section 139.2. To be listed as a QME in a particular specialty, the physician's licensing board must recognize the designated specialty board and the applicant for QME status must have provided to the Administrative Director documentation from the relevant board of certification or qualification.	**39G**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. The wording already proposed by the Administrative Director is more consistent with Labor Code section 139.2(b)(3) than that proposed by the commenter.	None.

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	Discussion To ensure a high professional standard for injured workers in California, commenter recommends the Division require a physician to be board certified in a specialty in order to be listed as a QME in that specialty. Medical legal assessments are now based on a single well qualified medical evaluator assigned by the Division or selected by the parties. Since there is no opportunity for either the employer or the injured worker to rebut that physician's opinion with a stronger, more knowledgeable medical opinion, a competent, well reasoned, and comprehensive medical legal report is essential to the fair administration of the workers' compensation system. If the Division declines to accept this recommendation, CWCI recommends identifying those QMEs that are board certified on the panel issued to injured employees, and comparing the performance of board certified and non-board certified QMEs in future Labor Code section 139.2(i) annual reports.				
13	Commenter disagrees with allowing non-Board Certified physicians to claim the specialty. Commenter recommends that a designation be provided on each panel showing which physicians are actually Board Certified.	**37D**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected.	None
14(b)(4)(E)	**Recommendation** "Continued ~~or~~ and future medical care." **Discussion** To the extent that these concepts are different, training in each is necessary.	**39H**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted.	§ 14(b)(4)(E) has been amended to read: "(E) Continued ***and*** future medical care."
17(c)	If is difficult to see how five hours a week at up to four "primary locations" will solve the fairness problem of assigning QMEs to QME panel list identified in the Initial Statement of Reasons. Commenter recommends revising this to eight hours per week at no more than three "primary locations."	**37E**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected.	For other reasons, subdivision 17(c) is being deleted.
29(b)	**Recommendation** (b) "Specified Financial Interests" means being a general partner or limited partner in, or having an interest of five (5) percent or more in, or receiving or being legally	**39I**	Brenda Ramirez Claims & Medical Manager Michael McClain	Accepted.	Subdivision has been amended to read: (b) "Specified Financial Interests" means being a

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	entitled to receive a share of five (5) percent or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation, goods or services for use in the California workers' compensation system. **Discussion** Goods are another area of financial interest that we believe should be added to the list in order to avoid a loophole for goods such as durable medical equipment, hardware and drugs.		General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment		general partner or limited partner in, or having an interest of five (5) percent or more in, or receiving or being legally entitled to receive a share of five (5) percent or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation ***goods or*** services for use in the California workers' compensation system.
29(b)	Commenter suggests making the addition, as shown below in underline, to include those who market pharmaceuticals, DME, implantables, and other goods: "Specified Financial Interests" means being a general partner or limited partner in, or having an interest of five (5) percent or more in, or receiving or being legally entitled to receive a share of five (5) percent or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation, goods or services for use in the California workers' compensation system."	**37F**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted.	Subdivision 29(b) has been amended, as noted directly above.
30(a)	**Recommendation** The claims administrator ~~(or, if there is none, the employer)~~ shall provide Form 105 along with the Attachment to Form 105 (How to Request a Qualified Medical Evaluator if you do not have an Attorney) to the unrepresented employee by means of personal delivery or by first class or certified mailing. … **Discussion** There will never be a claim without a claims administrator. A self-administered self-insured employer is encompassed in the claims administrator definition. Suggesting that an employer that is not a claims administrator may have a role to play in this process will	**39J**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. An unlawfully, uninsured employer is not included in the definition of a claims administrator, and it is highly unlikely that such an employer would have a claims administrator. However, there is some inconsistency in the way the phrase is punctuated so that is being corrected.	The phrase has been amended throughout the regulations to read: '…claim administrator, or if none the employer, ….'

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	create confusion. Language such as this needs to be revised wherever it occurs in the proposed regulation and forms.				
30(a)	This is the first of many places where the following term is used and it should be corrected, by deleting the stricken-through language, as follows: "…The claims administrator ~~(or, if there is none, the employer…)~~."	**37O**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. An unlawfully, uninsured employer is not included in the definition of a claims administrator, and it is highly unlikely that such an employer would have a claims administrator. However, there is some inconsistency in the way the phrase is punctuated so that is being corrected.	The phrase has been amended throughout the regulations to read: '…claim administrator, or if none the employer,…'
30(c)	New wording added to this subdivision allows the medical director to delay issuing a QME panel until the parties answer a request regarding a previously issued panel. Although commenter understands the need for information about a previously issued panel, she is concerned that the proposed language may cause a significant delay in many cases if such a request is made in all cases where the worker has been assigned a prior panel. Commenter recommends that information regarding the assignment of previous panels should be provided on the original request form.	**29B**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part. The QME panel request form may be amended to ask the requesting party to list such information. However, in some cases, especially where the parties are different, a party may not know or have the information. In those cases, the Medical Unit will need to request the information prior to issuing a QME panel, to ensure that two panel lists are not issued for the same dispute.	Forms 105 and 106 have been amended to ask for prior QME panel information if known.
30(c)	Commenter is concerned about the delay in issuing a QME panel to an injured worker considering there is a two year Temporary Disability payment cap. Commenter states that it is important to speedily get these panels issued so that the injured worker as the financial ability to undergo treatment, should it be authorized.	**T5**	Linda Atcherley, Legislative Chair California Applicant's Attorneys' Association January 14, 2008 LA Public Hearing – Oral Comment – Page 8	Rejected. While the Administrative Director shares the concern that QME panels be issued expeditiously, this section addresses events when the request form is incomplete or improperly completed, or when a QME panel was already issued. The Medical Director does not receive information explaining the status of the previously issued QME panel so must obtain that information, to avoid issuing multiple panels for the same dispute which would cause confusion among the parties about which QME panel to use.	Forms 105 and 106 have been amended to ask for prior QME panel information if known.
30(c)	Commenter is concerned about the delay for injured workers to obtain an additional panel QME. Commenter suggests that this section be revised as per Linda Atcherley's comments.	**T6**	Robert B. Zeidner, Esq. California Applicants' Attorneys Association January 14, 2008 LA Public Hearing - Oral Comment – Page 23	Rejected. The conditions for issuing additional panels are limited by Labor Code 4060 through 4062.3. Proposed regulation 31.7 now addresses the conditions in which the parties may obtain an additional panel in another specialty, if appropriate.	Forms 105 and 106 have been amended to ask for prior QME panel information if known to avoid such delays.
30(d)(1)	Commenter recommends that the wording of this paragraph be amended to conform to the requirements of Labor Code Section 4062.1. That code section provides that either an unrepresented worker or the employer may submit a form requesting a QME panel, but that "the employer may not submit the form unless the employee	**29C; T7**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written Comment	Accepted in part. The wording of section 30(d)(1) has been amended to read: "After a claim form has been filed, an employer, or the employer's claims administrator, may request a panel of Qualified Medical Evaluators only as provided in Labor Code section 4060, to determine	The wording of section 30(d)(1) has been amended to read: "After a claim form has been filed, an employer, or the employer's claims administrator, may request a

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	has not submitted the form within 10 days after the employer has furnished the form to the employee and requested the employee to submit the form." The proposed wording of this paragraph is unclear, and could be interpreted to suggest that the employer has the right to submit a form requesting a QME panel without first fulfilling this statutory requirement. Recognizing that the form, QME Form 105, does include a note that the employer must attach a copy of correspondence to the form showing that the worker was sent the form, commenter believes this paragraph should be revised to clarify the meaning. One possible amendment would be to add the word "only" before "as provided in Labor Code Section 4060..." With this amendment, paragraph (d)(1) would read: (d)(1) After a claim form has been filed, an employer, or the employer's claims administrator, may request a panel of Qualified Medical Evaluators only as provided in Labor Code section 4060, to determine whether to accept or reject part or all of a claim within the period for rejecting liability in Labor Code section 5402(b).		Oakland Public Hearing – Oral Comment – Page 10	whether to accept or reject part or all of a claim within the period for rejected liability in Labor Code section 5402(b), and only after providing evidence of compliance with Labor Code section 4062.1 or 4062.2."	panel of Qualified Medical Evaluators ***only*** as provided in Labor Code section 4060, to determine whether to accept or reject part or all of a claim within the period for rejected liability in Labor Code section 5402(b***), and only after providing evidence of compliance with Labor Code section 4062.1 or 4062.2."***
30(d)(3)	Commenter disagrees with this proposed section. There are many situations when a claim may be denied due to factual or legal reasons, but a comprehensive medical/legal evaluation may still be required to address disputed medical/legal issues. It would be unreasonable to require parties to litigate all factual or legal denials at the Board *before* obtaining a QME evaluation. Commenter opines that there is *no legal authority* in section 4060 indicating that an EMPLOYEE can obtain a medical/legal evaluation under 4060 if a claim is denied, but the EMPLOYER would have no similar right.	**5A**	Matthew Brueckner Law Office of Matthew Brueckner January 2, 2008 Written Comment	Rejected. Commenter ignores the requirement under Labor Code section 5402(b) that a presumption attaches that a claim is compensable if the claim has not been rejected within 90 days after the claim is filed, and only evidence discovered after the 90 day period may be used to rebut the presumption. In contrast, when a claims administrator or employer denies a claim entirely the employee's only remedy is to obtain a compensability evaluation if no prior evaluation has addressed that issue. Moreover, pursuant to Labor Code § 5402(b), disputes regarding compensability of a claim may be heard on an expedited priority trial calendar basis, without developing evidence on all other potential disputed issues first.	None.
30(d)(4)	Under this proposed paragraph, the Medical Director can issue a QME panel after the statutory 90 day period for determining compensability under Labor Code Section 5402(b) has expired if an employer or claim administrator "asserts for good cause that a comprehensive medical/legal evaluation is needed to determine compensability." Commenter strongly objects to this	**29D**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part.	Proposed section 30(d)(4) will be amended to read: ***(d)(4) After the ninety (90) day period specified in Labor Code section 5402(b) for denying liability has expired, a***

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	proposed procedure. Section 5402(b) establishes a rebuttable presumption that a claim is compensable where liability is not rejected within 90 days. Determination of whether this presumption is rebutted is a judicial determination that can be made only by a workers' compensation judge. This paragraph must be amended to provide that a QME panel can be issued after the 90 day period specified in Section 5402(b) for the purpose of determining compensability only after a finding of good cause by a workers' compensation judge.				***request from the claims administrator, or if none from the employer, for a QME panel to determine compensability shall only be issued upon presentation of a finding and order issued by a Workers' Compensation Administrative Law Judge that the presumption in section 5402(b) has been rebutted and that a QME panel should be issued for this purpose. The order shall also specify the medical specialty of the panel or which party may select the medical specialty.*** Move to new 31.7 ***(a) Once an Agreed Medical Evaluator or a panel Qualified Medical Evaluator has issued a comprehensive medical/legal report in a case and a new medical dispute arises, the parties, to the extent possible, shall obtain a follow-up evaluation or a supplemental evaluation from the same evaluator.***
30(d)(4)	Commenter strongly objects to any language that would give a judge the power to order further QME evaluations which would extend the 90-day period in which to investigate and gather evidence to support or reject a claim.	**T8**	Robert B. Zeidner, Esq. California Applicants' Attorneys Association January 14, 2008 LA Public Hearing - Oral Comment – Page 22	Accepted. See response directly above.	See proposed amendment to subdivision (d)(4), directly above.

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30(e)	Commenter recommends that this paragraph be amended to provide that where a worker is represented, the geographic area of the QME panel selection shall be determined by the principal office of the employee's attorney. Furthermore, this rule should apply regardless of which party files the request for a QME panel. Commenter suggests the following language: (e) If the request form is submitted on a claim of an employee who no longer resides in the state of California, the geographic area of the QME panel selection within the state shall be determined by agreement between the claim administrator, or, if none, the employer, and the employee. If no agreement can be reached, the geographic area of the QME panel selection shall be determined for an unrepresented employee by the employee's former residence within the state, and for a represented employee by the principal office of the employee's attorney.	**29E**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part.	The subdivision will be amended to read: (e) If the request form is submitted by or on behalf of an ~~unrepresented~~ employee who no longer resides within the state of California, the geographic area of the QME panel selection within the state shall be determined by agreement between the claims administrator, or~~,~~ if none~~,~~ the employer, and the employee. If no agreement can be reached, the geographic area of the QME panel selection shall be determined ~~***for an unrepresented employee,***~~ by the employee's former residence within the state ~~***and for a represented employee by the office of the employee's attorney.***~~
30(f)	Commenter feels that he is more objective when performing examinations at various locations throughout the state. Commenter believes that the proposed section is discriminatory it that he gives local physicians a 50 percent advantage and does not provide equal opportunities for traveling physicians.	**17A**	Arun Mehta, M.D., QME, January 14, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter objects to the change in sections 30(f), (1)(x) and 17 pertaining to the 1.5 rule for primary practice locations because: 1) he has worked as a QME since inception of the QME process; 2) after heart bypass surgery he was restricted by his own doctors from continuing orthopedic surgery practice, so continued to work as an orthopedic QME at several locations; 3) he believes he provides 'unbiased' quality evaluations that he believes can be more objective as a QME from outside the community; 4) he believes it would be counterproductive to favor doctors with primary practice locations over specialists like himself when compiling QME panels; 5) semi-retired and retired specialists like himself have the time to address cases with multiple injuries and 10" of medical records whereas physicians with busy practices are not that interested in such cases.	**24A**	Richard Byrn, M.D., QME	Rejected. The commenter does not appear to have read the proposed regulations very carefully as each panel would be comprised of QMEs having the same specialty, not a mixture of general practice and specialists. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations.	The Administrative Director decided to withdraw this proposed change for other reasons.

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30(f)	This subdivision authorizes the Medical Director to give "primary practice locations" and extra 50% weight in the selection of QME panels. This may not be lawful in that Labor Code Section 139.2(h)(1) requires the panel selection process to be random. Giving some elements extra weight, as proposed, would not be random. Commenter recommends against adoption of this revision.	**30I**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter believes that the 1.5 multiplier advantage mechanically applied is arbitrary and that there is neither statutory foundation nor data to support its application or claims of necessity. Commenter opines that this proposed multiplier will have a profoundly adverse impact on a class of retired and disabled QMEs who provide tremendous benefit and relief to a system in need of such practitioners. Commenter suggests that instead of applying an arbitrary multiplier whose application itself can cause confusion and inequity that the Division place some form of qualification on the number of locations sought by QMEs within the same zip code.	**36A**	Charles S. Poochigian Dowling Aaron Keeler January 17, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter states that the current process of using zip-codes makes the evaluation process easier for the applicant because a QME panel of three doctors is arbitrarily selected by the computer based upon the applicant's location. Commenter believes the proposed changes would negate the impartiality of the process of selecting a QME by giving preference to certain physicians to the detriment of others. The fairness and objectivity of the process will be lost and the physicians who do travel will not be able to complete in the QME arena. Commenter states that if this modifier is adopted there will be fewer QMEs practicing.	**18A**	David M. Broderick, MD January 14, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. Moreover, one reason for the proposal was complaints from QMEs who maintain the overhead of a few full time primary practice locations, but are trying to compete with other QMEs who have numerous locations listed throughout the state but whose 'overhead' is paid only on an 'as used' basis.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter objects to this section and opines that any	**32A**	David E. Fisher, MD,	Rejected. Every QME who is appointed is	The Administrative Director

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	change to the current system would be discriminatory against evaluators that have devoted a considerable amount of time and effort to understand the legal terminology and regulatory changes in order to prepare well written and ratable reports. Commenter believes that any change in ratios would be difficult to monitor and that this is especially true in regards to whether an evaluator would be actually available to treat patients at a set time per week or whether he or she only lists the location as a treating facility and is only present for QME exams.		Orthopaedic Surgeon January 17, 2008 Written Comment	expected to have spent sufficient time and effort learning the applicable laws and regulations in order to prepare admissible, ratable reports that help resolve disputed issues. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations.	decided to withdraw this proposed change for other reasons.
30(f)	Commenter objects to the 1.5 multiplier, determined on the basis of the number of hours per week that a practitioner purports to spend at a certain location. Commenter feels that this proposal would create potential for more abuse as this could not be monitored. Commenter states that this is discriminatory to the individuals whose primary practice is doing forensic evaluations and seems to be restraint of trade from a legal point of view. Physicians who are willing to work more hours, do more traveling, and go to underserved areas should not be punished.	**14A**	Edward J. Troy, MD and QME January 11, 2008 January 17, 2008 Written and Oral Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations. With the exception of physicians who apply for appointment or reappointment as a QME on the basis of having performed 8 or more Agreed Medical Evaluator evaluations in the prior 12 months, every other physician applicant must attest that he or she spends at least one third of their medical practice time engaged in direct medical treatment. (Lab. Code § 139.2(b)(2).) Accordingly, it is not 'discriminating' against any applicant.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter states that it is discriminatory to impose time and practice requirements on older and experienced evaluators. Commenter is a physician who no longer performs surgery and has limited treatment hours and would fail to qualify as a QME if a mandatory number of treatment hours were required.		Edwin W. Clark, MD January 17, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter is concerned about the proposed subsection for the following reasons: • Objectivity: Commenter feels that a QME from outside of a particular community is less likely to have any financial or personal ties to the treating physician handling a case. • Timely Ratable Reports: Commenter is concerned that a practitioner engaged in active surgical practice has less time to devote to producing a timely ratable report. • Inconvenience to Injured worker: Commenter believes that a QME traveling to an area to perform evaluations cuts down on the amount of time an injured worker will wait for a QME and	**33A**	Ernest L. Washington, MD QME January 17, 2008 Written Comment	Rejected. Other QME regulations allow for the QME to be replaced if financial or personal ties to the treating physician create a conflict of interest. (8 Cal. Code Regs. §§ 29, 31.5, 41.5) The QMEs who request extensions of time for completion of their reports are spread out among those with active treating practices and those with forensic practices. As for the last point, QMEs who travel do provide more choices in more remote or less populated areas. However, traveling QMEs would, under the proposed rule, have the same advantage as non-traveling QMEs at up to any four locations the traveling QME would care to designate. In	The Administrative Director decided to withdraw this proposed change for other reasons.

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	that by giving advantage to local QME's they will be less inclined to provide services to outlying underserved areas.			outlying underserved areas the multiplier, as proposed, may have no impact because fewer QMEs of the same specialty will exist and a QME's name can appear on any given panel only once, so the computer will keep searching until it is able to select 3 different QMEs within the designated specialty and geographic area.	
30(f)	Commenter objects to the 1.5 panel advantage to treating QMEs who spend a minimum of 5 hours per week in treatment at a location. Commenter opines that he will consider re-thinking his involvement as a QME if this proposal in enacted.	**35A**	George Glancz, MD January 17, 2008 Written Comment	Noted.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter opines that if preference is given to the primary practice location with an arbitrary 1.5 weight over all other office locations, there will be a deterrence of other QME offices in that community, and will discourage doctors who might wish to become a QME with a secondary office in that community. Commenter states that there should be equal opportunity for QMEs outside a community to provide evaluations and that this will encourage objectivity and the timely submission of reports.	**22A**	George S. McCan, MD January 15, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter opines that this subsection is unfair, discriminatory and a restraint of free trade. He states that this proposal is difficult to police and will result in a more cumbersome system that is more susceptible to corruption.	**9A**	Gonzalo Covarrubias, MD January 12, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations. When a QME with over 70 QME listings in California is named to a QME panel of 3 physicians where the two other QMEs share the same address as the first QME, that leads to complaints from the parties that they are not being given a choice of 3 independent evaluators.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter states that this subsection is unfair and discriminatory to older, retired physicians.	**16A**	Hal D. McConnaughey, MD January 14, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter states that this proposal is discriminatory against non-local, unbiased medical opinions and encourages cronyism.	**21A**	James D. Mays, MD January 15, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. When a QME with over 50 QME listings in California is named to a QME panel of 3 physicians where the two other QMEs share the same address as the first QME, that leads to complaints from the parties that they are not	The Administrative Director decided to withdraw this proposed change for other reasons.

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				being given a choice of 3 independent evaluators.	
30(f)	Commenter opines that this subsection discriminates against semi-retired physicians who travel to provide QME evaluations. Commenter states that traveling QMEs are able to serve less populated areas while at the same time are less likely to be influenced or biased by the treating physician and his or her community.	**13A**	James L. Strait, MD January 14, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location. Moreover, traveling QMEs would, under the proposed rule, have the same advantage as non-traveling QMEs at up to any four locations the traveling QME would care to designate. In outlying underserved areas the multiplier, as proposed, may have no impact because fewer QMEs of the same specialty will exist and a QME's name can appear on any given panel only once, so the computer will keep searching until it is able to select 3 different QMEs within the designated specialty and geographic area.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter believes this section will adversely affect the injured workers and compromise the integrity of the QME process. The availability of local QME physicians cannot match that of a traveling QME physician. Commenter stresses that traveling QME physicians are better suited to render unbiased and impartial opinions to all involved parties because they are removed from the influences of local reputation, practice patterns or legal connections.	**19A**	Jason J. Chiu, MD, QME January 14, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations. When a QME with over 70 QME listings in California is named to a QME panel of 3 physicians where the two other QMEs share the same address as the first QME, that leads to complaints from the parties that they are not being given a choice of 3 independent evaluators.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter states that this section is biased and unfair by giving treating physicians an advantage over non-treating QMEs. Commenter opines that non-treating QMEs are not biased like the treating QMEs.	**11A**	John L. Branscum, MD January 13, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations. When a QME with over 80 QME listings in California is named to a QME panel of 3 physicians where the two other QMEs share the same address as the first QME, that leads to complaints from the parties that they are not being given a choice of 3 independent evaluators. Moreover, Labor Code section 139.2(b)(2) requires all physicians to attest that the physician spends one third or more of his or her practice time in direct medical treatment, unless he or she applies on the basis of having performed 8 or more Agreed Medical Evaluator cases in the prior 12 months. Therefore, the legislature envisaged that the majority of QMEs would be treating physicians.	The Administrative Director decided to withdraw this proposed change for other reasons.

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30(f)	Commenter opposes this section. Commenter opines that it is discriminatory to limit the availability of any doctor for a panel of QME evaluators. Commenter speaks of the benefit to the patient having the doctors come to their area.	**20A**	John G. Colias, MD January 14, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations. The proposed regulations do not impose any restriction on the total number of locations at which a physician may wish to be listed as a QME.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter is concerned that this subsection favors the local treating physician over the visiting QME to the ratio of 1. 5 to 1 and requests that this provision be removed. Commenter opines that this provision is antagonistic to the QME process by reintroducing needless bias into the system by favoring the local physician who knows and competes against the doctor writing the report on the applicant to be evaluated.	**25A**	John J. O'Hara, MD, QME January 13, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness or bias.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter opines that this subsection is unfair because it gives a 1.5 advantage to physicians who have the money and resources to establish four primary practice locations. Commenter states that the current system is open and equal for all physicians. Commenter believes that this proposal would not improve the delivery of care to the injured worker and would have the effect of decreasing the availability of physicians who are willing to travel to see patients.	**10A**	John D. Santaniello, MD Santeniello Orthopaedic Medical Corporation January 12, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. Moreover, one reason for the proposal was complaints from QMEs who maintain the overhead of a few full time primary practice locations, but are trying to compete with other QMEs who have numerous locations listed throughout the state but whose 'overhead' is paid only on an 'as used' basis. When a QME with over 80 QME listings in California is named to a QME panel of 3 physicians where the two other QMEs share the same address as the first QME, that leads to complaints from the parties that they are not being given a choice of 3 independent evaluators.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter objects to this subsection and opines that this is unjust discrimination against a group of physicians who are providing additional services to a community and are incurring the cost of traveling in order to facilitate the QME process. Commenter points out that these physicians are helping to reduce the loads of medical/legal evaluations in a system that is already short of QMEs.	**8A**	Khosrow Tabaddor, MD January 12, 2008 Written Comment	Rejected. As explained in the response to others who commented on section 30(f), other QMEs have raised concerns about being able to compete with QMEs having, for example, 65 or more QME location listings throughout the state and parties have made objections about lack of choice when 2 or 3 QMEs listed on a 3 person QME panel all share the same address.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	As a retired orthopedic surgeon who currently performs QME evaluations, commenter feels discriminated against by this proposed section. Commenter goes as far as to suggest that this constitutes discrimination on the basis of age and disability. Commenter urges the division to reject this proposed subsection.	**26A**	Louis Dean, MD January 16, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled	The Administrative Director decided to withdraw this proposed change for other reasons.

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				criteria to count time spent in QME work within the definition of primary practice location.	
30(f)	Commenter appreciates the effort the Division has made to make the QME selection process fair. Unfortunately, given the ridiculous number of office locations listed by some QME physicians, commenter does not believe the proposed language will correct the problems now endemic in this procedure. For example, recently a CAAA member in San Jose examined the list of QMEs for one particular specialty. There were 47 individuals on the list, but 27 of those individuals (more than half) were physicians who have their primary offices outside of the San Jose area. Among those 27 physicians, the number of different office locations ranged from a low of 12 to a high of 64! The end result is that even with a weighting of 1.5 for the "primary practice locations" the truly local physicians will continue to be almost statistically irrelevant and the vast majority of panels will consist mainly of out-of-area physicians, to the detriment of locally-based treating and evaluating physicians. Given that the definition of "primary practice location" requires that the physician spend at least 5 hours per week engaged in direct medical treatment, and that physicians may list up to four such "primary practice locations," it is apparent that any other office that is listed by a physician is little more than a mail drop. Consequently, commenter recommends that these regulations be amended to provide that only those offices that qualify as "primary practice locations" be included in the QME lists. Alternatively, if it is determined that other locations must be considered, commenter strongly urges that the multiplier in this subdivision be substantially increased. Unless a multiplier of at least 5.0 to 10.0 is used, some QMEs will continue to receive inappropriate assignment to panels simply because they have listed a huge number of locations at which they do not maintain a regular practice.	**29F**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Rejected.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter opposes this subsection. Commenter believes that it is counterproductive to favor doctors with primary practice locations over specialists when compiling QME	**24A**	Richard Byrne, MD January 15, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no	The Administrative Director decided to withdraw this proposed change for other

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	panels. Commenter states that semi-retired specialists, like him, are the backbone of the QME system because they are less biased and have the time and temperament to persevere.			impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location.	reasons.
30(f)	Commenter objects to this subsection and finds it discriminatory to older orthopedists that are no longer performing surgery.	**23A**	Robert L. Horner, MD January 15, 2008 Written Report	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter objects to this subsection and finds it discriminatory to older orthopedists that are no longer performing surgery.	**7A**	Ronald Portnoff, MD January 11, 2008 Written Comment	Rejected. The proposed change would give all QMEs the same advantage at up to 4 primary practice locations and in so doing, it would have no impact on randomness. The proposed definition of 'primary practice location' allowed QMEs appointed through the faculty, retired and disabled criteria to count time spent in QME work within the definition of primary practice location.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Commenter opposes this subsection as it promotes a system of unfair competition. Commenter opines that treating QMEs tend to be busy with their own practice and schedule QME evaluations far into the future. Commenter believes traveling QME evaluators are less biased which in turns fosters a more objective environment.	**27A**	Stephen Choi, MD January 16, 2008 Written Comment	Rejected. All QMEs are expected to schedule an appointment within 60 days of the call for an appointment, or the QME's name is replaced with another QME. (8 Cal. Code Regs. § 31.5.)	The Administrative Director decided to withdraw this proposed change for other reasons.
30(f)	Consider as an alternative: (f) To compile a panel list of three QMEs, in the specialty designated by the party holding the legal right to request a panel, the Medical Director shall ~~give 1.5 times the weight to those QME locations identified as~~ randomly select from those QME locations identified as "primary practice locations" within the meaning of section 1(x) of Title 8 of the California Code of Regulations. If the are not at least 7 primary practice locations within the requested specialty for the geographic area, the Medical Director shall randomly select QME locations from all the practice locations within the specialty for that geographic area.	**39K**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected.	The Administrative Director decided to withdraw this proposed change for other reasons.

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	Discussion Commenter offers this language as an alternative to the proposed language. It may provide a way to more fairly distribute QME panel opportunities to QMEs, yet provide additional QME choices in geographic areas with a scarcity of specialty QMEs. Commenter also suggests reducing the maximum number of primary practice locations from four to three, as this will also more fairly distribute QME panel opportunities, which may encourage more interest by physicians.				
30(f)	Commenter believes the primary practice location should be included in the QME list and be where the doctor actually has his practice headquartered, not someone else's doctor's office, a hotel room or a store front.	**T9**	Linda Atcherley, Legislative Chair California Applicant's Attorneys' Association January 14, 2008 LA Public Hearing – Oral Comment – Page 9	Rejected.	The Administrative Director decided to withdraw this proposed change for other reasons.
30(g)	This subdivision requires the Medical Director to exclude any QME from the panel if that QME has some financial relationship with some other QME. If two QMEs have a financial relationship with one another, commenter cannot determine whether the Medical Director will exclude both of them, or only one. If only one, commenter does not know how the AD will decide which one. Commenter questions how this proposal will affect physicians in large group practice such as Kaiser Permanente Medical Group. The regulations could preclude all Kaiser doctors from performing panel QME exams. Commenter believes such an exclusion process would make the panel selection process non-random, in violation of Labor Code section 139.2(h)(1). Commenter requests that the Division defer adoption of this section until such time that a more appropriate solution can be determined.	**30I**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Rejected. The Medical Director will randomly select the QME or QMEs to be excluded from the panel due to sharing a financial interest previously disclosed to the Medical Director. After the panel list is issued, if a party requests replacement of any QME due to a shared financial interest, the Medical Director will address the request at that time, such as making a random or 'blind' selection between the QMEs on the panel who share a financial interest. Based on our information from the Kaiser Permanent group of physicians, such physicians would not be excluded on the basis of having a shared ownership interest of 5% or more.	None.
31(a)	Commenter states that this section is confusing. In cases of REPRESENTED panels, he does not believe the party submitting the panel QME request form should control the specialty of the physician. This is not supported by the Labor Code wherein the party submitting the request is supposed to identify the specialty of the submitting party, the opposing party and the treating physician – and in order to give meaning to this section, the panel should comprise one doctor from each of the three specialties. Otherwise, there will be a "race" to obtain a panel QME and that doesn't seem fair.	**5B**	Matthew Brueckner Law Office of Matthew Brueckner January 2, 2008 Written Comment	Rejected. The proposed wording is consistent with Labor Code sections 4062.1 and 4062.2. Commenter is concerned with represented cases which are subject to Labor Code section 4062.2. It provides, on the issue of which party designates the specialty, in subdivision 4062.2(b): "The party submitting the request shall designate the specialty of the medical evaluator…."	None.

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31(b)	Commenter does not understand the reference in this subdivision to the employee or employer making an appointment request with a QME listed on the panel. Section 31 deals with the selection of the panel by the Medical Director. If the "appointment request" referenced in this subdivision means the appointment made by the employee with the QME, it appears to be totally out of place. Furthermore, the language doesn't apply to a represented worker in any case, since the process for selecting the QME allows each side to strike a physician. Commenter recommends that the first sentence of this subdivision be deleted.	**29G**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part. Subdivision (b) of section 31 will be moved and re-numbered as a new section 31.3 which will also address the process for represented panel cases.	See proposed new wording for subdivision 31.3, below.
31(b)	Commenter states that this subsection does not read clearly. It starts out stating that an employee or Claims Administrator shall make an appointment from the panel and then speaks to aspects of deciding on a specialty. If they already have the panel, the specialty would have already been specified. This section would also benefit by clearly delineating procedures for represented as opposed to unrepresented employees, rather than providing information regarding all employees and then providing exceptions for unrepresented employees. Commenter suggests the following changes: The employee, or the employer under the circumstances set forth in Labor Code section 4062.1 and 4062.2, shall make an appointment request with a QME listed on the panel ~~and may consult with the injured worker's primary treating physician as to the appropriate QME specialist. Neither the claims representative nor a representative of the employer nor a QME may discuss or make the selection of a panel QME for an unrepresented worker at any time~~. In the case of an unrepresented worker, neither a QME, nor a claims representative or a representative of an employer who has not yet acquired the legal right pursuant to Labor Code section 4062.1 to request a QME panel, may discuss or make the selection of a penal QME for the unrepresented employee.	**37G**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part. Proposed subdivision (b) will be moved to another new subdivision, 31.3.	New subdivision 31.3 provides: ***§ 31.1 Scheduling an Appointment with the Panel QME*** ***(a) When the employee is not represented by an attorney, the unrepresented employee shall select a QME from the panel list, contact the QME to schedule an appointment and inform the claims administrator of the QME selection and the appointment .*** ***(b) Neither the employer, nor the claims administrator nor any other representative of the employer shall discuss the selection of the QME with an unrepresented worker who has the legal right to select the QME.*** ***(c) If the unrepresented employee fails to select a QME from the QME panel or fails to schedule an appointment with the selected QME, the claims administrator may schedule an appointment with a panel QME only as provided in Labor Code section 4062.1(c), and shall notify the employee of the appointment as provided in that section.***

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					(d) Whenever the employee is represented by an attorney and the parties have completed the conferring and striking processes described in Labor Code section 4062.2(c), the represented employee shall schedule the appointment with the physician selected from the QME panel. If the represented employee fails to do so within ten (10) business days of the date a QME is selected from the panel, the claims administrator or administrator's attorney may arrange the appointment and notify the employee and employee's attorney.
31.1	Commenter suggests a 3 day period as opposed to a 1 day period. This would discourage a party from merely attempting to being "the first to file" only to get the strategic advantage of specialty selection. Commenter suggests having a 10 day "objection" window for the other party to make an objection to the selection in a particular specialty. The advantage to the "first" party to file a form does not seem inherently conducive to then having the same parties "meet and confer" upon a potential AME from the three member panel.	**28G**	Corey A. Ingber, Sr. Vice President/Lega1 Zenith Insurance Company January 16, 2008 Written Comment	Rejected. The Legislature designed the process under Labor Code section 4062.2(b) and the suggestions of added time are unnecessary. Prior to making a panel request in a represented case the parties are given a 10 day period to confer on an AME. The DWC Medical Unit receives over 2400 panel requests per week. The suggested time extensions will only create more delay, which is contrary to the requirement for an expeditious process. (Cal. Constitution, Art. IV, § 4.)	None.
31.1(b)	Commenter believes this subdivision is unnecessary. Today, most injured workers initially receive treatment from a physician selected by the employer, and in many cases receive subsequent treatment from different physicians, physician assistants, or even nurse practitioners who are part of a medical clinic. Consequently, the specialty of the "treating physician" in many cases is either not relevant or in other cases there may not be a true "treating physician." In those cases in which the represented employee has the statutory right to "designate the specialty of the medical evaluator" it is not appropriate for the Medical Director to reject that selection for any reason. Accordingly, commenter recommends that this subdivision be amended to delete the requirement that a party must submit any relevant	**29H**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Rejected. Under current law, there can only be one primary treating physician at a time (8 Cal. Code Regs. § 9785(b)(1) and generally a dispute over an opinion or determination by the primary treating physician is the basis for obtaining an AME or QME examination. (See, Lab. Code §§ 4061.5, 4062.1(b) and 4062.2(a).) The PTP at the time a dispute giving rise to a request for a QME panel may or may not be the same PTP at the beginning of the claim. As proposed, this regulation allows a party who seeks a QME panel in a specialty that is different than that of the treating physician to provide evidence supporting the other specialty being requested.	None.

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	documentation supporting a different specialty. Instead, this subdivision should specify that the Medical Director shall issue the QME panel in the specialty as designated by the party having the right to submit the request. If the opposing party disagrees with assignment of the requested specialty, that party may seek an order from a workers' compensation judge that a panel be issued in a different specialty.				
31.1(b)	Commenter states that for some injured workers with multiple injuries there is a need for multiple panel doctors in order to appropriately rate their level of disability. Commenter suggests adding a couple of more questions on Form 111 to determine good cause to request an additional QME panel.	**T10**	Linda Atcherley, Legislative Chair California Applicant's Attorneys' Association January 14, 2008 LA Public Hearing – Oral Comment – Page 10	Rejected. Proposed regulation 31.5(b), now re-numbered to be proposed regulation 31.7 provides a mechanism for the parties to obtain another QME evaluator in a different specialty. Also, it is unnecessary to add text to the QME Form 111 since this form will only be used in unrepresented cases, not all cases.	Form 111 has been amended to add questions for the QME to answer regarding the need for another evaluation by a QME in a different specialty. Since this form is only for use in unrepresented cases, in represented cases the parties will need to raise this issue themselves with the evaluator.
31.1(c)	Commenter believes that forcing the parties to get an order from a judge will only add unnecessary administrative delay and cost, and still does not guarantee that the employee will timely receive the evaluation that is needed. Furthermore, under Labor Code Section 139.2(h)(1), if a panel is not assigned within 15 working days an unrepresented worker shall have the right to a QME of his or her choice. Adoption of the proposed language would establish a lesser remedy with a longer time line for represented workers. While there obviously will be some necessary procedural differences in administering cases involving represented versus unrepresented employees, a worker must not have his or her rights restricted solely due to the fact the employee hired an attorney. This subsection should be amended to provide the same remedy and time limits for represented employees as are statutorily required for unrepresented workers. Adoption of any lesser remedy would restrict employee's rights solely due to the fact that the employee obtained representation.	**29I**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Rejected. Although SB 899 made minor wording amendments to Labor Code section 139.2(h)(1), it did not add language to section 139.2 or to section 4062.2 specifying the time limit for filling a panel request in a represented case. Therefore the 15 day limit for issuing a QME panel in unrepresented case was not extended to represented cases. The remedy suggested appears to go beyond what the legislature intended in represented cases. From the wording of Labor Code section 4062.2 the legislative intent is clear that a panel of 3 QMEs be issued, and that the represented parties then confer on selecting one of the physicians to serve as an AME or otherwise to use striking procedure to obtain a QME from the panel letter.	No change from the existing proposed time limit of 30 days, with a remedy to obtain an order from a Workers' Compensation Administrative Law Judge.
31.1(c)	This section states that when the medical director fails to issue a panel to a represented employee within 30 days,	**T11**	Linda Atcherley, Legislative Chair	Rejected. Same response as above.	None.

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	either party may seek an order from a workers' compensation judge. Under Labor Code section 139.2(h)(1), if a panel is not assigned within 15 working days, an unrepresented worker shall have a right to a QME of his or her choice. Commenter believes that the differential in these two timelines seems to unfairly impact injured workers that have sought representation.		California Applicant's Attorneys' Association January 14, 2008 LA Public Hearing – Oral Comment – Page 12		
31.1(c)	Commenter suggests that instead of requiring a court order, the division develop some type of written procedure – perhaps the filing of a petition with notice to the other parties – in absence of showing good cause, further panel QME is required.	**T12**	Robert B. Zeidner, Esq. California Applicants' Attorneys Association January 14, 2008 LA Public Hearing - Oral Comment – Page 24	Rejected. An additional filing with the Medical Director will be duplicative. The workers' compensation bar is already familiar with the process for filing a motion or appearing on a hearing calendar in order to obtain an order from a Workers' Compensation Administrative Law Judge.	None.
31.5(a)	Commenter recommends that this provision be amended to provide that where the parties in a represented case have already struck names from a panel and it is then necessary to replace the remaining QME, it is mandatory that the entire panel be replaced. In addition, commenter recommends that where there is a challenge to an individual QME on a panel (for example, where a party challenges one of the named physicians on a panel alleging that the physician does not practice in the requested specialty), the regulations should set forth a time deadline for the Medical Director to respond to the challenge, and the time limits applicable to the panel QME process shall be tolled during that time period. If this is not done, and the challenged physician is not replaced within 10 days, an unrepresented worker would have a choice of only the two remaining names, or would lose the right to select the evaluating physician. In a represented case the time period for selecting the AME could expire or, more importantly, the subsequent three days to strike one name from the list could expire, and the parties may be unsure of whether to strike the challenged physician.	**29J**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accept in part.	Proposed subdivision 31.5(b) will be moved to new subdivision 31.7. New proposed language for 31.5(b): ***(b) Whenever the Medical Director determines that a request made pursuant to subdivision 31.5(a) for a QME replacement or QME panel replacement is valid, the time limit for an unrepresented employee to select a QME and schedule an appointment under section Labor Code section 4062.1(c) and the time limit for a represented employee to strike a QME name from the QME panel at issue under Labor Code section 4062.2(c) shall be tolled until ten (10) days after the replacement QME or QME panel is issued.*** ***(c) New subdivision 31.5(c): In the event the parties in a represented case have struck two QME names from a panel and subsequently a valid***

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					<u>ground under subdivision 31.5 arises to replace the remaining QME, none of the QMEs whose names appeared on the earlier QME panel shall be included in the replacement QME panel.</u>
31.5(b)	Because an evaluation to assign an impairment rating under the AMA *Guides* is fundamentally different from an evaluation to assign a disability rating under the prior PDRS, the ability to obtain an evaluation in more than one specialty is critically important. Determining the *whole person* impairment will, in far more cases, involve an evaluation of more than one body system. Commenter strongly supports the adoption of rules that recognize that the correct impairment rating may necessarily involve an evaluation in more than one medical specialty.	**29K**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Rejected. The regulations as proposed allow an evaluator to advise the parties that an additional evaluation in a different specialty is needed whenever a disputed medical issue is beyond the scope of the evaluator's license or clinical competence.	Proposed wording in subdivision 31.5(b)(2) provides a mechanism that addresses this concern.
31.5(b)(2) and 32	Commenter states that if DWC adopts these revisions that it will also be necessary to amend the Medical-Legal Fee Schedule (8 CCR 9795) to create a new billing code for medical-legal consultations. Since the scope of the medical-legal consultations is very broad, commenter recommends a new code, ML-107, that would be reimbursed in the same manner as ML-104, ML-105 and ML-106. Furthermore, commenter believes that a QME should be able to select a consultant of his/her choice. In difficult cases, a QME/AME needs to obtain an opinion from someone he/she knows and respects. Otherwise, the QME/AME may be reluctant to rely on or incorporate the consultation report from a physician whose specialized clinical knowledge, expertise and reputation are unknown. A system in which the DWC selects a consultant is unnecessarily complex and will delay the evaluation process. Commenter is unaware of any problem with the current system whereby the QME/AME selects the consultant and recommends that the practice continue.	**30E**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Accepted in part.	Subdivision 31.5(b)(2) has been reworded to read: (2) The AME or QME selected advises the parties and the Medical Director, or his or her designee, that she or he has completed or will complete a timely evaluation of the disputed medical issues within his or her scope of practice and areas of clinical competence but recommends that a ***<u>new evaluator</u>*** ~~physician of~~ ***<u>in</u>*** another specialty…" Existing wording in subdivision 32(c) will be retained.
31.5(b)(2) and Form 111	This paragraph provides that it is good cause to request an additional QME panel where the AME or QME "advises the parties, and the Medical Director" that a physician of another specialty is needed to evaluate remaining disputed issues. Commenter is unclear exactly how the Medical Director will be informed that the AME/QME has made	**29L**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part. The method for an AME or QME to advise the parties and the Medical Director of the need for another evaluator in another specialty is described in subdivision 35.5(d). Moreover, QME Form 111 is to be used only in <u>unrepresented</u> cases involving permanent	QME Form 11 has been amended to add: ***<u>22. Are there any unresolved disputed issues beyond the scope of your licensure or clinical competence that should</u>***

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	this declaration. Commenter recommends that Form 111, the Findings Summary Form for AME/QMEs be amended to include this information. Specifically, on page 3, before the signature line, two new questions could be added, as follows: 22. Is there a need for an evaluation by a physician of a different specialty? G Yes G No 23. If the answer to #22 was "yes", what specialty or specialties? __________________ With this certification, either the instructions for Form 111 could be amended to require the AME/QME to file the form with the Medical Director, or Section 31.1(b) could be amended to require the parties to notify the Medical Director when they receive a form that states the need for an evaluation in another specialty. Commenter recommends that the instructions for Form 111 on page 4, under "QME Signature," be amended to specify that the medical-legal report and the form must be filed with the Disability Evaluation Unit only for unrepresented workers.			impairment and permanent disability However, similar questions have been added to the form for those cases and additional text has been added to the instructions page.	***be addressed by an evaluator in a different specialty?*** ***23. If the answer to # 22 is yes, what disputed issue(s)?*** ***24. Based on the answer in # 23, what specialty (or specialties)?*** In addition, the instructions on page 3 include additional text: ***Need for Additional Evaluation in Another Specialty: Labor Code section 4062.3 directs each evaluator to address all contested medical issues arising from all injuries reported on one or more claim forms prior to the evaluator's initial evaluation. Each evaluator is expected to address permanent impairment consistent with the AMA guides for the evaluator's specialty. In the event there are contested medical issues outside of the scope of your licensure or clinical competence that require evaluation by a physician in a different specialty, complete the information required in questions 22 through 24, and serve a copy of your report on the Medical Unit of DWC.***
31.5(b)(4)	Commenter recommends the following revised language on line (4) after "in the presence of the Officer": **or by signed mutual agreement: on the specialty….**	**15D**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Accepted in part.	Proposed subdivision 31.5(b)(4) has been moved to new subdivision 31.7(c) and shall read: In an unrepresented case, that the parties have ***conferred*** ~~met~~ with an Information….QME panel. ***The parties shall confer with the Information and Assistance Officer in person or by a conference call in which all parties are participating. The Information and***

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					Assistance Officer shall then sign the panel request form for the injured employee and fax or email it to the Medical Unit.
31.5(c)	Commenter recommends the following revised language after "Medical Director": **or the employer and employee or their legal counsel.**	**15D**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Accepted in part.	Subdivision 31.5(c) has been re-lettered to be 31.5(b) and has been amended to read: ***(b) Whenever the basis for objecting to an evaluator under this subdivision is known to a party in a represented case but is not served in writing on the opposing party at least three (3) calendar days prior to the date of the QME examination, the Medical Director shall not replace the evaluator unless ordered to do so by a Workers' Compensation Administrative Law Judge.***
32(b)	§32(b) describes the requirements of LC§§ 4660 through 4664 per the AMA guides. The title of the guides 'AMA Guides [Fifth]' consistent with the definition listed under '§1 Definitions' should be listed throughout the regulations in order to prevent confusion and the inadvertent use of the Sixth Edition (recently released) by the medical evaluators prior to a statutory change. In order to be consistent with the definition, commenter recommends the following: Except as provided...and the AMA ~~g~~Guides [Fifth Edition].	**38C**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Rejected. Section 1(d) defines the phrase 'AMA guides' to mean the fifth edition.	None. ***(c) Whenever a party requests the Medical Director to replace an evaluator after the medical/legal report has been served by the evaluator, on the grounds that the report is untimely, the Medical Director shall not replace the evaluator unless ordered to do so by a Workers' Compensation Administrative Law Judge.***
32(c)	Commenter is in agreement with Carl Brakenseik (CSIMS) that you should not eliminate the ability of a Panel QME to obtain a consultation with either a treating doctor or other physician.	**T13**	Barry Gorelick, Esq. California Applicants' Attorneys Association January 17, 2008 Oakland Public Hearing - Oral Comment – Page 25	Accepted in part..	Section 32(c), as amended, will provide: ***(c) For injuries occurring on or after January 1, 1994, a QME may obtain a consultation from any physician as reasonable and***

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					necessary pursuant to Labor Code section 4064(a) or upon agreement by a party to pay the cost. .
32.6	Commenter recommends that the **"parties"** be given the opportunity to recommend the specialty of the QME panel to the judge.	**15E**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. Nothing in the proposed language would preclude the parties from making recommendations about the specialty to the Workers' Compensation Administrative Law Judge.	None.
32.7	This section proposes to require QMEs to reserve a minimum amount of calendar time for panel QME examinations. The minimum number of panel QME slots depends upon the annual fee the QME pays to the state. Commenter appreciates the problem DWC is trying to address, but fears the solution could have some significant unintended consequences, not the least of which is an exodus of many of the most qualified physicians form the QME list. Commenter understands that this section requires most QMEs and virtually all AMEs to schedule, on average, a minimum of three panel QME examinations every month and that, once scheduled (3 examinations with a 30-day period), they could decline to accept additional panel QMEs in that period. The concerns are: (1) Many QMEs and AMEs are booked up many months to more than one year in advance so, as a result of this regulation, these evaluators could bump another previously scheduled injured worker's evaluation or create at least 3 panel QME slots per month which may end up going unused; (2) The regulation is silent on when, if ever, a physician could release a PQME slot and fill it with another evaluation appointment, so there is a significant adverse economic consequence to evaluators in this proposal; (3) This regulation would require physicians to block out the maximum amount of time because they will not know how complex a particular case is until they receive the medical records and/or they interview the patient and could lead to an inefficient allocation of precious time resources; (4) Evaluators required to block time for penal QME exams (which may not be used) would have to reduce their other time commitments for treating injured workers and private patients, teaching, research, etc.; (5) Subdivision (e) give the QME credit for no-shows without notice but fails to give credit for situations where untimely notice is given;	**30F**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Rejected.	Section 32.7, as proposed, is being withdrawn for other reasons.

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	and (6) Subdivision (f) authorizes the Medical Director to demand "a copy of the evaluator's office appointment calendar showing schedule QME appointments" which may violate the patients' privacy rights under HIPPA or California's Confidentiality of Medical Information Act (Civil Code section 56, et. seq.).				
32.7	Commenter objects to this proposed regulation for the following reasons: • It will diminish the pool of physicians who are willing to serve as QMEs, and thus aggravate the problem it is meant to solve. • To the extent it demands that blocks of time be reserved without compensation for state use, it is an improper illegal tax on small business. • To the extent it would require that requests for panel appointments get priority, it is an illegal taking from those who had earlier made appointments. • The regulations required to enforce it invade the privacy rights of others.	**12A**	Samuel I. Miles, MD, Ph.D. January 14, 2008 Written Comment	Rejected.	Proposed new section 32.7 is being withdrawn for other reasons.
33 (c)	This proposed subdivision would prohibit a QME who is temporarily "unavailable" to perform QME panel evaluations for performing any AME evaluations. Commenter believes that his proposed solution will encourage the best AMEs to resign their QME appointments, thereby further shrinking the QME pool.	**30G**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Accepted in part. The Administrative Director does not agree with the commenter's prediction that the proposed language would result in shrinkage of the QME pool.	The words "or AME" have been deleted from subdivision 33(c).
33(e)	The revised regulation requires a party to notify the Medical Director if a QME is unavailable to schedule an appointment within 60 days, even if the party is willing to waive the right to a replacement QME. This amendment will have the unintended consequence of forcing parties to provide unnecessary reports and for the Medical Director	**30H**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association	Accepted in part.	This subdivision has been amended to read: (~~e~~ e) If ~~an unrepresented employee~~ ~~a party with the legal right to schedule an appointment with a QME~~ ***an unrepresented***

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	to receive additional paperwork that does not require any action on the Medical Director's part.		Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment		***employee*** is unable to obtain an appointment with a selected QME within 60 days after an appointment request, ~~the employee~~ ~~**that party**~~ ~~may~~ ***the unrepresented employee may*** ~~shall~~ report the unavailability of the QME to the Medical Director. The Medical Director shall provide a replacement QME or replacement QME panel at random to be added to the employee's panel in accordance with section 31.5(d) of Title 8 of the California Code of Regulations, ~~The employee~~ ~~**unless the party with the legal right to schedule the QME appointment**~~ ~~may choose~~ ~~**decides**~~ ***The unrepresented employee may choose*** to waive his or her right to a replacement ~~QME~~ ***QME*** and to accept a later appointment with the originally selected QME ***no more than ninety (90) days after the date of the initial appointment request.*** ~~or select one of the two remaining QME's on the panel.~~ ***In a represented case, if the party with the legal right to schedule the QME appointment is unable to obtain an appointment within sixty (60) days of the date of the initial appointment request with the selected QME, the Medical Director shall provide a replacement QME or QME panel, unless both parties agree in writing to accept a later appointment date which is no more than ninety (90) days after the initial appointment request. The Medical Director shall provide a replacement***

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					QME or replacement QME panel upon request in accordance with section 31.5 of Title 8 of the California Code of Regulations.
33(e)	This subdivision was previously applicable solely to unrepresented employees, but was amended to apply to all employees. However, the consequence of this change is to give the employer the right to delay an evaluation of an injured employee. Commenter doesn't believe this was the intent of the change. Commenter recommends that the subdivision be amended to provide two tracks, one for unrepresented workers and one for represented workers. For unrepresented workers, the rule will be essentially unchanged from the current rule. For represented workers, the rule should provide that the Medical Director shall provide a new panel of QMEs unless both parties choose to accept a later appointment.	**29M**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part.	Subdivision 33(e) shall be amended to read: (~~e~~ e) If ~~an unrepresented employee~~ ~~a party with the legal right to schedule an appointment with a QME~~ ***an unrepresented employee*** is unable to obtain an appointment with a selected QME within 60 days after an appointment request, ~~the employee~~ ~~**that party**~~ ~~may~~ ***the unrepresented employee may*** ~~shall~~ report the unavailability of the QME to the Medical Director. ~~The Medical Director shall provide a replacement QME or replacement QME panel at random to be added to the employee's panel in accordance with section 31.5(d) of Title 8 of the California Code of Regulations~~, ~~The employee~~ ~~**unless the party with the legal right to schedule the QME appointment**~~ ~~may choose~~ ~~**decides**~~ ***The unrepresented employee may choose*** to waive his or her right to a replacement ~~QME~~ ***QME*** and to accept a later appointment with the originally selected QME ***no more than ninety (90) days after the date of the initial appointment request.*** ~~or select one of the two remaining QME's on the panel.~~ ***When the selected QME is unable to schedule the evaluation within ninety (90) days of the initial appointment***

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					request, the unrepresented employee shall request and the Medical Director shall issue a replacement pursuant to subdivision 31.5 of Title 8 of the Regulations. ***(f)In a represented case, if the party with the legal right to schedule the QME appointment is unable to obtain an appointment with the selected or designated QME within sixty (60) days of the date of the initial appointment request, that party may choose to waive his or her right to a replacement QME for up to 90 days from the date of the initial request. The Medical Director shall provide a replacement QME or QME panel upon request, unless both parties agree in writing to accept an appointment date with the selected or designated QME for a date beyond ninety days following the initial appointment request.***
33(e)	Commenter does not agree that the decision to waive the 60 day limit for setting an appointment should be unilateral. It is recommended that this only be allowed if the parties agree.	**37H**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	See proposed language directly above.
33(g)	Commenter recommends reducing the 30 day timeline to 10 days to expedite the process.	**15F**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The 30 day period has been used very effectively under the existing regulations.	None.
34(b)	Current regulations provide that a panel QME evaluation may only be performed at the medical office listed on the panel selection form. The AD has recognized that another location may be more convenient to the patient, but has	**30I**	Frank Navarro, California Medical Association Diane Przepiorski, California	Rejected. The Administrative Director has jurisdiction only over the physician's offices listed with the Medical Unit.	None.

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	limited any alternative to another location listed with the Medical Director as an "additional office location." Commenter recommends that this limitation be deleted so as to permit the evaluation to be performed anywhere it is most convenient for the injured worker, with the mutual consent of the parties.		Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment		
35(a)	Commenter recommends the following revised language: "At least 10 days prior to the scheduled QME evaluation, any party may provide, and where the employee is unrepresented, the claims administrator, if none, the employer shall, provide the following information to the QME..."	**30J**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Rejected. Once the QME notice of appointment is sent, the parties are free to begin preparing and exchanging the medical and non-medical reports to be sent to the evaluator. Because both Labor Code section 4062.3(b) and proposed regulation 35 (c) required each party to serve on the other all information to be sent to the evaluator at least 20 calendar days in advance, leaving the receiving party up to 10 days to object to any of the proffered information, the time lines are too short to require in every case that the information not subject to an objection be sent to the QME 10 days in advance of the scheduled QME exam. QMEs are able to proceed with the in person scheduled examination and report and to advise the parties that a supplemental report based on review of the submitted material will be issued.	None.
35(a)	Under subdivision (a), in a represented case "any party may provide" information to the QME. Commenter believes that if this rule provides that the furnishing of information to the QME is permissive to all parties, the end result may be that no party submits the necessary information. Commenter recommends that this subdivision be amended to provide that "in represented cases, the claim adjuster, or if none, the employer, shall provide, and the employee may provide, the following information to the QME." In addition, the same requirement should be added to subdivision (b), paragraph (2) which applies to information that is to be provided to an AME.	**29N**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part.	Subdivision 35(a) is being amended to read: (a) ~~Any party may provide, and where the Where an employee is unrepresented, the~~ ***The claims administrator,*** or~~,~~ if none~~,~~ the employer, shall, ~~and the employee may,~~ provide, ***and the injured employee may provide,*** ~~to~~ the following information to the-QME ***or AME evaluator***: Subdivision 35(c) is being amended to read: ~~(b)~~ (c) ~~In no fewer than~~ At least twenty (20) days before the

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	Commenter strongly recommends that these rules be amended to require that any information provided to an AME or QME by either party must include a cover sheet with an inventory of all records and other documents included in the submission. In far too many cases the material sent to the evaluating physician includes a cover sheet that merely states "Attached are medical records" or similar vague language. In a case with extensive records, this forces the employee or his or her attorney to manually compare all available documents to the submitted records. This is unduly burdensome and an unnecessary expenditure of resources and in many cases the end result is that duplicate records are sent to the physician, confusing that office and resulting in more delay and expense. Requiring that any submission to the evaluating physician include a summary document with an inventory of records and other documents provided would eliminate all of these problems, and since the party submitting the documents probably used an inventory checklist to consolidate the documents before making the submission, it should not add any additional work for the submitting party.				information is to be provided to the AME or QME, the party providing such medical and non-medical reports and information shall serve it on the opposing party. ~~: the following:~~ ***In both unrepresented and represented cases the claims administrator shall, and in represented cases the employee's attorney shall, attach to the front of the records and information being sent to the opposing party a log, that identifies each record or other information to be sent to the evaluator and lists each item in the order it is attached to or appears with the log.*** The claims administrator **,** ~~or~~ ***or if none*** the employer **,** shall include a cover letter ~~or other document~~ when providing such information to the employee which shall clearly and conspicuously include the following language: ….
35(a)(4) 41(c)(4) 43(b) 44(b) 45(b) 46(b) 47(b)	Interchanging the use of the terms "Claims Administrator" and "employer" could lead to confusion and errors. Commenter suggests the word "employer" to "Claims Administrator" in the referenced sections.	**370**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. However, in some cases the phrase 'the claims administrator, or if none the employer,' has been inserted for clarity.	See amendments in: 35(a)(4) 41(c)(4) 43(b) 44(b) 45(b) 46(b) 47(b)
35(d)	Commenter opines that it is unfair that the QME doctor is NOT provided with the facts of the case and that extra time and legal costs are necessary to get an ALJ involved. Commenter opposes this language.	**15G**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The material objected to during the exchange of information period generally involves *alleged facts*, not facts found by a Workers' Compensation Administrative Law Judge. The AME and QME do not have the authority to rule on admissibility of evidence, the credibility of witnesses nor whether the claimed injury arose out of and occurred in the course of employment. Their function is to evaluate the disputed medical issues in the case. Should such disputed material later be found to be admissible or true by a WCALJ, the material can be submitted to the	None.

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				evaluator with a request for a supplemental report.	
35(f)	Commenter states that discovery should be done at the Board level AFTER the QME exam. Commenter recommends that the QME review the non-medical information and issue their report based on the entire facts of the case. If the employee and/or their applicant attorney disagree they can proceed through the legal process.	**15H**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The AME and QME do not have the authority to rule on admissibility of evidence, the credibility of witnesses nor whether the claimed injury arose out of and occurred in the course of employment. Their function is to evaluate the disputed medical issues in the case. This section makes clear that such discovery may be done prior to the filing of an application for adjudication.	None.
35(k)	**Recommendation** The Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. If an employer or claims administrator or the injured employee or employee's representative communicates with a QME in violation of Labor Code section 4062.3, the Medical Director shall provide the aggrieved party with a new panel in which to select a new QME or the aggrieved party may elect to proceed with the original QME. **Discussion** The ex parte communication in violation of the regulations can occur through the injured worker or the agent of the injured worker and however it occurs; the sanction should be the same.	**39L**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. Commenter's proposal goes beyond what is provided in section 4062.3.	Subdivision 35(k) has been revised as follows: (k) The Appeals Board shall retain jurisdiction in all cases to determine disputes arising from objections and whether ex parte contact in violation of Labor Code section 4062.3 or this section of Title 8 of the California Code of Regulations has occurred. If ~~**an employer or claims administrator or the injured employee**~~ ***any party*** communicates with a QME in violation of Labor Code section 4062.3, the Medical Director shall provide the ~~unrepresented employee~~ aggrieved party with a new panel in which to select a new QME or the ~~unrepresented employee~~ aggrieved party may elect to proceed with the original QME. ~~If an employee communicates with a QME either before or after the evaluation, in violation of Labor Code section 4062.2, the claims administrator or employer may request the Medical Director to issue a new panel to the unrepresented employee. The Appeals Board shall retain jurisdiction to determine whether ex parte contact has occurred in all cases.~~ Oral or

					written communications by the employee, or if the employee is deceased by the employee's dependent, made in the course of the examination or made at the request of the evaluator in connection with the examination shall not provide grounds for a new evaluator unless the Appeals Board has made a specific finding of an impermissible ex parte communication.
35(k)	Commenter recommends deleting the word employer in this subsection.	**37O**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. The references to employer, claims administrator and injured employee were deleted and replaced with the words 'any party'.	Subdivision 35(c) has been amended to read: "If ~~an employer or claims administrator or the injured employee~~ ***any party*** communications with a QME…."
35(l)	Commenter suggests that the AD, in addition to the parties, should be advised in writing of disputed medical issues.	**15H**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. This subdivision is being moved to become a new subdivision 35.5(c). The recommended change is unnecessary because the wording already requires a panel QME to notify the Medical Director. When an AME makes such a determination, if the parties are unable to agree on a new AME in another specialty, then one or the other will apply for a panel QME without the need for other language.	Subdivision re-numbered only.
35.5	Commenter notes that there is no requirement in this section for the AME/QME doctor to respond to the questions posed by the parties which need to be answered by them in their report. The ACOEM guides lines are noted but not the AMA Guides to rate permanent disability. Commenter recommends that the AMA Guides be included.	**15I**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Accepted in part. The recommendation for additional language in this section referring to the AMA guides is unnecessary, since subdivisions 43 through 47 address this issue.	Subdivision 35.5(c) has been amended to add: ***The reporting evaluator shall attempt to address each question raised by any party in the issue cover letter sent to the evaluator pursuant to subdivision 35(a)(3).***
35.5 (c)	Commenter recommends reducing the 120 day timeline of the process to either 60 or 90 days.	**15I**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The 120 day time period is needed to allow for conflicting calendars among the attorneys and medical evaluator.	None.
35.5(d)	**§ 35.5 (d)** proposes that the evaluator's opinion shall	**38D**	Marie W. Wardell	Accepted in part.	This subdivision has been re-

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	apply and be consistent with the standards of evidence-based medicine as set out in Division 1, Chapter 4.5, Subchapter 1, sections 9792.20 *et seq* of Title 8 of the California Code of Regulations (Medical Treatment Utilization Schedule). If the condition or injury is not addressed by the Medical Treatment Utilization Schedule (MTUS), the evaluator's medical opinion shall be ***consistent*** with Medical Treatment Utilization Schedule regulations (Article 5.5.2), regarding other scientifically and evidence-based medical treatment guidelines, rating randomized controlled trials and rating the strength of the evidence. To ensure the best possible medical outcomes, the medical evaluator's decision should be subject to the same standards set forth in the utilization review regulation §9792.8(a)(3), and cite the criteria or guidelines used to reach his/her conclusion. If the decision of the evaluator is not supported by evidence based guidelines, the report should indicate that accordingly. Commenter recommends adding the following to proposed subsection (d*)*: …the evaluator's medical opinion shall be consistent with the provisions of section 9792.2~~5~~2 of Title 8 of the California Code of Regulations, regarding other scientifically and evidence-based medical treatment guidelines, rating randomized controlled trials and rating the strength of the evidence. The relevant portion of the criteria or guidelines used by the medical evaluator shall be disclosed in written form. If there is no guideline to reference, this should be stated in the medical evaluator's report.		Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment		lettered as 35.5(f), and amended to read: (~~d~~ *f*) Whenever an Agreed Medical Evaluator or Qualified Medical Evaluator provides an opinion in a comprehensive medical/legal report on a disputed medical treatment issue, the evaluator's opinion shall be consistent with **and apply** the standards of evidence-based medicine as set out in Division 1, Chapter 4.5, Subchapter 1, sections 9792.20 *et seq* of Title 8 of the California Code of Regulations (Medical Treatment Utilization Schedule). In the event the disputed medical treatment, condition or injury is not addressed by the Medical Treatment Utilization Schedule, the evaluator's medical opinion shall be consistent with ~~the provisions of section 9792.25 of Title 8 of the California Code of Regulations, regarding~~ ***and refer to*** other ~~scientifically and~~ evidence-based medical treatment guidelines, ~~rating randomized controlled trials and rating the strength of the evidence.~~ ***peer reviewed studies and articles, if available, and otherwise explain the medical basis for the evaluator's reasoning and conclusion.***
35.5(e)	The AMA Guides (Fifth) is specific in how impairment should be explained and has instructions on how to report the impairment. Reports on injuries occurring on or after 1/1/2005 and those occurring prior to 1/1/2005 that meet certain criteria are required to contain the AMA Guides (Fifth) method(s) in the determination of permanent disability. These reporting standards should be reflected in the medical evaluator's report.	**38E**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Rejected. The wording already proposed provides the evaluator with sufficient direction in sections 43 to 47.	None.

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	Commenter recommends adding the following new subsection (e): **§ 35.5** **(e)** When a Qualified Medical Evaluator provides an opinion in a comprehensive medical/legal report on a disputed permanent disability issue, the evaluator's opinion shall be consistent with the reporting standards of the AMA Guides [Fifth], where applicable, and the requirements under Division 1, Chapter 4.5, Subchapter 2, section 10606 of Title 8 of the California Code of Regulations (Physicians' Reports As Evidence).				
35.5(d)	This subdivision requires that an evaluator's opinion must be consistent with the standards of evidence based medicine as set out in sections 9792.20 *et seq*. It is recognized that the Legislature intended that reasonable medical treatment be based on evidence based, peer-reviewed, nationally based standards of care. However, commenter continues to believe that the strength of evidence standards adopted in Section 9792.22 are unnecessarily complicated and will only cause unnecessary confusion for both judges and physicians. While the provisions of Section 9792.22 cannot be amended in this administrative process, in order not to exacerbate this problem commenter recommends that subdivision (d) be deleted as unnecessary and duplicative.	**29O**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Rejected.	Wording in the subdivision has been amended as follows: In the event the disputed medical treatment, condition or injury is not addressed by the Medical Treatment Utilization Schedule, the evaluator's medical opinion shall be consistent with ~~the provisions of section 9792.25 of Title 8 of the California Code of Regulations, regarding~~ ***and refer to*** other ~~scientifically and~~ evidence-based medical treatment guidelines, ***peer reviewed studies and articles, if any, and otherwise shall explain the medical basis for the evaluator's reasoning and conclusions.*** ~~rating randomized controlled trials and rating the strength of the evidence.~~
35.5(d)	Commenter states that doctors should address the medical treatment utilization guidelines and that they should adhere to those guidelines; however, she is not sure that this regulation is the way to go about ensuring that they do that.	**T14**	Linda Atcherley, Legislative Chair California Applicant's Attorneys' Association January 14, 2008 LA Public Hearing – Oral Comment - Page 13	Rejected. See responses above about this subdivision.	None.

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35.5(d)	Commenter believes that requiring an evaluator to cite studies to elaborate on the standards of evidence based medicine as set out in 9792.2 is unduly burdensome.	**T15**	Robert B. Zeidner, Esq. California Applicants' Attorneys Association January 14, 2008 Oral Comment – Page 26	Rejected. The proposed regulation is asking evaluators to apply the standards mandated by the Labor Code.	None.
36	Commenter views this new proposal that permits the delivery of certain reports to designated physicians so they can discuss them with the injured workers as controversial. If the regulation is to be adopted commenter believes that one ambiguity must be resolved. Subdivision (c) requires the employer to reimburse the physician named by the injured worker for "one office visit at the OMFS office visit rate for reviewing and discussing the report with the injured employee." This regulation should be revised to clarify that in addition to the office visit, the physician may also charge, as appropriate, for records review, additional face-to-face time beyond that specified in the office visit CPT code, and the time required to prepare the report, if any.	**30K**	Frank Navarro, California Medical Association Diane Przepiorski, California Orthopaedic Association Carlyle R. Brakensiek, California Society of Industrial Medicine and Surgery Stephen J. Cattolica, California Society of Physical Medicine and Rehabilitation January 17, 2008 Written and Oral Comment	Accepted.	Subdivision 36(c), the last sentence has been amended to read: " As an additional medical expense incurred in the case within the meaning of section 4600 of the Labor Code, the ***claims administrator, or if none the*** employer ***,*** shall ~~pay~~ ***reimburse*** the physician named by the injured employee for one office visit***, for the purpose of reviewing and discussing the evaluator's report with the injured employee,*** at the OMFS office visit rate ***, including, as appropriate, record review, any face-to-face time during the visit in excess of that provided by the appropriate CPT office visit code and for time required to prepare a treatment report, if needed.*** ~~For reviewing and discussing the report with the injured employee.~~
36	Commenter opines that it is unclear from the language of this section whether it applies only to evaluations for unrepresented workers. If so, then references to an "AME" should be eliminated. However, if this section is intended to apply to evaluations for both unrepresented and represented workers, that should be made clear. In addition, if the section does apply to all workers, it should be amended to provide that the form must be submitted to the Disability Evaluation Unit only for unrepresented workers.	**29P**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted.	The section name is being changed as follows: **§ 36.** ~~**Summary Form for Comprehensive Medical-Legal Evaluation Performed Pursuant to Labor Code Section 4061 by QMEs or AMEs; Service of Form and Evaluation**~~ ***Service of Comprehensive Medical-Legal Evaluation Reports by Medical Evaluators Including Reports Under Labor Code section 4061*** Amended subdivision 36(b) has been created:

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					(b) In an unrepresented case, the QME ~~The evaluator~~ shall serve, ~~the~~ ***a*** comprehensive medical-legal evaluation ***report***, the summary form ***(QME Form 111)***, and DEU forms 100 (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. § 10161) and 101 (Request for Summary Determination of Qualified Medical Evaluator's Report) (See, 8 Cal. Code Regs. § 10161) ***, within the time frames specified in Section 38 of Title 8 of the Calfiornia Code of Regulations,*** on the ~~unrepresented employee and the claims administrator, or, if none, the employer, as well as~~ the appropriate local DEU office, ~~within the time frames specified in Section 38 of Title 8 of the California Code of Regulations,~~ ***the claims administrator, or if none the employer, and the unrepresented employee,*** except as provided in subdivision (~~e~~) below ***or in subdivision 36.5.*** . Also, subdivision 36(a) is amended to expressly provide that QME Form 111 is not required in cases in which the injured employee is represented. A new subdivision 36(c) is added as follows: ***(c) Whenever the injured employee is represented by an attorney, a comprehensive medical/legal report report that addresses disputes under Labor Code section 4061 shall be served on each party and on the party's attorney with QME Form 122 (AME or QME Declaration of Service of***

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					<u>Medical-Legal Report).</u> The new QME Form 122 is a general proof of service form for evaluators to use when serving a comprehensive medical/legal report in a case in which the injured employee is represented.
36(c)	This proposed form allows the injured employee to designate a physician to meet and review the report. This proposed regulation does not accommodate the Health and Safety Code §123115(b) where if a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient, the provider may decline to permit inspection or provide copies of the records to the patient and may process the request by other methods. In addition, the 'designated' physician should be the primary treating physician (PTP). The PTP can explain the QME report or refer the patient to another physician for the purpose of explaining the QME report as proposed by this regulation. State Fund recommends amending the proposed regulation and including information about these issues on the QME Form 120. Commenter recommends adding the following language in subsection (c): (c) In a matter involving…The evaluator shall attach the original executed Form 120 to the original medical legal report, and provide copies of the executed Form 120 as specified on the form when serving the report on the injured employee and the ~~designated~~ <u>primary</u> <u>treating</u> physician. As an additional medical expense incurred in the case within the meaning of section 4600 of the Labor Code, the employer shall pay the physician named by the injured employee for one office visit at the OMFS office visit rate for reviewing and discussing the report with the injured employee. <u>When an evaluator determines there is a substantial</u>	**38F**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Accepted in part. The choice of physician in such a circumstance should be left to the employee and not limited to the primary treating physician in a disputed workers' compensation case. However, in view of the issues raised in Health and Safety Code § 123115, additional language is being proposed for this section	Subdivision 36 has been amended to provide an exception for service of a report in a disputed injury to the psyche case, as provided in a new subdivision 36.5. The section now addresses service of the report in unrepresented cases, with QME Form 111 and service of the report in represented cases with QME Form 122. A new subdivision 36.5 has been added to address cases in which the evaluator makes a determination under Health and Safety Code section 123115 and cases that do not rise to that level but in which the evaluator is concerned that the report should be reviewed first by the injured employee with a physician who can explain it. In addition a new QME Form 121 is proposed for evaluators to use if the determination under the Health and Safety Code is made. Also, QME Form 120 has been amended slightly to correspond to the changes in proposed section 36.5.

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	risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of the comprehensive medical-legal report requested by the injured employee, the evaluator may decline to permit inspection or provide copies of the records to the patient, subject to the conditions pursuant to the Health and Safety Code §123115(b).				
36(c)	Commenter objects to allowing a patient to view his own psychological evaluation. He opines that there is potential for some patients to become extremely upset after reading their content. Commenter recommends instead providing "patient reports" which are easily understood by a layperson and devoid of psychopathological terminology with can be inflammatory. These frequently suffice for most patients.	**3A**	Robert M. Brizendine, Ph.D., QME, AME, IME December 20, 2007 Written Comment	Accepted in part.	See reply directly above. These proposed changes permit the medical evaluator to make the determination appropriate for the presenting condition of the injured worker.
36(c)	**Recommendation** In a matter involving a disputed issue of injury to the psyche of an unrepresented employee, where the injured employee has voluntarily agreed, prior to or at the outset of the medical/legal evaluation exam, to an alternate method of service of the comprehensive medical-legal report on the employee's primary treating physician by completing QME Form 120 (Voluntary Directive For Alternate Service of Medical-Legal Report on Disputed Injury to Psyche) (See, 8 Cal. Code Regs. § 120), the evaluator's duty to serve the comprehensive medical-legal evaluation report on the employee shall be satisfied by use of the method of service directed by the injured employee who completes the form. The evaluator shall attach the original executed Form 120 to the original medical-legal report, and provide copies of the executed Form 120 as specified on the form when serving the report on the injured employee's primary treating physician ~~and the designated physician~~. As an additional medical expense incurred in the case within the meaning of section 4600 of the Labor Code, the employer shall pay the employee's primary treating physician named by the injured employee for one office visit at the OMFS office visit rate for reviewing and discussing the report with the injured employee. **Discussion** The proposed regulations offer the employee an additional medical consultation in the case of psychiatric	**39M**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. The choice of physician to be designated to review the report with the employee should be left to the employee and not limited to the primary treating physician in a disputed workers' compensation case. The choice of treating physician in a workers' compensation claim may be made or controlled by the employer, with whom the injured employee may not have a trusting doctor-patient relationship.	None.

	injury in order to understand the medical legal evaluation. Rather than have the injured employee select a consulting physician, the primary treating physician, who has a relationship with the injured employee already, should be tasked with this consultation. Since the PTP is more likely to understand both the medical and the legal consequences of the report he or she is in the best position to explain them to the employee.				
38	Commenter believes that the division needs to construct a separate section to address requirements for AMEs. Commenter opines that the 30 day timeframe for initial, re-evaluation, and Supplemental Reports for Panel QMEs is reasonable. However, commenter believes that a reasonable timeframe for AME reports is 60 days. Also, AMEs should not have to file extension requests or be reviewed for the request unless the report is past 90 days post exam. However, a 30 day extension from 60 days (60-90 days for large cases) should be available. Commenter suggests that if authorized by all parties, the AME may defer issues. Commenter believes that the availability requirement of 3 PQMEs every 30 days is overly burdensome for AME evaluators who are often booked up 6-12 months in advance. She requests that this requirement be altered to 1 PQME every 60 days. Commenter requests that the division remove the non-payment and QME appointment loss for AMEs.	**6A**	Janice Skiljo Haris, RN January 6, 2008 Written Comment	Rejected. The Legislature expressly mandated in Labor Code section 139.2(j)(1)(A) that the Administrative Director develop time limits for completion of medical/legal reports for <u>both</u> Agreed Medical Evaluators and Qualified Medical Evaluators. Both AMEs and QMEs are able to request extensions of time, when appropriate and necessary.	None
38(a)	Commenter recommends adding penalties to (a) of Section 38 of Title 8 of the CA Code for the following infractions: (1) the QME fails to request an extension; (2) the QME does not issue the report by the approved extension date; (3) the time frame for comprehensive medical-legal evaluations to be prepared and submitted shall not exceed 30 days after the QME or AME has seen the employee or otherwise commenced the comprehensive medical-legal evaluation procedure.	**15J**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The disciplinary process is an effective deterrent since it can result in precluding an errant physician from continuing to be appointed as a QME.	None.
38(h)	Commenter recommends that this timeline be reduced to 30 days UNLESS additional reports are needed and then allow 60 days.	**15K**	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company January 14, 2008 Written Comment	Rejected. The timelines follow the requirements of the statute, Labor Code section 139.2, are well understood, and some have argued too short. Further reduction of the time limits will lead to confusion.	None.

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38(h)	**Recommendation** ~~An extension of the sixty (60) days may be agreed to by the parties in writing without the need to request an extension from the Medical Director.~~ **Discussion** The workers' compensation system abounds with statutes and regulations attempting to deal with untimely reporting. Late treatment reports, medical legal evaluations, and supplemental reports, cause delays in medical treatment and other benefits that depend on medical opinions. The proposed language should be eliminated, at least, in absence of a showing of good cause. If not eliminated, then CWCI recommends modifying the language to clarify that both parties must agree to the extension and the Medical Director should be advised of the extension so that the additional delays can be tracked and analyzed by the Division.	**39N**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. If the parties agree to extend the time by 60 days, they only need inform the evaluator, not the Medical Unit. When there is no agreement, either party is free to advise the Medical Unit and seek a remedy.	None.
40(a)(2)	This paragraph requires an evaluator to advise an injured worker that the worker may terminate the evaluation based on good cause. The paragraph then repeats language from Labor Code Section 4062.1 on specific events that are to be considered "good cause." However, it should be noted that the statutory list is not all inclusive, but merely states that good cause "includes" certain specific events. Consequently, commenter recommends that this paragraph be expanded to provide further explanation of prohibited conduct by an evaluator, specifically "offensive, hostile, or rude conduct, including conduct that clearly demonstrates the physician's bias toward injured workers."	**29Q**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part.	**Subdivision 40(a)(2) has been amended to add the following phrase:** ***"…abusive, hostile or rude behavior including behavior that clearly demonstrates a bias against injured employees…"***
41(a)(7)	This subdivision proposes not rescheduling a QME examination more than three times. Commenter opines that it appears this would be three rescheduled examinations beyond the initially scheduled appointment. Commenter states this is unacceptable and recommends that this subsection be amended to no more than two rescheduled examinations.	**37I**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted.	Subdivision has been amended to read: (7) Refrain from ***unilaterally*** rescheduling a panel QME exam ~~three (3) or~~ more ***than two*** times in the same case.
41(a)(8)	This subdivision states that the rescheduling of the QME examination should occur within 30 days. If this is the third time the appointment has been rescheduled, it is potentially five months from the time the initial appointment was requested. Commenter finds this an unacceptable delay. Commenter recommends that any and all rescheduling must occur within the initially	**37I**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. This suggestion is an unworkable intrusion into the scheduling practices of a given medical office.	None.

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	allowed 60 day time period to set an appointment unless the parties agree to waive the 60 day limit.				
41(c)	**Recommendation** (8) Address contested medical issues in a manner consistent with the Medical Treatment Utilization Schedule pursuant to Labor Code §§ 4600(b) and 5307.27 and include the relevant portion(s) of the criteria or guidelines relied upon. **Discussion** The revised curriculum contained in the proposed regulations makes it clear that evaluating physicians must understand and apply the medical standard of care as stated in the Medical Treatment Utilization Schedule (MTUS). Many medical legal reports fail to note or are inconsistent with the dictates of the treatment schedule and many more make no reference to the treatment guidelines relied upon by the evaluator. The Institute strongly recommends this addition to clarify that evaluators must comply with the philosophy of the MTUS and demonstrate their reliance on the statutes and regulations to support their medical conclusions.	**39O**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. This has already been addressed under proposed wording in subdivision 35.5(f).	None.
41(c)(2)	This paragraph requires a QME to review all available medical and non-medical records, and Form 111 asks the evaluator to "check" a box confirming that he or she has done this. It is understood that this form is being signed under penalty of perjury, however, commenter recommends that the rules be amended to provide that the evaluation report must also summarize all medical and non-medical records reviewed.	**29R**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part.	Subdivision 41(c)(2) has been amended to add: ***The report must summarize all medical and non-medical records reviewed as part of the evaluation.***
41.5(c)	Commenter recommends adding **"other purveyor of medical goods or services".**	**37J**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	Subdivision 41.5(c) has been amended to add: ***(7) Other purveyor of medical goods or medical services, only if the medical necessity for using such goods or services are in dispute in the case***
41.5(f)	Commenter recommends deleting "employer or insurer" and replacing it with "Claims Administrator."	**37O**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	Wording was changed to 'claims administrator, or if none the employer,..'
41.6(b)	Commenter recommends that language be amended as follows: An evaluator shall proceed with an scheduled	**37K**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008	Rejected. Other wording to clarify the section has been proposed.	(b) An evaluator shall proceed with any scheduled evaluation involving a physical examination or ~~requested~~

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	evaluation involving a physical examination or requested supplemental report needed in the case, unless either the evaluator declines to conduct the evaluation report due to disqualifying himself or herself pursuant to section 41.5(e) of Title 8 of the California Code of Regulations or any entitled party ~~is entitled~~ requests ~~to~~ a replacement QME pursuant to this section.		Written Comment		supplemental report ~~needed~~ in the case, unless either the evaluator declines to ~~conduct~~ ***proceed*** ~~the evaluation or report~~ due to disqualifying himself or herself pursuant to section 41.5(e) of Title 8 of the California Code of Regulations or ***unless, pursuant to this section, the injured employee or the claims administrator*** ~~party~~ is entitled to a replacement QME ~~pursuant to this section~~.
50(5)	**Recommendation** Add: (5) Attesting that he or she is not on probation and his or her license is not restricted. **Discussion** It is appropriate for a QME applicant to attest under penalty of perjury to an unrestricted license and that he or she is not on probation for a medical issue.	**39P**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part. The language suggested has been included in the attestations on QME Form 104 which is adopted by rulemaking for many years.	The following has been added to subdivision 50(c): ***(4) attesting that the physician's license to practice as a physician, as defined under Labor Code section 3209.3, is neither restricted nor encumbered by suspension or probation, nor has the physician been convicted of a misdemeanor or felony related to the physician's practice or a crime of moral turpitude, and that the physician will notify the Administrative Director if the physician's license to practice is subsequently suspended or placed on probation or if the physician is convicted of a misdemeanor or felony related to the physician's practice or of a crime of moral turpitude; and*** ***(5) attesting that the physician shall abide by all regulations of the Administrative Director and shall refrain from making referrals in violation of those regulations; and*** ***(6) attesting that the***

					<u>physician has not performed a QME evaluation during a time when the physician was not appointed as a QME.</u> .
50(c)	Commenter recommends that that QME also be required to attest to his/her license being unrestricted and that he/she is not on probation.	**37L**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part. The language suggested has been included in the attestations on QME Form 104 which is adopted by rulemaking for many years.	See reply above.
53	**Recommendation -- Section 53** Add: Section 53: **Reappointment: Failure to Comply with Medical Treatment Utilization Guidelines** <u>As a condition for reappointment, when addressing medical disputes, all QMEs shall evaluate medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury pursuant to Labor Code §§ 4600(b) and 5307.27, consistent with the Medical Treatment Utilization Schedule, and must include in the report the relevant portion of the criteria or guidelines relied upon. The Administrative Director may deny reappointment to any QME who has failed to comply with this requirement on at least three occasions during the calendar year.</u> **Discussion** The proposed regulations makes it clear that evaluating physicians must understand and apply the medical standard of care as stated in the Medical Treatment Utilization Schedule (MTUS). As previously noted, many reporting medical legal physicians fail to note or are inconsistent with the dictates of the treatment schedule and many more make no reference to the treatment guidelines relied upon. The Institute strongly recommends this addition to clarify that evaluators must comply with the philosophy of the MTUS and demonstrate their reliance on the statutes and regulations to support their medical conclusions and that their repeated failure to do so may affect their reappointment.	**39Q**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. The requirements to issue evaluation reports with opinions consistent with the Medical Treatment Utilization Schedule are sufficiently addressed in other sections.	None.
54	Commenter states that there appears to be no operative definition (8 CCR 1) as to what is a "rejection." Rarely, if ever, are WCAB Judges issuing specific findings of "rejection." Instead, a WCJ may simply find another medical report "more persuasive" than the subject medical report. Commenter questions if this is a "rejection."	**28H**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Rejected. The Administrative Director cannot create a definition of 'rejection' to control or govern the determinations made by Workers' Compensation Administrative Law Judges. The wording of this section already specifies the types of findings that can result in the use of reports	None.&&&&

	Commenter requests that this section be changed or replaced.			under this section for QME disciplinary purposes.	
54	Commenter complains that in many cases even if the rater sends the evaluation to the workers' compensation administrative law judge (WCALJ) marked unrateable, the parties are told to settle the claim or the judge makes a finding. Commenter believes that this section should be amended to get a report of unrateable evaluations directly from the DEU, rather than from the WCALJ.	**37M**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. This comment involves internal administrative processes of the Division and goes beyond the scope of this rulemaking.	None.
60	Commenter suggests adding an audit provision here, so that the DWC can audit medical reports, rather than basing discipline upon violations or "rejected" reports from the WCAB.	**28I**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Rejected. This comment involves internal administrative processes of the Division and goes beyond the scope of this rulemaking.	None.
65	Under Violations of Material Statutory/Administrative Duties Which May Result in Alternative Sanctions, for "15.Failure to Follow AD Evaluation Guidelines (Labor Code section 139.2(h); Labor Code section 139.2(k); Labor Code section 4628; 8 Cal. Code Regs. Section 41(c)(5))", commenter proposes changing this from three to two or more instances.	**37N**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. The Administrative Director has found the current provision fairly addresses the cases that warrant disciplinary action.	None.
65	For "16.Report Deficiencies (Labor Code section 139.2(k))", commenter recommends adding: Absence of or inadequate discussion re: Medical Treatment Utilization Schedule or, when the condition is not included in the Medical Treatment Utilization Schedule, other science based, peer-reviewed, nationally recognized medical literature when treatment is at issue.	**37N**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Rejected. The Administrative Director has added other language to address this and other types of report deficiencies.	This provision of the QME sanction guidelines in section 65 has been amended to add: ***<u>- Other report deficiencies that affect the substantial rights of a party and are in violation of the regulations governing QMEs;</u>***
65(C)(B)(16)	**Recommendation** Add: - Failing to comply with Medical Treatment Utilization Guidelines - Failing to include relevant portion(s) of the criteria or guidelines relied upon **Discussion** If there are sanctions specifically imposed in these regulations as a consequence for failing to base treatment determinations on the Medical Treatment Utilization Schedule regulations, such behavior is more likely to be corrected and as a result, injured employees will benefit	**39R**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Rejected. The Administrative Director has added other language to address this and other types of report deficiencies.	This provision of the QME sanction guidelines in section 65 has been amended to add: ***<u>- Other report deficiencies that affect the substantial rights of a party and are in violation of the regulations governing QMEs;</u>***

	from more effective medical treatment.				
100	Specialty codes reflect deletion and merger of some specialty categories to address certain problems (such as insufficient numbers of QMEs in existing categories of specialty, to accommodate injured workers by limiting the distance they must travel, etc.). While some reorganization of specialty categories may be useful, commenter opines that it is important to consider whether implementation of the proposed change could yield less efficiency and more burden. Ex.: MHH, as proposed would include general surgery, plastic surgery and orthopedics. For a patient with carpal tunnel syndrome, sprain/strain to the shoulder and neck pain, will this process differentiate between such injured workers by designing the panel to include only the orthopedist to avoid the necessity for two doctors to see the patient (a plastic surgeon and an orthopedist?)	**36B**	Charles S. Poochigian Dowling Aaron Keeler January 17, 2008 Written Comment	Accepted in part.	The lists of QME specialty areas for M.D. and D.O.s on page 2 of QME Forms 105 and 106 now include: MHH Hand, which will include physicians who are certified specialists in orthopaedic surgery, general surgery, and plastic surgery; MNB – Spine, which will include certified specialists in orthopaedic surgery and neurological surgery; MPA-Pain Medicine, which will include certified specialists in pain medicine, neurology, physical medicine and rehabilitation, psychiatry, anesthesiology and pain management. MTT Toxicology, which will include certified specialists in emergency medicine, general preventative medicine, and occupational medicine. Similarly, the specialty lists for QME Forms 100 and 104 have been revised to enable physicians to select any of these as is appropriate to their specialty certification, or to select a variation of the specialty that would exclude such a focus, e.g. MPD Psychiatry (other than Pain Medicine), MSY Surgery (Other than Spine or Hand); MPS Plastic Surgery (other than Hand)
100	The last page of this form includes a listing of medical specialties that will be used for QMEs. Commenter disagrees with the change that lumps together Anesthesiology and Pain Management/ Pain Medicine. While it is true that many anesthesiologists practice pain management, many others do not. Similarly, many pain management specialists are anesthesiologists but many	**29S**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Rejected. The Administrative Director has no evidence to support the contention that anesthesiologists who are appointed as QMEs are not also qualified to address pain management. At the present time, all but one of the physicians who are appointed as QMEs under the code for anesthesiology are also listed as QMEs under the	None.

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	are not. Artificially joining these two specialties in a single category will necessarily result in assignment of panels with members who are the wrong specialty, causing delay and unnecessary administrative action and expense. Commenter recommends that this grouping be eliminated, and that pain management and anesthesiology be maintained as separate specialty categories.			code for pain management-anesthesiology or pain management-pain medicine. The Medical Director is advised by the one QME who is not listed in these additional specialty codes that it was an oversight on his part.	
105	This form is to be used for an unrepresented employee to request a QME panel to resolve a dispute under Labor Code Sections 4060, 4061, and 4062. Both Sections 4060 and 4061 include the requirement that "each notice ... shall ... advise the employee of his or her right to consult an information and assistance officer or an attorney" and both include mandatory language that must be included in the notice. Although this form does include a statement that if the employee has questions he or she may call an I&A officer, there is no notice of the right to consult with an attorney. The form should be amended to include the required notice.	**29T**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part. Commenter refers to form 105 but means the attachment to form 105.	The following language was added to the end of the attachment to QME Form 105: **<u>Your rights to an attorney</u>** **You are entitled to be represented by an attorney at any stage of your workers' compensation claim. However, after you have had an evaluation by a QME, you are not entitled to a new QME evaluation.** **Should you decide to be represented by an attorney, you may or may not receive a larger award, but unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.**
Form 105	Replace "Employer/Claims Administrator" with "Claims Administrator" and replace "W.C. Insurer/TPA" with "Claims Administrator (entity adjusting your claim)"	**29T**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI)	Accepted in part. The Medical Unit uses both the information about the employer and the information about the claims administrator and therefore asks for each name of the form.	The form now refers to 'Claims administrator (or if none, Employer)'.

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106	The top of this form includes a list of four reasons that the QME evaluation is requested, and specifies that "the reason" should be specified. Commenter recommends that this language be revised to require "the reason(s)" to be specified, as more than one of the reasons may be applicable. In addition, to clarify the third reason, Section 4062, commenter recommends that the parenthetical phrase following the section number be amended to read: "(medical treatment or disputed body part(s))."	**29U**	Susan Borg, President California Applicants' Attorneys Association via Mark Gerlach January 16, 2008 January 17, 2008 Written and Oral Comment	Accepted in part. .	Following the reference to LC 4062 on QME Forms 105 and 106, the wording has been amended to read: § 4062 (medical treatment/determination, UR dispute or disputed body parts)
Form 105 and 106	**Recommendation** Update the language in forms 105 and 106 and their attachments to reflect the correct procedure to follow when an injured employee subject to an MPN disputes the diagnosis or treatment prescribed by the treating physician in the MPN. **Discussion** Labor Code sections 4616.3 and 4616.4 describe the procedures to be followed when an injured employee subject to an MPN disputes the diagnosis or treatment prescribed by the treating physician in the MPN. The regulations, including forms and attachments must be modified to provide the correct information. As currently written the forms 105 and 106 and their attachments direct the injured parties only to the QME process, which may result in confusion and disputes when the employee is receiving treatment under the MPN program.	**39aa**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	The forms and their attachments now include questions regarding MPN issues.
Form 105 and 106	The terms "employer" under Party Making Panel Request, and "Employer/Insurer" in the Claims Administrator information block should be removed.	**37Q**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the forms.
QME Form 105 and 106	Both of these forms contain objection option boxes at the top for §4062 (medical treatment dispute). This proposed option verbiage should be consistent with LC§ 4062, which uses the term 'objection to medical determination'. Commenter recommends the following for page 1 option box for §4062 near the top of each form: ☐§4062 (medical ~~treatment~~ determination dispute)	**38G**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Accepted in part.	Following the reference to LC 4062 on QME Forms 105 and 106, the wording has been amended to read: § 4062 (medical treatment/determination, UR dispute or disputed body parts)

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Attachment to Form 105	Commenter recommends clarifying that 'on delay' is specific to a liability decision, and the claim form requirement per LC §4060(c) [similar to Form 106 Attachment]: **Select § 4060** if a liability decision on your claim is "on delay" or if the employer/insurance company disputes that your injury was caused by work (i.e. compensability) or denies your claim or if you disagree with the treating physician's opinion that work was not a medical cause of your claimed injury or illness. If the employer/insurer has accepted any body part as compensable for this date of injury, this reason may not apply. The claim form must have been filed with the employer. The QME evaluation will be used to determine whether the employer is liable for this injury. To further clarify when LC §4062 applies and when it doesn't apply in the case of an approved Medical Provider Network (MPN), commenter recommends the following: **Select § 4062** if you dispute a medical ~~treatment~~ determination by the treating physician, a utilization review decision (LC §4610), or any issues not covered by §4060 or §4061 ~~is in dispute~~. The dispute may be over whether any treatment is needed, whether further treatment is needed, the form or type of treatment, or the frequency of treatment recommended by the treating physician. Either party may request the panel. If you are receiving treatment through a Medical Provider Network (MPN) and you disagree with the treating physician's diagnosis or treatment, a different process must be followed. See the information on the MPN provided by your employer.	**38H**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Accepted in part.	A sentence stating the injured employee must have filed a claim form before obtaining a QME or benefits has been added to the first paragraph of the attachment to Form 105. The MPN comment is addressed just below the explanations on which dispute box to select.
Form 106	Replace "employer/Insurer" with "Claims Administrator".	**39T**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President	Accepted in part.	The term Claims Administrator is now used in the forms.

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			California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment		
Attachment to Form 106	Similar to the comments noted regarding Attachment to Form 105 (unrepresented), commenter recommends the following: **Selecting the reason for your request for a QME panel** **§ 4060** applies if liability decision on your ~~the~~ claim is “on delay” or if the employer/insurer disputes that the injury is compensable. If the employer/insurer has accepted any body part as compensable for this date of injury, this reason may not apply. The claim form must have been filed with the employer. ~~(Labor Code 4060(c)).~~ Either party in a represented case may request a QME panel to resolve the issue of compensability under §4060. (Labor Codes §4060(c) and §4062.2(b)). **§ 4062** applies if you dispute a medical ~~treatment~~ determination by your treating physician, a utilization review decision (LC §4610), or any issues not covered by §4060 or §4061. ~~is in dispute~~. The dispute may be over whether any treatment is needed, whether further treatment is needed, the form or type of treatment, or the frequency of treatment recommended by the treating physician. Either party may request the panel. If you are receiving treatment through a Medical Provider Network (MPN) and you disagree with the treating physician's diagnosis or treatment, a different process must be followed. See the information on the MPN provided by your employer.	**38I**	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund January 17, 2008 Written Comment	Accepted in part.	The attachment to forms 105 and 106 have been substantially revised to clarify this and other issues regarding when selecting Labor Code section 4060, 4061 or 4062 is appropriate.
Form 106 – Instructions	Under the “AME or QME Selection Process in Represented Cases” it states that: After the panel is issued, represented parties have ten (10) days to communicate and to agree on one QME from the list to serve as an Agreed	**37R**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	New definitions for 'Agreed Panel QME' and for 'Panel QME' have been added to section 1 definitions and to the attachment to Form 106.

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	Medical Evaluator. If the parties have not agreed on an AME by the 10th day after assignment of the panel, each party may then strike one name form the panel. Use of the term Agreed Medical Evaluator and the abbreviation, AME are incorrect in this context. Agreeing upon a panel QME does not confer AME status, along with a 25 percent increase in fees, upon the chosen QME. Commenter suggests converting the language to read "an Agreed Panel QME."				As the definition for 'Agreed Panel QME', when the parties in a represented case selected one of the panel QMEs to act as an AME during the 10 days after the panel is issued, as provided in Labor Code section 4062.2(c), that evaluator is entitled to bill using the -94 modifier for an AME under section 9795 of Title 8 of the California Code of Regulations.
Form 107	Replace "Ins./Adj./Agency" with "Claims Administrator".	**39U**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the form.
Form 108	Delete "(or if none, your employer)" and "or employer". Replace "claims adjuster/employer" with "claims adjuster".	**39V**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the form.
Form 108	The term "claims adjustor" to "Claims Administrator", and "(or if none the employer)", should be removed in Sections 1 and 4. In the second paragraph of Section 4, the injured worker is instructed to send medicals to the employer, however, this should not be required. Change "claims adjustor" to "Claims Administrator" and delete the word "employer". In Section 6, delete "employer" and insert "Claims Administrator".	**37S**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the form.
Form 110	Replace the heading "INSURER or CLAIMS	**39W**	Brenda Ramirez	Accepted in part.	The term Claims Administrator

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	ADMINISTRATOR INFORMATION" with "CLAIMS ADMINISTRATOR INFORMATION" and replace "CLAIMS ADMINISTRATOR/EMPLOYER (or attorney if known)" with "CLAIMS ADMINISTRATOR".		Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment		is now used in the form.
Form 110	The term "Insurer" should be deleted from the Claims Administrator Information block.	**37T**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part. The term Claims Administrator is now used in the forms.	The term Claims Administrator is now used in the form.
Form 111	Replace the heading "INSURER or CLAIMS ADMINISTRATOR INFORMATION" with "CLAIMS ADMINISTRATOR INFORMATION" and replace "CLAIMS ADMINISTRATOR/EMPLOYER" with "CLAIMS ADMINISTRATOR".	**39X**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the form.
Form 111	The term "Employer" should be deleted from the caption for items 6 through 8.	**37U**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the form.
Form 113 and 116	Replace "(Claims adjuster/Employer or Attorney)" with "(Claims Administrator)"; replace "Employer/Insurer name" with "Claims Administrator name"; and replace "Adjuster/Employer (or Attorney) Signature" with "Claims Administrator Signature"	**39Y**	Brenda Ramirez Claims & Medical Manager Michael McClain General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the forms.
Form 120	Replace "Employer/Insurer" with "Claims Administrator"; and replace "employer or employer's insurer or claims agent"" with "Claims Administrator"	**39Z**	Brenda Ramirez Claims & Medical Manager Michael McClain	Accepted in part.	The term Claims Administrator is now used in the form.

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	Discussion There will never be a claim without a claims administrator. A self-administered self-insured employer is encompassed in the claims administrator definition. Suggesting that an employer that is not a claims administrator may have a role to play in this process will create confusion. Language such as this needs to be revised wherever it occurs in the proposed regulation and forms.		General Counsel & Vice President California Workers' Compensation Institute (CWCI) January 17, 2008 Written Comment		
Form 120	Replace "employer or employer's insurer" with "Claims Administrator". Commenter also recommends that an additional option be added as follows: "Only by sending a copy to the following physician who will review it with me and will be paid for an office visit for this purpose by my ~~employer~~ Claims Administrator."	**37V**	Steven Suchil Assistant Vice President American Insurance Association January 17, 2008 Written Comment	Accepted in part.	The term Claims Administrator is now used in the form.
General	AME reports should be accorded the highest of scrutiny and therefore should be routinely audited by the DWC Medical Unit to assure compliance with the required examination and report preparation standards. This means setting up a process by which randomized reports are reviewed to assure quality and compliance. The current system permits the Medical Unit only limited information, coming from "rejected" reports by the WCAB. Commenter states that he does not know what this term means and that he can find no operative definition of the term "rejection" under 8 CCR 1. Commenter suggests that there be a tie into from the audit process to the discipline criteria.	**28A**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Noted. The Medical Unit does conduct a random review of AME and QME reports for quality and reports the results of this review annually to the Administrative Director, as required by Labor Code section 139.2(i). The review involves obtaining a random selection of AME and QME reports from each of the Divisions 15 district WCAB hearing offices where the Disability Evaluation Unit receives and rates medical-legal reports. The reference to 'rejected' reports is in Labor Code section 139.2(d)(2) and requires a finding by a Workers' Compensation Administrative Law Judge in a decision that has become final.	None.
General	Commenter suggests that in order to facilitate quality and consistency, the Medical Unit promulgate a prescribed format under which the AME must structure his/her reports, together with a specific section relating to apportionment to causation, which still appears to be a continuing subject of confusion and inconsistency.	**28C**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Noted. The evaluation guidelines, the *Physician's Guide* and WCAB rule 8 Cal. Code Regs. § 10606 provide direction for both AMEs and QMEs. The Administrative Director may develop other format recommendations at a future time.	None.
General	Commenter recommends scalable payments to AMEs based upon how fast they get the examination done (not the reports written).	**28B**	Corey A. Ingber, Sr. Vice President/Legal Zenith Insurance Company January 16, 2008 Written Comment	Noted. A change in the compensation level for AMEs is beyond the scope of this rulemaking but may be considered in future rulemaking pertaining to the medical-legal fee schedule in 8 Cal. Code Regs. § 9795 *et seq.*	None.

General	Commenter requests that when information is directed to a QME or AME, that there be some structure with regarding to the information that is being transmitted to the QME or AME in writing. Commenter states that it is the employers, or their claims administrators, responsibility to copy and transmit all records to the physician. The best mechanism for doing this would be to require an inventory of all medical documentation and evidentiary information they feel the physician should have.	**T16**	Robert B. Zeidner, Esq. California Applicants' Attorneys Association January 14, 2008 LA Public Hearing - Oral Comment – Page 24	Accepted in part. Already addressed in response to comments about subdivision 35.	Already addressed in response to comments about subdivision 35.
General Comment	Commenter, as a member of CAAA, is in full agreements with the comments submitted by their President, Sue Borg.	**T17**	Barry Gorelick, Esq. California Applicants' Attorneys Association January 17, 2008 Oakland Public Hearing - Oral Comment – Page 25	Noted.	None needed.
	COMMENTS RECEIVED AFTER CLOSE OF PUBLIC COMMENT PERIOD				
12 and 13	Commenter objects to the change that would list all chiropractic QMEs under one designation. He believes the existing designations, such as chiropractic – orthopedic, are clear and will not lead to confusion. He predicts the change will result in inferior QME chiropractic evaluation reports, to the deteriment of injured employees.	**P-1**	Robert A. Griffin, D.C. Robert A. Griffin, Inc. April 4, 2008 Written comment	Noted.	None needed.

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[i] [[-3207 as amended by SB 899 [4/19/04] deleted the phrase 'including vocational rehabilitation'.

When AB 227 became effective (1/1/2004), LC 3207 still included words 'including vocational rehabilitation' although the bill repealed prior section 139.5 (which described vocational rehabilitation benefits) and replaced it with section 139.5 which expressly stated it applied only to injuries on or after 1/1/2004 and provides for supplemental job displacement benefits.
SB 899 repealed LC 139.5 as adopted by AB 227 and added a new 139.5, reinstating traditional vocational rehabilitation and the voc rehab unit, limiting the newly adopted section to apply only to claims with date of injury on or before 1/1/2004, and added a sunset clause through 1/1/2009, unless reenacted.]]