

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	<p>“Injured Employee” or “Injured Worker”? Throughout the proposed regulations, existing paragraphs that contained the word “employee” were being switched to “worker.”</p> <p>Recommendation: Commenter recommends being consistent with the Labor Code where “employee” is widely used. Labor Code §3351 defines employee which helps determine eligibility for workers’ compensation benefits.</p>	21A	<p>Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund November 6, 2008 Written Comments</p>	<p>Rejected. The regulation text used both phrases. Both phrases are clear enough for the regulated public to understand what is required to comply.</p>	None.
General Comment	<p>In these proposed regulations, the Division has done an outstanding job of crafting a more comprehensive training curriculum and improving the QME certification testing with respect to compliance with the Medical Treatment Utilization Schedule (MTUS) and reporting timeframes. However as discussed in greater detail in previous written comments, commenter believes the Division has a responsibility to go further to ensure evaluator compliance. Under these regulations as currently crafted, evaluators may ignore the MTUS with impunity when making medical decisions in their reports. It is important that these regulations both encourage and require evaluators to conform with the statutory definition of covered medical treatment in Labor Code section 4600(b) and with case law determined in the recent Sandhagen Supreme Court decision. The lack of a consequence for evaluators who do not comply with the MTUS standards and requirements means noncompliance will likely continue.</p> <p>Commenter urges the Administrative Director to consider clarifying in regulation that reports that do not comply with the MTUS are incomplete and not reimbursable.</p>	22A	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers’ Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. The Administrative Director has the authority to discipline QMEs for violations related to deficiencies in the medical legal evaluation report, under sections 35.5(g) and 41(c)(5) of title 8 of the California Code of Regulations, and as more fully described in the QME Sanction Guidelines at 8 Cal. Code Regs. § 65, at part II (B) 15 [Failure to follow AD evaluation guidelines] and 16 [Report deficiencies].</p> <p>Moreover, under existing law, whenever a Workers’ Compensation Administrative Law Judge (hereafter, WCALJ) finds that a medical/legal report is so deficient so as not to be capable of “proving or disproving a contested claim”, the WCALJ may reject that report and order that the employer is not liable for paying for that report, or that the provider must reimburse the</p>	None necessary.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter also recommends tracking of MTUS non-compliance under the Labor Code section 139.2(i) annual reporting on medical legal reports and enforcement by specifying discipline in section 60 et al, including denial of QME reappointment for repeat violators. Evaluators who consistently submit deficient or untimely reports or make medical determinations that are not consistent with the Medical Treatment Utilization Schedule can be targeted for decertification, other discipline, and additional training. Injured workers, WCALJs, employers, and insurers rely on the validity of the QME opinions, so the competence of the medical legal physician cannot be compromised.</p>			<p>employer for that report. (See, Lab. Code §§ 4620(a); 4621; 4625(b).) Finally whenever a party or a WCALJ believes a report by a QME is deficient, a complaint may be filed with the Medical Unit and the complaint will be investigated and where warranted the QME will be subject to discipline and may be barred from reappointment. (See, Lab. Code §§ 139.2(k)(1) and 139.2(d)((2).)</p> <p>The recommendation to track compliance and non-compliance with the MTUS will be taken under advisement. The mechanics of such a compliance program go beyond the scope of this rulemaking.</p>	
Medical Privacy	<p>Commenter appreciates deleting “or if none, the employer” from “claims administrator, or if none, the employer” and similar language from certain forms, but is concerned that such language has been retained in section 30(a) and other sections and forms in these regulations. The definition of claims administrator in Section 1(j) encompasses situations where the employer is a self insured employer. If the employer is self insured, only the claims administration department of that employer may request the panel or otherwise handle the claim. Using the term “employer” as well as the term claims administrator may unintentionally result in a serious breach of the injured employer’s medical privacy by an employer. A claims administration department of a self insured employer has a duty to safeguard the</p>	22B	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers’ Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. As the commenters acknowledge, the claims administration department of a self insured employer is required to ensure the medical privacy of its employees’ medical information from others in supervisory or management positions who do not have a business reason to have, regardless of whether the medical information pertains to general medical or workers’ compensation medical treatment. Usage of the phrase “, or if none the employer,” throughout the regulations has been</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>medical privacy of an injured employee from the rest of the employer organization. To avoid confusion and safeguard medical privacy, the term “claims administrator/employer,” “claims administrator or if none, the employer,” or other similar terms needs to be replaced by “claims administrator.”</p>			<p>carefully drafted to be clear that where there is no claims administrator, what the employer’s duty is. This language is needed to be consistent with the Labor Code, which places the legal responsibility for providing compensation benefits on the employer. While an employer may become insured or self insured, and therefore contract out the obligation to administer claims in compliance with the Labor Code, this phrase is needed to address those employers who are neither insured nor self insured. Such an employer’s civil and criminal liability for breaches of medical privacy laws exists independent of the use of this phrase in these regulations.</p>	
MTUS guidelines	<p>Commenter states that there should be consequences to make the evaluator responsible for following the MTUS guidelines in their examinations, diagnosis and in rating PD. Commenter suggests the proposed regulations should include language that requires these examiners to be responsible for their actions by not considering their report and not paying their fee if they do not follow the MTUS.</p>	15A	<p>Tina Coakley, Legislative and Regulatory Analyst The Boeing Company November 5, 2008 Written Comments</p>	<p>Rejected. As discussed above in response to the similar general comment by Ms. Ramirez and Mr. McClain, existing law already allows a WCALJ to order that the employer is not liable for paying for a deficient medical/legal report, or that the evaluator must reimburse the employer for the deficient report. Further existing statutes and regulations provide mechanisms for disciplining evaluators or refusing to reappoint evaluators who write deficient reports.</p>	None required.
1(d)	<p>Commenter is in favor of the proposed language in this</p>	1A	<p>Robert Cooper, MD</p>	<p>Comment is noted.</p>	None required

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>section.</p> <p>There is a huge need for and requests for panel QMEs as well as AMEs. As a psychiatrist who does all his own work on a case, commenter has time enough to evaluate only 2-3 applicants per week.</p> <p>Commenter's wait list for appointments is almost one year away. Commenter saves some appointment time slots for special cases. A Panel QME is a special case, but commenter has always wondered why he doesn't get paid the AME rate for doing a Panel AME. The responsibility, challenge, stress, vast record reviews and future supplemental reports and depositions are inevitable.</p> <p>Thus, the change created by the new proposal only makes a wrong thing right. Perhaps it would also cause other AME quality doctors to save some time slots. Commenter gets paid by the hour per the fee schedule. Panel QMEs should get the AME rate for the same reasons AMEs already are paid 25% more per hour for doing an evaluation that hopefully will be one of the last evaluations needed before a case can be settled.</p>		<p>October 21, 2008 Written Comment</p>		
1(d), 1(k)	<p>For Sec. 1 (d), "Agreed Panel QME" commenter strongly recommends that "or if none the Employer" be deleted. If the Employer is self-insured and self-administered he/she is a Claims Administrator, as provided in the definition in Subdiv. (k). Likewise, if the Employer is self-insured and using a TPA, the TPA is the Claims Administrator. Finally, if the Employer is insured the Insurer is the Claims Administrator as provided in the definition of Claims Administrator in Subdiv. (k). The only "employer" that does not fall within the Claims Administrator definition seems to be</p>	20A	<p>Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment</p>	<p>Rejected. This phrase is needed to address situations in which there is no claims administrator, such as when the employer is uninsured and the Uninsured Employers' Benefits Trust Fund is not yet joined in the case. The words "or if none" make it clear that the employer is legally obligated to act if there is no claims administrator. The employer will know when that is the case.</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>the illegally uninsured. The language, "Claims Administrator, or if none the employer", found throughout these regulations and some of the forms is unclear and could be misinterpreted to imply that an insured employer must comply with the many duties of his/her Insurer or that a physician must send personal medical information directly to the employer. We ask that this confusion be removed here as well as in all other sections of these proposed regulations. Commenter notes and appreciates that the language has been removed on most of the forms although it does still appear on QME Forms 110 and 111.</p> <p>Commenter does not see that the mere agreement of the parties upon a panel QME changes the nature of the evaluation and warrants a 25 percent increase in the fee. If this is to be the case, however, there must be a specified way of denoting this situation on the bill. We note that the use of modifier 94 has been deleted. It is true that utilizing this modifier for other than a true AME will skew that data but without it, or a new modifier, payors will not know of the increased amount and bills will be cut, creating unnecessary and avoidable disputes. Without a specific identification method there is also the potential for all Medical-Legal fees to be skewed. Commenter recommends the addition of a new modifier for this purpose. Commenter is also concerned that an unintended consequence of this regulation may be that the parties are less likely to agree on a Panel QME.</p>			<p>On the issue of paying the Agreed panel QME the same rate as an AME, the Labor Code clearly provides for and requires the parties to attempt to agree on a QME from the panel list to act as an AME. (See, Lab. Code § 4062.2(c).) It is clear from the language used in this subdivision that the Legislature intended these physicians to be treated like other AMEs, therefore there is no reason to pay such evaluators less.</p> <p>This subdivision limits the time the represented parties have to reach such an agreement, and once that period expires, the subdivision specifies the time frame for each party to strike a name from the panel of 3 QMEs.</p> <p>The modifier is a matter to be addressed in another rulemaking involving 8 CCR § 9795. That is beyond the scope of this rulemaking but will be considered in the future when section 9795 is reviewed. The parties in a represented case who agree on an Agreed Panel QME will know the agreement was reached and can alert the claims administrator to identify the report as an agreed medical evaluation</p>	
--	---	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				report. Generally, the evaluators identify on the report itself whether it is an AME or QME report and the time spent performing various activities needed to produce the report, as they are required to do so by Labor Code § 4628.	
1(d)	<p>Commenter recommends the following revised language:</p> <p>(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. An Agreed Panel QME shall be entitled to be paid at the same rate as an Agreed Medical Evaluator under section 9795 of Title 8 of the California Code of Regulations for medical/legal evaluation services.</p> <p>Commenter recommends designating in this section a new Modifier to identify medical-legal services by agreed panel QMEs. If the DWC decides not to designate a new modifier, commenter recommends retaining in this section the requirement to use AME modifier “-94.”</p> <p>If medical legal service is billed without a modifier, bill review systems will have no way to identify the need for increased payment. A new separate modifier is preferable in order to distinguish services by agreed panel QMEs from AMEs. If there is no separate modifier</p>	22C	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers’ Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. This phrase, “or if none the employer”, is needed to address situations in which there is no claims administrator, such as when the employer is uninsured and the Uninsured Employers’ Benefits Trust Fund is not yet joined in the case. The words “or if none” make it clear that the employer is legally obligated to act if there is no claims administrator. The employer will know when that is the case so will not be confused. Employers who have claims administrators will not be confused as the language does not apply to them.</p> <p>Rejected. The text of any modifier would appear in 8 Cal. Code Regs. Section 9795. This section is not within the scope of this rulemaking. While the Administrative Director understands the merits of creating a separate modifier to enable researchers using bill review data to</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>named in this section, valuable research data will be lost because agreed panel QME panel data will be indistinguishable from AME data.</p> <p>Also see comment for Section 30(a).</p>			<p>distinguish between AMEs and Agreed Panel QMEs, the creation of a new modifier is beyond the scope of this rulemaking. The actual modifier to be used will be addressed in future rulemaking for section 9795.</p> <p>This reference in commenter's letter to a comment for Section 30(a) is referring to the Medical Privacy comment, addressed at the beginning of the chart.</p>	
1(ff)	<p>In Sec. 1 (ff), this definition provides that "Treating physician" means a physician who has provided direct medical treatment to an employee which is reasonably required to cure or relieve the effects of an industrial injury pursuant to Sec. 4600 of the Labor Code. Commenter recommends changing this definition to only include the Primary Treating Physician(s) and Secondary Physicians, those whose reports are admissible. As the definition now reads, it could include those who have seen the injured employee but whose reports would not have standing at the Workers' Compensation Appeals Board. If this change is made the words "treating physician" should be removed from Sec. 35 (e).</p>	20B	<p>Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment</p>	<p>Rejected. Reports of physicians other than the current primary treating physician, who have treated the injured employee in the past for the same injury or body part, may be relevant and important to the medical record that must be reviewed and commented on by an AME or QME. Because there can be only one primary treating physician at any given time (see, 8 Cal. Code Regs. § 9785(b)(1)), when the injured employee has changed primary treating physicians during the course of a claim, the reports of the prior treating physicians are both relevant and</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				probative. For the same reason, the wording of subdivision 35(e) of this rulemaking will not be amended.	
30(h)	<p>Although commenter agrees with the intent of this subdivision, he believes the proposed wording is confusing. Specifically the use of the word "resolve" in the first sentence is misplaced, and suggests instead the word "process" so that the sentence reads:</p> <p>"The time periods specified in Labor Code sections 4062.1(c) and 4062.2(c), respectively, for selecting an evaluator from a QME panel and for scheduling an appointment, shall be tolled whenever the Medical Director asks a party for additional information needed to process the panel request."</p> <p>In addition, commenter recommends that this subdivision be amended to provide that the Medical Director shall notify all parties whenever he or she makes any request for additional information needed to process a panel request that triggers this tolling of the statutory time periods. This notice should also specify that the responding party must notify all other parties when the requested information is provided to the Medical Director. Without such notices, all parties will not be aware of the fact that the time periods are tolled and actions could be taken that would be inappropriate and cause additional delay and expense to resolve.</p>	18A	Mark Gerlach for Todd McFarren, President California Applicants' Attorney Association November 5, 2008 Written Comments	<p>Rejected. At times, the Medical Director receives objections to panel lists issued to represented parties. In determining whether and how to respond to those requests, the Medical Director contacts the parties to obtain more information. At times it is necessary to void a panel that was already issued. For these reasons, the word resolve better describes the efforts of the Medical Unit. In contrast, the word 'process' would leave some ambiguity, such as when the Medical Unit has enough information to 'process' a panel request, even though additional information leads staff to realize the initial information received was inaccurate or incorrect.</p> <p>In regard to the proposal regarding notice to the parties, the practice of the Medical Unit at the present time is to send a copy of any such written correspondence to each party and their attorney if known to the Medical Unit. Accordingly, no additional regulatory language is needed.</p> <p>The Medical Unit will ensure that such correspondence directs the</p>	<p>In regard to the proposal regarding notice to the parties, the practice of the Medical Unit at the present time is to send a copy of any such written correspondence to each party and their attorney if known to the Medical Unit. Accordingly, no additional regulatory language is needed. The Medical Unit will ensure that such correspondence directs the responding party to copy the other parties with any response sent to the Medical Unit. Generally, it appears the parties do so at the present time already.</p>

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				responding party to copy the other parties with any response sent to the Medical Unit. Generally, it appears the parties do so at the present time already.	
32(g)	Commenter requests that, should the QME receive additional reports or information from a party or parties that he/she does not forward to the Consulting physician, that the QME disclose this to both parties in writing.	20C	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Accepted.	Subdivision 32(g) has been amended to add: <u>The referring evaluator shall list, in the report commenting on a consulting physician's report, all reports and information received from each party for the consulting physician, indicate whether each item was forwarded to the consulting physician, and for the items not forwarded the reason the referring evaluator determined it was not necessary to forward the item to the consulting physician.</u>
32(g)	Commenter recommends the following revised language: (g) With the exception of verbal communications between an injured worker and the consulting physician in the course of the consulting examination, all other communications by the parties, as well as any reports and other information from the parties for the consulting	22D	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers' Compensation	Accepted in part.	The added language shown directly above provides clearer direction to the referring physician about how to notify the parties.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>physician, if any, shall be made in writing directed only to the referring QME, who may forward such communications on to the consulting physician as appropriate. <u>The QME shall notify the parties whether or not the information was forwarded on to the consulting physician.</u> With the exception of deposing the consulting physician if necessary and except as provided in this subdivision, neither party nor a party's attorney, shall communicate directly with nor send correspondence or records directly to the consulting physician.</p> <p>Unless the QME notifies the parties or is deposed, they will not know whether or not the submitted information was forwarded to the consulting physician.</p>		<p>Institute November 6, 2008 Written Comments</p>		
34	<p>The workers' compensation community should consider that physicians have personal responsibilities outside the medical-legal realm. The thirty (30) days to reschedule a cancelled appointment with only sixty (60) day limit may not allow for personal or other considerations. There is no reasonable consideration for 'good cause' for rescheduling an appointment for personal long-term family emergencies, or out of country family emergencies.</p> <p>Suggestion for §34: There should be consideration for 'good cause' with reasonable rescheduling time frames beyond thirty (30) days or sixty (60) days.</p>	2A	<p>Janet Skiljo Haris, RN, MS – President MEDLink October 27, 2008 Written Comment</p>	<p>Rejected. Proposed subdivision 34(e) allows the parties to agree in writing to a date beyond the sixty (60) day period. Failure to schedule an evaluation examination within sixty days of the initial call has been grounds for obtaining a new QME since 1996 due to the Legislature's clear intent that the evaluation process be expeditious. (See, Lab. Code §§ 139.2(j)(1)(A) and 139.2(j)(1)(C).) Moreover, QMEs are able to make themselves unavailable, if necessary due to family or other emergencies or demands, as described in 8 Cal. Code Regs. § 33.</p>	None.
34(f)	<p>Commenter recommends that the timeline for the AME be reduced from 60 calendar days to reschedule to 30 days, which is what's proposed for QME cancellations. It allows for consistency and speeds up the process by</p>	15B	<p>Tina Coakley, Legislative and Regulatory Analyst The Boeing Company November 5, 2008</p>	<p>Rejected. Already the Administrative Director is hearing reports about Agreed Medical Evaluators who schedule</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	resolving the issue for the employee quickly.		Written Comments	appointments far out into the future (such as 6 to 12 months), due to very full calendars. Accordingly, additional time for the AME to reschedule a cancelled appointment is appropriate.	
34(d)	This prohibits cancellation of an evaluation by the AME, Agreed Panel QME or QME except for good cause. Commenter opines that a definition of good cause is elusive and ultimately should rest with the Appeals Board. However the conditions of "Medical or family emergency" and "death or serious illness" are already found in Section 33(a) and (d) respectively and refer to exceptions to the 30 day notice of QME unavailability. With this precedent in mind and in order to eliminate at least some possible disputes commenter urges the Division to add these same references to paragraph 34(d).	17A	Stephen J. Cattolica AdvoCal November 5, 2008 Written Comments	<p>Rejected. It is unclear how adding the phrase 'including but not limited to medical or family emergency and death or serious illness' would eliminate disputes. It is hard to imagine when any of those specific circumstances as the reason for a 'late' cancellation would not be found to constitute good cause.</p> <p>The consequences to an AME, Agreed Panel QME or QME, for cancelling a scheduled appointment less than six business days prior to the appointment are, in the immediate term, to be replaced as the evaluator and potentially to be disciplined by the Administrative Director for violation of this regulation, and in the long term, to be denied reimbursement by the Appeals Board for the evaluation report produced after the re-scheduled evaluation is conducted.</p> <p>The Administrative Director, and Executive Medical Director, are able and have demonstrated the ability to determine good cause even though a</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				regulation does not enumerate examples. (See the existing text of 8 Cal. Code Regs. § 31.5(b)(3).)	
34(e)	<p>This stipulates that an Agreed Panel QME must reschedule a cancelled appointment within the same time frame as a panel QME. Notwithstanding the added accommodation for written agreement to a longer timeframe, the Division must consider that in the majority Agreed Panel QMEs are chosen because they have the same reputation as AMEs chosen outright. One would expect that their schedules are thus impacted in the same manner as the AMEs addressed in Section 34 (f). Commenter suggests that Agreed Panel QMEs be grouped into Section 34 (f) rather than Section 34 (e).</p> <p>As mentioned previously, commenter also suggests that the same written agreement for an extension of the reschedule time frame be accorded to the subjects of Section 34 (f) as is provided panel QMEs in Section 34 (e).</p>	17B	Stephen J. Cattolica AdvoCal November 5, 2008 Written Comments	Rejected. QMEs, unlike AMEs who are selected by represented parties without use of the QME panel system, are subject to being replaced from a panel at the request of either party if an appointment is not available within 60 days of the initial call for an appointment (see, 8 Cal. Code Regs. § 31.5(a)(2).) Section 34(e) only applies when the QME or Agreed Panel QME cancels a scheduled appointment, not when a party cancels an appointment. If both parties who have already agreed to designate an Agreed Panel QME. Proposed subdivision 34(e) allows the Agreed Panel QME who cancels an appointment to reschedule it beyond 60 days from the date of the initial call for the appointment, as long as both parties agree in writing to do so. Where either party refuses to do so, the Administrative Director believes that party should be entitled to obtain a replacement QME, as provided under 8 Cal. Code Regs. § 31.5(a)(2). Since the inception of	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				the QME process, the Legislature has shown a clear intention that the medical-legal evaluation process be expeditious, as shown by the express statutory time limits that require both AMEs and QMEs to complete the evaluation report within 30 days of the date of the exam, except where an approved extension of time or statutorily allowed extension of time applies. (See, Lab. Code §§ 139.2(j)(1)(A); 4062.5.) The Administrative Director can find no reason to believe the Legislature would wish to allow greater delays, due to rescheduling appointments, to be allowed before the injured employee is seen by the evaluator.	
34(f)	Commenter recommends deleting the extended period of time provided for AME's to reschedule cancelled appointments. Any physician providing this service should be held to the same standards. Commenter believes this is especially true if they will be paid at the same rate.	20D	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Rejected. As noted in reply to other comments (see comment from S. Cattolica, below) at the current time existing AMEs are having difficulty scheduling appointments. Given the role of AMEs in the California workers' compensation system and the demand for their assistance, it is reasonable to allow an AME a longer time in which to reschedule an cancelled appointment	None.
34(f)	This requires rescheduling an AME within 60 days of a cancellation of an evaluation by the AME. The Division is aware that many AMEs are scheduled many weeks	17C	Stephen J. Cattolica AdvoCal November 5, 2008	Accepted in part. The Administrative Director is concerned, based on comments and	The phrase “, unless the parties agree in writing to accept an

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	and months into the future. While no one would argue that some accommodation must be accorded these cancellations, a mandate such as this will likely cause a "domino effect" with the evaluator's schedule that results in many rescheduled appointments in order to comply. A more practical time frame would be 90 days plus the additional relief provided if the parties agree in writing to a date beyond the 90 days.		Written Comments	complaints from parties, that the parties' have experienced unending delays in obtaining supplemental reports from AMEs. The AME who cancels a scheduled appointment has an obligation to the parties' who have had to accept the initial cancellation, even in cancellations due to good cause.	appointment date no more than thirty (30) calendar days beyond the sixty (60) day limit" will be added to subdivision 34(f).
34(f)	<p>Commenter recommends the following revised language:</p> <p>(e) An <u>Agreed Medical Evaluator</u>, Agreed Panel QME or a QME who cancels a scheduled appointment shall reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation. The rescheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.</p> <p>(f) An Agreed Medical Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation.</p> <p>Commenter believes the same cancellation and rescheduling requirements should apply to AMEs as to QMEs and Agreed Panel QMEs.</p>	22E	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers' Compensation Institute November 6, 2008 Written Comments</p>	Rejected. As noted in the replies to other commenters about section 34, AMEs currently have difficulty scheduling evaluation exams.	None.
34(g)	This specifically excludes the absence of medical records as 'just cause' for a cancellation. We want to	17D	Stephen J. Cattolica AdvoCal	Accepted in part. Commenter raises an important medical issue that goes	For consistency with the evaluation

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>echo concerns already submitted earlier to the Division regarding what should be considered an unfortunately routine "good cause" that adversely affects mental health evaluators different than other evaluators. To clarify, commenter provides the following excerpt from one such comment:</p> <p>"In psychiatry people are often impaired in their ability to recall and concentrate with resulting inconsistencies in their history versus the medical records. This might cause the defense to seriously question the applicant's credibility but in fact the inconsistency may be due to the psychiatric disorder present. Ultimately this would probably result in the need for a reevaluation in order reconcile the applicant's history with the medical records and then to attempt to render an opinion regarding the crucial issues within reasonable medical probability. But much damage would already have been done to the applicant's case. Much of this could be avoided if the records are present at the time of the initial agreed medical examination."</p> <p>Commenter urges the Division to adopt a solution that would exclude mental health evaluations from Section 34(g).</p>		November 5, 2008 Written Comments	to the core of the medical evaluation process a psychiatrist or psychologist is required to make in conducting some but not all evaluations in a disputed claim to the psyche.	<p>guidelines that an evaluator must use in a disputed claim of injury to the psyche as well as the long-standing process followed under 8 Cal. Code Regs. § 35(i), the following phrase will be added to the end of existing subdivision 34(g):</p> <p>"...unless the evaluator is a psychiatrist or psychologist performing an evaluation regarding a disputed injury to the psyche who states in the evaluation report that receipt of relevant medical records prior to the evaluation was necessary to conduct a full and fair evaluation."</p>
34(g)	Commenter states that this section has the potential to seriously compromise the quality of the examination. As a psychiatrist, commenter states that medical records are crucial in assessing not only the applicant's history but also their credibility. Commenter has reviewed many reports from examiners in other specialties going	4A	Thomas Preston, MD November 4, 2008 Written Comment	<p>Accepted in part; see language added to 8 Cal. Code Regs. 34(g).</p> <p>The proposed rule in subdivision 34(g) has no more potential to wreak havoc than the existing rules</p>	As noted directly above, additional language has been added to subdivision 34(g) for psychiatrists or psychologists

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>through the entire litany of the examination and then rendering <u>no</u> opinions with a comment that an opinion will be offered once the records are received. This makes the entire process somewhat of a travesty and an enormous waste of resource.</p> <p>In psychiatry people are often impaired in their ability to recall and concentrate with resulting inconsistencies in their history versus the medical records. This might cause the defense to seriously question the applicant's credibility but in fact the inconsistency may be due to the psychiatric disorder present. Ultimately this would probably result in the need for a reevaluation in order to reconcile the applicant's history with the medical records and then to attempt to render an opinion regarding the crucial issues, within reasonable medical probability. But much damage would already have been done to the applicant's case. Much of this could be avoided if the records are present at the time of the initial agreed medical examination.</p> <p>The six-day rule has the potential to wreak havoc with the schedule of a psychiatric office. Appointments are made well in advance and if there is cause to cancel or postpone an appointment, because, for example, no agreed medical examination joint letter has been generated, then the time allotted to the examination may be lost for professional use. Commenter sets aside at least four or five hours for each agreed medical examination and usually more.</p> <p>Obviously, an illness of the Examiner would probably constitute good cause for cancellation.</p> <p>But what are the other criteria? Is the absence of a joint</p>			<p>which are silent about cancellations. Proposed subdivision 35(i), formerly subdivision 35(d), directs the evaluator on the procedure to use when relevant medical records are not received prior to an evaluation.</p> <p>The Administrative Director can understand the difficulty described by the commenter when represented parties fail to send a joint letter or the business loss when an appointment is cancelled less than 6 business days prior to the scheduled date. The Administrative Director believes this new regulation will reduce the burden on evaluators from late cancelled appointments. Currently, there is no cancellation time limitation in place. Should this proposed regulation be shown to be insufficient time, the regulation may be amended in the future.</p> <p>The rule as proposed would allow for illness of the evaluator to constitute good cause.</p> <p>Possible remedies for the represented parties' failure to send a joint issues letter and timely medical records may be addressed further in a future rulemaking.</p>	<p>performing an evaluation in a disputed injury to the psyche claim.</p> <p>No other changes will be made at this time.</p>
--	--	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>letter good cause? Is the inability to contact the applicant good cause?</p> <p>If the division is going to impose these stringent cancellation regulations are they also going to impose regulations on those responsible for generating the joint letter and providing the records.</p> <p>Commenter recommends that at least 3 weeks represent the timeframe for cancellation allowing a psychiatric office to fill the professional time allotted to the appointment which was canceled.</p>				
35(c)	<p>This section gives instructions when providing medical and non-medical records to the opposing party in preparation for the A/QME evaluation. However, it does not address handling of psychiatric records protected by Health and Safety Code 123115(b). Withholding those records would violate our obligation to provide information under LC4062.3, whereas releasing them directly to the injured employee for review would violate the requirements of Health and Safety Code 123115(b). Commenter recommends providing for an exception for this special circumstance.</p> <p>Recommendation: Commenter recommends the following revision:</p> <p>(c) At least twenty (20) days before the information is to be provided to the evaluator, the party providing such medical and non-medical reports and information shall serve it on the opposing party. <u>Mental health records that are subject to the protection of Health & Safety Code 123115(b) shall not be provided to the injured employee.</u> In both unrepresented...</p>	21B	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund November 6, 2008 Written Comments	Accepted in part. Commenter's proposed wording does not go far enough in notifying the injured employee of the existence of the protected mental health record and of the option under the Health and Safety Code to have the record reviewed by a designated health care provider.	For consistency with the provisions of Health and Safety Code section 123115(b), subdivision 35(c) will be amended to add, after the first sentence: "Mental health records that are subject to the protections of Health and Safety Code section 123115(b) shall not be served directly on the injured employee, but may be provided to a designated health care provider as provided in section 123115(b)(2), and the injured employee

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

					shall be notified in writing of this option for each such record to be provided to the evaluator.”
35(e)	<p>Commenter recommends the following revised language:</p> <p>(e) In no event shall any party forward to the evaluator: (1) any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code section 4062.5; (2) any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical legal process in Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a Workers' Compensation Administrative Law Judge; or (3) any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible, by a Workers' Compensation Administrative Law Judge, or which otherwise has been deemed inadmissible to the evaluator as a matter of law.</p> <p>The plain language of the statute in Labor Code section 4062.3 in paragraph (a) permits any party to submit to a panel QME medical and non-medical records that are relevant to the issue, and in paragraph (c) to provide to an AME any information agreed upon by the parties. Commenter believes the language in (2) restricts the scope of the statute, which the Administrative Director</p>	22F	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers' Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. The language the commenters want to strike applies only to reports by physicians who were not involved in the case as a treating or evaluating physician. It would require the proponent of such a report to obtain a finding from a Workers' Compensation Administrative Law Judge that the report is admissible and relevant. The language is necessary to preclude parties from circumventing the medical/legal evaluation process created by the Legislature, by obtaining reports from third party physicians about the very issues the AME or QME is required to evaluate and address, such as permanent impairment, permanent disability or apportionment. Some parties attempt to obtain such third party opinion reports commenting on a report by a treating physician or evaluating physician in order that the third party physician's opinion become part of the 'medical records' in a case which are sent to a properly selected AME or QME, and which there must be identified and commented on by the evaluating</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>does not have the authority to do.</p> <p>If the language is not removed, depositions may replace the reports by precluded physicians, unnecessarily delaying benefits and increasing costs.</p>			<p>physician as required by Labor Code § 4062.3(d). By requiring the proponent of such a third party medical opinion to obtain an admissibility determination from a WCALJ in advance, the medical record to be reviewed by the AME or QME is protected. Should a WCALJ subsequently rule such a third party physician opinion is relevant and admissible, the AME or QME in the case can always be asked to write a supplemental report to discuss whether this new report would change the evaluator's opinion on a disputed issue. On the other hand, if the third party physician opinion is commented on by the AME or QME and then a WCALJ later rejects the AME or QME opinion due to the inclusion and reliance on an inadmissible third party medical opinion, the parties must start over to develop the medical record and obtain an admissible evaluation. Such a consequence is far more time consuming and costly than deposing the evaluator when a party has reason to believe the evaluator's opinion on an issue is deficient.</p>	
35.5(f)	<p>Commenter objects to the language that all depositions of doctors occur in their office "unless" an order is obtained or the parties agree.</p>	3A	<p>Rene Thomas Folsie, JD, Ph.D., Esq., Licensed Psychologist October 23, 2008 Written Comment</p>	<p>Accepted in part. The Administrative Director is concerned that the evaluator to be deposed be available for deposition</p>	<p>To be consistent with the provisions governing depositions under the California</p>

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>He points out that most doctor's offices are ill equipped for a deposition as they rarely have a conference room or table for the deposing party to use to hold the file, note paper and/or other accoutrements.</p> <p>Commenter refers to Labor Code section 5710 which says that depositions are to be taken in like manner as depositions are taken in civil actions in the Superior Court and this labor code makes reference to the Code of Civil procedure sections commencing with section 2016.010. In that regard, the Code of Civil Procedure then makes restriction on the location of the deposition, which is selected by the party scheduling the deposition (any agreement or order is not required).</p> <p>CCP, section 2025.250 (a) Unless the court orders otherwise under Section 2025.260, the deposition of a natural person, whether or not a party to the action, shall be taken at a place that is, at the option of the party giving notice of the deposition, either within 75 miles of the deponent's residence, or within the county where the action is pending and within 150 miles of the deponent's residence.</p> <p>Using this statutory authority, the doctor's deposition can be scheduled in such a conference room as needed. If the doctor must travel, then the deposing party must pay compensation of his/her time and effort. The Medical Legal Fee Schedule pays \$250 for his/her time which can include travel time for the physician if required.</p> <p>Commenter suggests to possible alternative versions of the language:</p>			<p>in a manner that is both consistent with Labor Code section 5710 and the California Code of Civil Procedure, and at a place that is reasonably close to the place the evaluation is performed, in order that the injured employee may participate if he or she desires to do so. Accordingly, additional language will be added to clarify this objective. The language already allows parties to agree to another location.</p>	<p>Code of Civil Procedure, which applies in workers' compensation cases pursuant to Labor Code section 5710, and for clarity, subdivision 35.5(f) will provide:</p> <p>(f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall, upon the request of either party, make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and <u>upon the request of the unrepresented injured worker and</u> whenever consistent with Labor</p>
--	---	--	--	---	---

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>(f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge order otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall, upon the request of either party, make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, whenever consistent with Labor Code section 5710, <u>and at the request of the deposing party,</u> the deposition shall be held at the location at which the evaluation examination was performed.</p> <p>OR</p> <p>(f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge order otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall, upon the request of either party, make himself or herself available for deposition within at least one hundred twenty (120) days of the notice of deposition and, whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, <u>or a facility or office chosen by the deposing party that is not more than 20 miles from that office.</u></p>				Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed, <u>or at a facility or office chosen by the deposing party that is not more than 20 miles from the location of the evaluation examination.</u> "
35.5(f)	Commenter recommends the timeline for deposition be reduced from 120 days of the notice of the deposition (which is inappropriate for the employee) to 45 days.	15C	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company November 5, 2008 Written Comments	Rejected. As other commenters have noted, some of the evaluators have very full schedules and may need more than 45 days to find time to schedule a deposition. The limit of 120 days provides sufficient time for both the evaluator being deposed and the parties to find a date	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				workable for all concerned. Existing law under the California Code of Civil Procedure allows a party to notice a deposition for any time after 20 days from the date the deposition is served. The evaluator is always free to agree to an early date and the regulation as proposed will ensure the deposition will be scheduled no later than 120 days after the notice or the evaluator will be subject to discipline.	
35.5(f)	<p>Commenter recommends the following revised language:</p> <p>(f) Unless the Appeals Board or a Workers' Compensation Administrative Law Judge orders otherwise or the parties agree otherwise, whenever a party is legally entitled to depose the evaluator, the evaluator shall, upon the request of either party, make himself or herself available for deposition within no more than forty-five (45) at least one hundred twenty (120) days of the notice of deposition and, whenever consistent with Labor Code section 5710, the deposition shall be held at the location at which the evaluation examination was performed.</p> <p>A 6 month delay will unnecessarily delay benefits to the injured employee. Requiring a deposed evaluator to make himself or herself available for deposition within 45 days will shorten potential benefit delays by 4 ½ months.</p>	22D	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers' Compensation Institute November 6, 2008 Written Comments</p>	Rejected. As other commenters have noted, some of the evaluators have very full schedules and may need more than 45 days to find time to schedule a deposition. The limit of 120 days provides sufficient time for both the evaluator being deposed and the parties to find a date workable for all concerned. Existing law under the California Code of Civil Procedure allows a party to notice a deposition for any time after 20 days from the date the deposition is served. The evaluator is always free to agree to an early date and the regulation as proposed will ensure the deposition will be scheduled no later than 120 days after the notice or the evaluator will be subject to discipline.	None.
35.5(h)	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	21C	Marie W. Wardell Claims Operations Manager State Compensation Insurance	Rejected. Either party may object to an evaluator's report and opinion when the evaluator applies the	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>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.</p> <p>Recommendation: Commenter recommends adding the following new subsection (h):</p> <p style="padding-left: 40px;">§ 35.5 (h) <u>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).</u></p>		Fund November 6, 2008 Written Comments	wrong Permanent Disability schedule, fails to provide essential information to support a ratable report, or applies the applicable PD schedule incorrectly. The wording proposed by commenter may confuse parties and evaluators by suggesting that all cases must be evaluated and rated under the AMA guides.	
36(c)	<p>Commenter asks if there should be some mention made here about using the OCR format(s) for sending documents to the Disability Evaluation Unit? Commenter is concerned that, without this notation, there may be delays.</p>	20E	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Accepted in part. The current proposed language identifies the various forms by correct reference to the form name and number under the EAMS regulations and process.	A clarifying phrase, that provides the necessary cross reference to existing regulatory requirements, will be added to subdivision 36(c), sentence 1, after the "(Wee, 8 Cal. Code Regs. §§ 10160 and 10161)..." and before the words "...on the claims administrator...", as follows:

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
					<p><u>with the document cover sheet, DWC-CA form 10232.1 (see, 8 Cal. Code Regs. § 10232.1), and separator sheet, DWC-CA form 10232.2 (see, 8 Cal. Code Regs. § 10232.2), as required by Title 8, California Code of Regulations section 10160(d)(4), on the local DEU office, at the same time as serving the report, QME Form 111, DWC-AD Form 100 (DEU) and DWC-AD Form 101 (DEU)....</u>"</p>
36(c)	<p>Add language directing evaluators to the revised EAMS DEU 101 form and EAMS rules.</p> <p>It will be helpful to make evaluators aware of the revised DEU 101 form, where to find it and how to submit it to the DEU under the EAMS rules.</p>	22E	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers' Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. The EAMS forms are already correctly referred to in the proposed wording, and as discussed in reply to the commenter above, Mr. Suchil, language referring to the EAMS cover sheet and separator sheets is being added.</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p><u>fundamental part of claims handling since the inception of the QME process. It insures that reporting is fair and that claims personnel have timely information needed to provide the correct benefits.</u></p> <p>What is the rationale for the removal of such a vital tool from claims handlings? Is claims handling going to also become a function of DWC?</p> <p>Without the ability to clarify or obtain missing information from QMEs, how will claims administrators conscientiously manage their claims?</p>			<p>apportionment, section 4061(k) required the Administrative Director, through DEU, to submit the report to a Workers' Compensation Administrative Law Judge (WCALJ) prior to rating, in order for the WCALJ to determine whether the discussion of apportionment was consistent with the law. If the WCALJ concluded the apportionment was not consistent with the law on apportionment, the DEU rating would issue with a notation of the WCALJ's finding, in which case the evaluator would be requested to correct or clarify the apportionment discussion in the report (Labor Code section 4061(k).)</p> <p>Although by enacting SB 899 the Legislature made significant changes to the Labor Code provisions that govern permanent disability, apportionment and the QME panel process in represented cases, these two provisions of Labor Code section 4061 were re-enacted with virtually verbatim language, although the subdivision lettering changed:</p> <p>“(d) The qualified medical evaluator who has evaluated an unrepresented employee shall serve</p>	<p><u>response to a party's request until after the Disability Evaluation Unit has issued an initial summary rating report, or unless the evaluator is otherwise directed to issue a supplemental report by the Disability Evaluation Unit, by the Administrative Director in response to a petition for reconsideration of a disability rating or by a Workers' Compensation Administrative Law Judge. A party wishing to request a supplemental report pursuant to subdivision 10160(f) of Title 8 of the California Code of Regulations, based on the party's objection to or need for clarification of the evaluator's discussion of permanent impairment, permanent disability or apportionment.</u></p>
--	--	--	--	--	---

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>the comprehensive medical evaluation and the summary form on the employee, employer and the administrative director....Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and the employer.”</p> <p>“(f) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee’s permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 and 4664 shall first be submitted by the administrative director to a workers’ compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.”</p> <p>This wording, which applies only in cases of unrepresented injured employees and only to reports that discuss permanent disability and apportionment, is prescriptive and requires the QME to serve the report on the DEU in order that a summary</p>	<p><u>may do so only by sending the detailed request, within the time limit specified in subdivision 10160(f) directly to the DEU office where the report was served by the evaluator and not to the evaluator until after the initial summary rating has been issued.”</u></p>
--	--	--	--	--	---

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>rating be issued, or the report be returned to the QME by the DEU as unratable with a statement by the DEU as to the basis for this conclusion.</p> <p>In the view of the Administrative Director, this wording in the Labor Code shows the clear and specific intent that in the case of an evaluation report discussing the permanent disability and apportionment of permanent disability of an unrepresented injured employee, that a DEU rating specialist, who is not a party in the matter, provide the initial <i>disinterested</i> technical assessment of the evaluator's opinion on permanent disability. A report may be found by the DEU to be unratable for several reasons, such as because the rating factors and rating schedule have been applied incorrectly or because the evaluator failed to provide required information to determine the rating or because the evaluator applied the wrong PD schedule for the date of injury involved. Similarly, under the Labor Code section 4061 scheme, where the report discusses apportionment, once a WCALJ has determined the apportionment discussion is inconsistent with the</p>	
--	--	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>law, the report is returned to the QME by the DEU for correction.</p> <p>Accordingly, the proposed regulation implements this legislative scheme in Labor Code section 4061(e) and 4061(f) by preventing defendants from requesting the evaluator to issue supplemental reports, <i>prior</i> to the initial DEU summary rating or the WCALJ's review of the apportionment discussion.</p> <p>The proposed wording in subdivision 36(e) would allow the party to request a supplemental report on any of these issues, consistent with the rule in 8 Cal. Code Regs. § 10160(f) by sending the request for a supplemental report within the 20 day time limit to the DEU. Subdivision 10160(f) provides:</p> <p>“(f) Any request for the rating of a supplemental comprehensive medical evaluation report shall be made no later than twential days from the receipt of the report and shall be accompanied by a copy of the correspondence to the evaluator soliciting the supplemental evaluation, together with proof of service of the correspondence on the</p>	
--	--	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>opposing party.”</p> <p>In practice, this rule provides that DEU will only rate a supplemental report if the request for the supplemental report was made within 20 days of receipt of the original evaluation report and the correspondence from the party requesting the supplemental report is included with the supplemental report to be rated. This proposed version of the rule in 36(e) would allow a party to request supplemental reports after the initial DEU rating is issued.</p> <p>In regard to the statistics offered with Mr. Cordero’s comments:</p> <p>We note that Mr. Cordero does not provide the source for the ‘statistics’ provided with his comment.</p> <p>Labor Code § 139.2 (i) requires the Executive Medical Director to continuously review the quality of AME and QME medical-legal reports. The review is done annually by randomly selecting AME and QME reports from each of the 24 DEU offices throughout the state. From the review of reports received at DEU offices in 2007, the Medical Director found</p>	
--	--	--	--	--	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>only 21% of all AME and QME reports that discussed permanent disability were unratable. The most frequent reasons stated for being unratable were that the report “inconsistent with the AMA guides” (7%) or “failing to provide all the information needed to rate the report” (8%), with the remainder of reports being found unratable for some other reason. For this reason, the Administrative Director is not persuaded by Mr. Cordero’s statistics.</p> <p>The Administrative Director also notes, from Mr. Cordero’s email, contained in Ms. Niber-Montoya’s comment, that Mr. Cordero and Mr. Craig Lange are private rating consultants who may be hired by one party and therefore may have a financial interest in this issue.</p> <p>In regard to the argument that “the AMA guides allow any knowledgeable observer” to check findings with the AMA guides, the proposed regulation will not prevent a party from submitting supplemental questions once an initial DEU determination is made.</p> <p>Finally, once the DEU has served the initial rating report, either party</p>	
--	--	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				<p>may request a supplemental report from the evaluator to get clarification, or the aggrieved party may file a petition with the Administrative Director for reconsideration of the rating (See, Labor Code § 4061(g)).</p> <p>For these reasons, the Administrative Director concludes that the proposed regulation is consistent with the long standing legislative requirements of Labor Code sections 4061(f) and 4061(g) that apply to unrepresented employee cases with permanent disability.</p> <p>However, having considered the comments received on subdivision 36(e), the Administrative Director has determined that the syntax and wording of the subdivision can be clarified as now proposed.</p>	
36(e)	<p>Commenter questions the purpose of this regulation. Commenter wonders if the division believes that claims administrators are delaying the resolution of claims by asking for clarification? Commenter states that the insurance company is paying for the supplemental reports. Commenter opines that this section will delay things further for the injured worker and will require WCAB/AD involvement for issues that can be easily clarified by a simple supplemental report.</p>	6A	<p>Charlene K. Gualt State Compensation Insurance Fund November 4, 2008 Written Comment</p>	<p>Rejected. The proposed regulation, as explained above, allows for a supplemental report after the initial DEU rating report has been issued.</p>	None.
36(e)	<p>Commenter vigorously opposes the proposed QME regulation eliminating the ability of the parties to request</p>	7A	<p>Carol Powell, Esq. Mullen & Filippi, LLP</p>	<p>Rejected. The proposed regulation is consistent with the procedures and</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>QME supplemental reports on critical issues of PD and apportionment. In a system where the WCAB, AD/DIR and DEU are already overburdened, there is no need for only those entities to be able to write QME for supplemental reports. Often the parties need to write the QME, not to change an opinion, but to obtain clarification of an AMA rating. W/o such timely clarification, the amount of PDA's, SJDB vouchers, employer's ability to accommodate work restrictions, and settlements, will all be substantially delayed.</p> <p>The defendant is required to copy the applicant w/ any letters to the PQME already, so if there is some objection or concern, the applicant can seek assistance from an I & A officer or a judge. There is utterly no need for this regulation, which will result in increased litigation when ambiguous/contradictory QME reports cannot be timely clarified in a simple way. This will force defendants to depose QMEs to obtain clarification.</p> <p>As a workers comp atty for 21 years, a certified workers comp specialist for several years, pro tem judge, and long time partner w/ a large defense firm, commenter has the experience and knowledge to know what this proposed regulation will result in—more litigation, not less. Commenter is completely opposed to this regulation.</p>		<p>November 5, 2008 Written Comment</p>	<p>protections adopted by the Legislature. These procedures apply only to unrepresented employee cases involving permanent disability and apportionment. Both of these issues are complex medical and legal issues in the workers' compensation system and, as explained above, the Legislature enacted procedural protections that recognize the unequal positions of the unrepresented employee and the defendant in addressing these complex issues. While it is correct that in the past delays occurred to budgetary and staff reductions, the Division is no longer subject to such budget and staffing fluctuations due to user funding.</p> <p>Commenter's reference to the requirement that defendant copy the injured worker with any letter sent to a QME that asks questions leading to a supplemental report is neither dispositive nor persuasive.</p> <p>From the experience of Workers' Compensation Administrative Law Judges and disability rating specialists who work in the Division, the Administrative Director has come to conclude that many unrepresented injured</p>	
--	---	--	---	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>employees wait until an initial permanent disability rating is issued by the DEU before considering whether or not to contact the Information and Assistance Officer, an attorney or a WCALJ. Such unrepresented injured employees do not understand the medical and legal issues sufficiently to know whether to object to the wording or arguments made by defendant in such a pre-rating letter to the QME. Therefore the Administrative Director believes the proposed wording which would limit such requests until after an initial DEU rating report is issued will provide the protection intended by the Legislature and still allow either party to ask for clarification, when needed, in the form of a supplemental report.</p> <p>In reference to commenter's concern about the need of the employer to provide permanent disability advances (PDA's), extract information from the QME report in order to accommodate work restrictions and determine whether supplemental job displacement benefits, this argument also is misplaced. In a workers' compensation claim, the defendant receives reports addressing</p>	
--	--	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>permanent impairment, permanent disability and apportionment first from the primary treating physician. The defendant's obligations to provide permanent disability advances and workplace accommodations arise first upon such findings by the primary treating physician (PTP). If the parties can resolve the case on the basis of the PTP's opinion, no QME report is obtained. If either party objects to the findings and conclusions of the PTP on any issue, the QME evaluation is obtained. In short, generally the employer will have the initial basic medical information from which the employer's obligations to advance permanent disability indemnity or make work place accommodations or be obligated to offer supplemental job displace benefits (SJDB) well before a QME is involved. Even if the QME's initial report is the first report to find permanent disability, permanent impairment or apportionment, again the existence of the permanent disability triggers the defendant's obligations to advance PDA's, offer job modifications or SJDB even if the full extent of PD is in dispute.</p> <p>The proposed subdivision 36(e), as</p>	
--	--	--	--	--	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				<p>edited here, only applies to cases involving QME reports finding permanent disability and apportionment. Labor Code section 4061(h)(1) requires the employer to begin paying permanent disability indemnity advances (PDAs) or promptly commence proceedings at the WCAB, such as when the defendant prefers to rely on the opinion of the primary treating physician on this issue. This requirement, first enacted in 1993, is not new. Pursuant to Labor Code section 4061(e) the summary rating report must be calculated and served within 20 days of receipt of the report. Even when the defendant wishes to challenge the percentage of permanent disability, permanent disability indemnity benefits are paid only weekly, not as a lump sum, allowing defendant time to request a supplemental report after the summary rating report issues. The delay, if any, until after the DEU has issued an initial summary rating report, is minor.</p> <p>Finally, in regard to workplace job accommodations, the proposed regulation does not preclude a QME from describing work activities that an injured employee may perform, which is the information most</p>	
--	--	--	--	---	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				relevant to determining the nature of any accommodation.	
36(e)	<p>Commenter is opposed to this section. QME reports often times lack significant information the parties require to obtain ratings and resolve cases. In such cases, supplemental reports typically cure reporting defects and enable the parties to expediently conclude cases. To require that the DEU, AD and/or a WCJ become involved before parties may obtain supplemental reports would cause substantial delays, increase costs and promote/require litigation. The WCAB is already behind and overwhelmed, particularly with the new EAMS program. To require hearings/requests/litigation before supplemental QME reports may be obtained would serve to further congest and burden the courts.</p> <p>From the applicant's perspective, commenter questions why this regulation was proposed, as it is not necessary to protect injured workers. In cases involving unrepresented workers, all apportionment provisions must be reviewed by a WCJ before any settlement will be approved, and WCJ's very closely scrutinize all settlements involving unrepresented workers, regardless of whether apportionment is at issue. The WCJ's ensure that medical evidence is sufficient and that settlements are consistent with the medical evidence. To that end, parties are going to require supplemental reports to ensure a complete/accurate medical record. I can conceive of no benefit to applicants in requiring WCAB action before supplemental reports may be obtained. In fact, it seems the burdens of increased delay and litigation would far outweigh any potential benefit this regulation might have for applicants.</p>	8A	J.V. Thatcher, Esq. November 4, 2008 Written Comment	<p>Rejected for the reasons explained above in response to comments about subdivision 36(e).</p> <p>Further, Workers' Compensation Administrative Law Judges have observed misleading statements and argument about how permanent impairment must be measured and calculated and how apportionment is determined in the letters to QMEs by some of the defendant representatives who request supplemental reports. Requiring the parties in an unrepresented case to wait until the DEU issues an initial summary rating report is reasonable and after such an initial report issues, the parties are able to request supplemental reports as needed. If appropriate, those supplemental reports may be rated by the DEU (see, 8 Cal. Code Regs. § 10160(f).)</p> <p>Finally, if the parties wait until a proposed settlement is being reviewed by a WCALJ who then determines that the supplemental reports issued by the evaluator were unnecessary and incorrect, the WCALJ would have to conclude the</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				evaluator's opinion does not constitute substantial evidence, disapprove the settlement and tell the parties to start over with a new panel QME. That delay is unwarranted and too great a burden.	
36(e)	<p>Commenter states that since the changes with the AMA rating process, now more than ever supplemental reports from the QME physicians are required. To remove this tool from the claims personnel would have a severe negative impact on their future claims handling capabilities. This will no doubt prolong the settlement process, create unnecessary litigation on cases and create more work for all the parties involved.</p> <p>A majority of the ratings issued are already incorrect as the DEU does not seek clarification. Therefore, physicians reports require checking and double checking the whole person impairment, charts, page number calculations etc. Commenter finds that the physicians are very confused with apportionment and or what records are required or being provided for supplemental reports. To prolong this process and make the claims adjusters wait (6) six months to a (1) one year makes no sense and is just wrong.</p> <p>Most claims offices do not wait for DEU ratings, as they attempt to resolve and settle their cases upon receipt of the QME with in house or outside ratings. To remove the benefit of seeking clarification will eliminate this proactive claims management technique from the industry. This process occurs months before a rating from the State is ever received. To now make claims personnel wait will create unnecessary back logs</p>	9A	<p>Jeff Dalton Claim Supervisor Contra Costa Risk Mgmt November 4, 2008 Written Comment</p>	<p>Rejected. The delay, if any, caused by proposed subdivision 36(e), will be minor, as explained above. The rule is not 'removing' a tool; it only delays obtaining a supplemental report on permanent disability, permanent impairment or apportionment until after the initial DEU summary rating has issued.</p> <p>In regard to the statement that the majority of DEU ratings are incorrect, the proposed regulation will not prevent an aggrieved party from either requesting a supplemental report from the QME once the summary rating has issued or filing a petition for a rating reconsideration as allowed by Labor Code § 4061(g) (and 8 Cal. Code Regs. §10164.), or proceeding to a hearing at the WCAB and cross-examining the rater about the rating.</p> <p>The proposed wording will not eliminate the defendant's option to obtain in house or outside ratings after the initial DEU summary rating</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>everywhere. Commenter opines that this change will definitely have a very negative impact on employers and administrators throughout the state. Besides the unnecessary cost with cases staying open longer, it might also trigger additional rounds of QME evaluations as reports become old and out dated.</p>			<p>has issued or to request a supplemental report from the QME after the initial summary rating. Unlike the claims administrator, the unrepresented injured worker does not have access to 'in house' or 'outside' ratings, and nothing in the law would require the defendant employer or insurer to pay for such a private rating even if the injured worker wished to obtain one. The delay due to waiting for the initial DEU summary rating is minor and provides the parties with an objective basis on which to resolve the claim or obtain more information or litigate further.</p>	
36(e)	<p>Commenter states that QMEs, however well-intentioned, don't even have time to read her cover letters to find out what questions she has, let alone things that come up after the initial report is issued.</p> <p>The proposed limitation will do nothing, except create additional delays, which cost the carriers, self-insureds, and everything in between money while we are waiting to get the AD, DEU or WCAB to allow the parties to get a supplemental report. On the other side of the coin, she opines that if she were an injured worker and wanted a surgery that she believes would help improve the quality of her life and allow her to return to work, and would have to play "AD or WCAB may we" request a supplemental report, the delay would seem unconscionable.</p>	10A	Sue Karp-Simmons Adjuster November 4, 2008 Written Comment	<p>Rejected. Commenter misunderstands and misapplies the impact of the subdivision.</p> <p>Nothing in the proposed subdivision 36(e) would preclude or prevent a party from requesting a supplemental report on the need for medical treatment or future medical treatment even before the DEU issues the initial summary rating on permanent disability.</p> <p>In addition, for the reasons stated above in response to other comments about this subdivision,</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>Commenter opines that system is bogged down enough as it is and requests that the Division not make it any harder by taking the only tool besides a deposition away from the defense to get clarification from QMEs.</p>			<p>the edited and clarified wording of subdivision 36(e) will mean that as soon as the initial summary rating is issued, a defendant may request a supplemental if necessary.</p>	
36(e)	<p>Commenter opines that this proposed change in the law concerning permanent impairment and apportionment would end up costing insurance companies more money to litigate the case. Furthermore, the injured worker will have to wait longer for the case to be resolved.</p> <ol style="list-style-type: none"> 1. This proposed law will require claims examiners to refer the case to defense counsel. 2. Defense counsel will have to file a DOR for a court hearing to clarify an issue in the Panel QME report. 3. The WCAB will have to set a hearing, and the defense counsel, as well as the unrepresented worker, will have to appear before a WCAB judge. 4. If the judge is persuaded by the need to get a supplemental report, then he or she will have to issue an Order for a supplemental report. <p>This process will take several months, delay the settlement of the case, cost the WCAB more money and time, cost the insurance carrier more money in defense attorney costs, and eventually cause everyone's insurance premiums to increase.</p>	11A	<p>Yasmine Borghei, Esq. November 4, 2008 Written Comment</p>	<p>Rejected.</p> <p>There is nothing intrinsic in the proposed rule 36(e) that will require claims examiners to obtain a defense counsel prior to getting the initial summary DEU rating.</p> <p>Defense counsel requesting a hearing is not the only option upon receipt of the initial summary rating. The defendant may petition for a rating reconsideration.</p> <p>Both parties should appear before a WCALJ when a hearing on a disputed issue, including permanent disability (PD), is held.</p> <p>If a WCALJ determines that the medical record must be further developed on an issue like PD or apportionment, an order for a supplemental report would be appropriate.</p> <p>While there may be some delay, the goal is to fairly resolve the benefits</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				that the injured employee is entitled to receive, including permanent disability benefits.	
36(e)	<p>Most stakeholders (including experts on the use of the <i>AMA Guides</i>, DEU raters) are in agreement that the vast majority of the impairment ratings performed by QME physicians are incorrect; therefore feedback from individuals with years of experience in the use of the <i>AMA Guides</i> is very useful. When provided with positive constructive feedback, it is appropriate for the QME physician to comment on their agreement or disagreement. This improves the outcomes for specific cases and contributes to learning.</p> <p>The Fifth Edition of the <i>AMA Guides</i> states:</p> <p style="padding-left: 40px;">Two physicians, following the methods of the <i>Guides</i> to evaluate the same patient, should report similar results and reach similar conclusions. Moreover, if the clinical findings are fully described, any knowledgeable observer may check the findings with the <i>Guides</i> criteria.</p> <p>Commenter's firm reviews thousands of impairment ratings per years with the goal to assure accuracy. His clients include claims organizations, defense attorneys, plaintiff attorneys, and governmental jurisdictions. His most recent data analysis of California ratings reveals in only 17% of the cases reviewed are we able to support the same percentage opined by the QME physician. If one defines a rating as being "substantially correct" by using a definition of the ratings being within 3 rating units of each other our reviews have shown that only 35% of California impairment ratings are "substantially</p>	12A	<p>Christopher R. Brigham, MD, MMD, FACOEM, FAADEP, CIME President/CEO Brigham and Associates November 4, 2008 Written Comment</p>	<p>Rejected. Commenter's first assertion regarding incorrect ratings is mere opinion.</p> <p>The proposed regulation as edited for clarity will still allow parties to request a supplemental report and will allow parties to obtain a supplemental report on these issues after an initial DEU summary rating has been issued.</p> <p>The Administrative Director is aware of commenter's firm and that it issues private rating reports for a fee upon request.</p> <p>The proposed regulation 36(e) will still enable the parties to obtain a correct, <i>unbiased</i> rating consistent with the <i>AMA guides</i>. The edited rule does not preclude requests for supplemental reports after the initial DEU rating has been issued.</p> <p>The proposed rule, as edited, also will not delay or preclude an party from immediately, within 20 days of receipt of the initial QME report, from objecting to the discussion on PD or apportionment in the report and requesting a supplemental</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>correct.” To improve accuracy it is essential that physicians be trained in the appropriate use of the <i>Guides</i>, that other stakeholders do not advocate for misapplication of the <i>Guides</i>, that physicians are provided with thoughtful constructive feedback on their reports (with an opportunity to respond to this feedback), and that the quality of the evaluators is monitored.</p> <p>Significant improvement is possible in California; however the proposed change will interfere with this opportunity for needed improvement. Commenter recently completed data analysis for a client in another state where we review every impairment rating received (primarily independent medical evaluations requested by a workers compensation insurer, 422 cases have been reviewed to date.) All impairment reports received by that client that were associated with ratable impairment were reviewed by impairment rating experts at Brigham and Associates, Inc. Each ratable report is reviewed to assess quality and inter-rater reliability, i.e. independent application of the AMA <i>Guides to the Evaluation of Permanent Impairment</i> criteria to the data provided should result in the same numerical rating. The success of this intervention has been excellent, with significant ongoing improvement, with 87% substantially correct in the first 2008 quarter, to 88% in the second quarter, and to 97% in the third quarter. In general the feedback by the physicians in that state is received positively in that it provides an excellent opportunity for them to improve their skills. Without a process consistent total quality management involving feedback this 97% rate of substantial compliance would never be achieved – rather the State of California would continue to experience unacceptable rates such as 35%.</p>			<p>report that addresses the claimed deficiencies in the initial report. Under the edited rule, that request will simply be sent to the DEU, rather than the evaluator. DEU will be able to consider the party’s arguments in issuing its summary rating, or in concluding that the report is unratable and directing the QME on the issues to be addressed in order that the report may be rated. Moreover, the rule, as edited, will still allow a party to petition for a rating reconsideration, or request a supplemental report after the rating has issued, or cross examine the rating specialist or the QME. Each of these remedies remains intact and the communication and education process discussed by the commenter will still occur. The feedback process the commenter refers to will still be able to occur.</p> <p>The four factors the commenter makes about the benefits feedback to the evaluator from rating services such as his will still be able to occur.</p> <p>Contrary to commenter’s concluding opinion, the Administrative Director believes that the edited proposed rule will give the parties the benefit of the initial DEU summary rating, as well as the benefit of any</p>	
--	--	--	--	--	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>It is probable that this improvement to 97% substantially correct rates relates primarily to four factors:</p> <ol style="list-style-type: none"> 1. It appears probable that the recognition by evaluating physicians that their reports are being peer reviewed results in more attention to the evaluation and preparation of a quality, supportable report. 2. When there is significant difference in a rating, providing that physician with a detailed report to serve as positive constructive feedback likely results in a better understanding of the <i>Guides</i> and improvement on future evaluations. 3. The identification of problem areas has facilitated designing specific training sessions and communications to the evaluating physicians. 4. By monitoring physician performance, it is probable that more referrals are being made to those physicians who historically perform higher quality and more reliable assessments. <p>The proposed changes to the QME regulations are directly counter to what has been clearly shown to be essential in achieving the goal of accurate, unbiased assessments of impairment. If we want to improve the degree of ratings that are “substantially correct” from 35% to 97% achieved in other jurisdictions, then it is essential to apply commonly accepted practices of total quality management.</p>			<p>subsequent changes due to supplemental reports on this issue that may be obtained after the initial rating has issued from DEU.</p>	
--	--	--	--	--	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>It is also probable that this proposed change will result in need for more depositions, i.e. rather than receiving response in writing it will be necessary for the QMEs to be deposed. Physicians rating impairment should welcome constructive feedback and the opportunity to respond.</p> <p>The proposed changes may not be perceived as positive by certain QME physicians (who prefer not to receive constructive feedback) and special interest groups, however will ultimately be detrimental to process of assuring accurate, unbiased impairment assessments and thus ultimately detrimental to the injured worker, the employer / insured, and the State of California. I encourage you not to make these changes that are contrary to the goals of having a fair, efficient and quality workers compensation system.</p>				
36(e)	<p>Commenter finds the proposed changes unrealistic – for both the employer and the injured worker. In his experience 25% - 50% of QME reports require clarification for some reason or another. That often means a supplemental report. To expect that the QMEs will get all the issues/answers correct on the first go around is unrealistic.</p> <p>The proposed changes would also simply end up being used as a sword by both sides. An employer who might be happy with an incorrect QME report would argue against the injured worker’s getting a supplemental report, and vice a versa.</p> <p>Lastly, this would just require more unnecessary hearings and litigation as parties now battle over another issue. i.e. whether somebody can get a supplemental report. More cases that weren’t litigated would now</p>	13A	Victor M. Andersen, Esq. Finnegan, Marks, Theofel & Desmond November 5,2008 Written Comment	Rejected. The proposed regulation, as edited, will allow the parties to request a supplemental report after the initial summary DEU rating has issued.	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

36(e)	<p>force parties to attorneys.</p> <p>Commenter strongly recommends that changes to section 36 not be approved. A substantial percentage of reports do not comply with the AMA Guides, and most are rated too high. Allowing only the AD to request a supplemental will result in higher litigation, prolonged case life, and artificially high PD ratings. This regulation is not the appropriate method for addressing the issue of deficient reports.</p>	14A	<p>Ian Stewart Quality Assurance Manager – Tristar Risk Management November 5, 2008 Written Comment</p>	<p>Rejected. The proposed regulation, as edited, will allow the parties to request a supplemental report after the initial summary DEU rating has issued.</p>	None.
36(e)	<p>Commenter opines that this section is overly restrictive and will delay resolution of PD/WPI and increase litigation, without necessarily benefiting the injured worker. If additional protection is deemed necessary, the required inclusion of Information & Assistance Officers should be sufficient.</p> <p>With the increasing complexity of case issues between the appropriate PDRS application, cause based apportionment, duplication/overlap issues between injuries, benefit years and PDRS, QMEs are increasingly challenged to properly execute their duties within the allotted time.</p> <p>Allowing the parties to point out demonstrable errors and omissions in the QMEs' reports provides early correction – or explanation – allowing the informal resolution of the benefit issues without the delays of the Administrative Director's review, directives and appeal.</p> <p>The bulk of carriers and TPAs seek to promptly resolve their cases without the extra cost of defense counsel. The medical evaluation procedures should facilitate the early procurement of QMEs' reports which are correct and complete. Preventing requests for supplemental comment would increase the incidence of litigation – and</p>	19A	<p>William R. Jones, Esq. Mullen & Filippi, LLP November 6, 2008 Written Comment</p>	<p>Rejected. The proposed regulation, as edited, will allow the parties to request a supplemental report after the initial summary DEU rating has issued.</p> <p>This rule will facilitate the parties' efforts to resolve a claim fairly with a minor delay until the initial summary DEU rating is issued.</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

36(e)	<p>further delay of benefits to the injured worker.</p> <p>Commenter objects to prohibiting the QME from submitting a Supplemental Report except under the specified circumstances. This would prevent the QME from correcting even self-discovered errors and would also not allow for reporting on additional records or reports from Consulting physicians as is regulated in Sec. 38 (g) and (h).</p>	20F	<p>Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment</p>	<p>Accepted in part. As edited for clarity, the proposed regulation 36(e) specifies ‘supplemental reports requested by a party’, so self-discovered errors could be corrected by the evaluator. Also this wording would enable the QME to issue a supplemental report upon late receipt of a consulting physician’s opinion.</p>	None.
36(e)	<p>Section 36(e) leaves out the opportunity to obtain additional information or clarification from the QME without invoking the formal process of requesting for reconsideration.</p> <p>Recommendation: Commenter recommends the deletion of section 36(e). Due to the current experience of AMA Guides reporting and formal ratings, there is a need for claims administrators to be able to request clarifications from the QME prior to the issuance of a summary rating.</p>	21D	<p>Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund November 6, 2008 Written Comments</p>	<p>Rejected. The proposed regulation, as edited, will allow the parties to request a supplemental report after the initial summary DEU rating has issued, if needed.</p>	None.
36(e)	<p>Commenter requests that this section be stricken from the proposed regulations.</p> <p>A QME may need to issue a supplemental report in order to provide a complete and accurate medical-legal report. An error or omission may be discovered by the evaluator or pointed out by the claims administrator. A supplemental report may be necessary and requested by the claims administrator to address new information, to clarify an issue, or to correct an error or omission in the report. Forcing claims administrators to go through the DEU or the Board will result in more QME depositions, benefit delays and significant additional costs.</p>	22F	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers’ Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. The rule as edited for clarity would allow a QME to issue a supplemental report to correct an error or omission; only requests by a party prior to issuance of the initial summary rating would be delayed until after the summary rating had issued.</p> <p>The proposed regulation, as edited, will allow the parties to request a supplemental report after the initial summary DEU rating has issued, if needed.</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>In order to properly manage claims and provide timely benefits, claims administrators must be able to request QMEs to supply missing information and clarification and to correct errors as soon as possible. Missing and incorrect information may not only result in incorrect permanent disability calculations, it may also delay return to work, medical treatment, and other benefits and raise associated costs. This cannot be permitted.</p> <p>With respect to permanent disability, according to feedback from CWCI members and the DEU, the AME Guides are incorrectly applied in most QME reports. Most reports are rated by the DEU with annotations of assumptions, require clarifications, and some reports are altogether unratable. The DEU does not catch all errors and many DEU ratings in various district offices are incorrect because of AMA Guide errors and miscalculations, and rule misapplications.</p> <p>Claims administrators will still need to review the reports for omissions and errors, and where a supplemental report is necessary, must request the DEU or the Board to ask the QMEs to submit supplemental reports to address deficiencies, additional records, or needed clarifications. The financial impact of the resulting unnecessary delays, costs, and duplicated effort, has not yet been addressed in the regulatory documents.</p>			<p>Nothing in the proposed rule as edited for clarity would prevent obtaining supplemental information on medical treatment issues or even descriptions of the work capabilities of an injured worker in order to implement job modifications and accommodations.</p> <p>In regard to the comments about errors not caught by DEU, the parties retain the existing remedies for such problems: 1) petition for a rating reconsideration; 2) request a supplemental report after the initial DEU summary rating has issued; 3) cross examine the rating specialist about the assumptions made in drafting the rating; 4) present the disputed interpretations to a Workers' Compensation Administrative Law Judge.</p> <p>The regulation as edited keeps intact the parties' respective remedies; it only slightly delays the time when a party may request a supplemental report on these important and complex benefit issues until after the DEU has issued a summary rating, which it is required to do within 20 days of receipt of the evaluator's report. (Lab. Code § 4061(e).) For this reason, the Administrative</p>	
--	---	--	--	--	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				Director does not believe it will lead to an increased cost.	
36.5	<p>Psychiatric QME/AME Reports are generally not for the purpose of self-exploration, but rather, their purpose is to clarify the medical-legal issues. The information in the report may be misunderstood or misinterpreted by an applicant who does not have a medical background. Psychologically damaging problems may develop if the report is served directly on an unrepresented applicant who may be emotionally fragile from the get go.</p> <p>Suggestion for §36.5 Commenter advises that the Regulations clarify that the Psyche Panel QME for an unrepresented applicant be submitted to the treating physician or their primary care physician. But, if they are represented, the language in the regulations should direct that the report be submitted to their applicant attorney or treating/primary care physician.</p>	2B	Janet Skiljo Haris, RN, MS – President MEDLink October 27, 2008 Written Comment	Rejected. Labor Code sections 4062.3(i) and 4061(e) expressly require the evaluator to serve a completed medical evaluation report on the employee. Under the regulations as currently proposed, the evaluator who makes a determination under Health and Safety Code section 123115(b) that the injured employee should not see the evaluation report will have a mechanism for both complying with the service requirements under the Labor Code and ensuring the evaluation report is served either on a physician designated by the injured employee or, where the employee is represented, on the employee’s attorney. There is no legal basis for unilaterally designating the physician upon whom the report should be served, as suggested by the commenter.	None.
36.5	Commenter suggest that they types of reports not be sent to injured employees, who probably do not have a medical background and the contents might disturb them and/or exacerbate their condition. Commenter recommends submitting the report directly to the treating physician and their attorney, if there is one. The treating physician may then determine if the report should be shared with their patient.	15D	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company November 5, 2008 Written Comments	Rejected. The treating physician in a workers’ compensation claim may or may not be a physician selected by the injured worker. Allowing the injured worker to designate a physician to review the evaluation report with ensures that the designated physician is in fact selected by the injured employee,	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				rather than by the employer. Such a designated physician is fully capable of determining whether, given the finding by an evaluator under Health and Safety Code section 123115(b), the report should be provided to the injured employee or provided the continued protection required by the Health and Safety Code.	
Section 36.5	<p>This section deals with evaluations involving a disputed injury to the psyche. As proposed, when the evaluator makes a determination pursuant to Health and Safety Code section 123115 (b) that there is substantial risk of significant adverse medical consequences from allowing the injured worker to see a copy of the evaluation report, the evaluator must inform the worker that a copy of the report may be served only on a licensed physician designated by the worker. Under both subdivision (a) and (b)(2), the worker must designate this alternative physician in writing prior to leaving the evaluator's office.</p> <p>Commenter believes that the requirement to make this designation before leaving the evaluator's office is both unnecessary and unwise. A similar requirement is <u>not</u> included in Health and Safety Code section 123115(b). Under that statute, a patient has the right to name another physician to receive the report, but is <u>not</u> required to designate this physician before leaving the office.</p> <p>Although it is likely the injured worker will usually designate his or her treating physician, commenter believes it is more appropriate to allow the worker a short period of time to consult with and get advice from</p>	18B	Mark Gerlach for Todd McFarren, President California Applicants' Attorney Association November 5, 2008 Written Comments	<p>Rejected. Unlike other medical records subject to a Health and Safety Code § 123115(b) finding, the medical-legal report must be served within a specified, limited period of time, e.g. within 30 days of the date of the examination unless an extension is granted.</p> <p>Also the Administrative Director is concerned that unless the evaluator obtains the employee's preference for service of the employee's copy of the report during the examination, there could be delays and confusion about whether the employee's failure to decide was good reason to delay serving the report. Nothing in section 36.5 would prevent an injured employee from changing his or her designation, if necessary, until the report is served.</p> <p>The injured employee is able to designate the primary treating physician, or another physician,</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>the treating physician regarding a consultation under these circumstances. Accordingly, he recommends that this section be amended to provide that the worker shall be requested to complete QME form 120 or 121 designating a consulting physician before leaving the office. However, in the event the worker declines or refuses to designate a physician before leaving the office, the worker shall be provided with a copy of QME form 120 or 121 and may return this form to the evaluating physician within 10 working days designating a physician to receive this report. Where the worker does not return this form timely, the provisions of proposed subdivision (k) would apply.</p>			<p>whether QME form 120 (voluntary directive for alternate service of the report) and QME form 121 (Declaration regarding Protection of Mental Health Record) is used.</p>	
<p>36.5(b) and (k)</p>	<p>As stated in 36.5(b), when an injury to the psyche is claimed and in the course of the evaluation, the evaluator makes a determination pursuant to Health & Safety Code 123115(b) that there is a risk of significant adverse medical consequence to the injured employee from seeing/receiving a copy of all or part of a mental health record, QME Form 121 must be completed and the injured employee advised of the determination and that the report can only be served to a licensed physician as designated by the employee.</p> <p>However, 36.5(k) makes it optional for the injured employee to decline this method of alternative service, thereby requiring the direct service of the protected medical record to the employee. The provisions of Health & Safety Code 123115(b)(2) makes it clear that the healthcare provider “to whom the records are provided for inspection or copying shall not permit inspection or copying by the patient.” The only way for a patient to know what is in the records is by reviewing them with a licensed healthcare provider.</p>	<p>21E</p>	<p>Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund November 6, 2008 Written Comments</p>	<p>Accepted in part. Deletion of the subdivision entirely will not address how the evaluator should serve a report when the injured employee’s condition does not warrant a finding under Health and Safety Code section 123115(b), and therefore is unworkable. However, clarifying wording will be added to subdivision 36.5(k) to provide that when the injured employee refuses or fails to designate a physician while at the evaluator’s office, the evaluator shall serve the employee’s copy of the report subject to the Health and Safety Code 123115(b) protection on the employee’s attorney, if represented, or on the employee’s primary treating physician.”</p>	<p>Subdivision 36.5 has been amended for clarity and consistency with Health and Safety Code section 123115(b) and the Labor Code, to read: “(b) (2) Advise the injured worker that the determination under Health and Safety Code 123115(b) has been made regarding the evaluation report as a mental health record and that the evaluator only may serve the injured worker’s copy of the evaluation report on a person</p>

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>Recommendation: Commenter recommends the deletion of 36.5(k). It goes against the provisions of Health & Safety Code 123115(b) which protects the patient from ‘substantial risk of significant adverse or detrimental consequences’ to himself and presumably to others around him. Allowing the employee to bypass this protective mechanism would expose the patient to the very risky consequences that the physician has warned against in the first place.</p>				<p>who is a licensed physician, as defined in Labor Code section 3209.3, whose name the injured worker <u>may</u> designate in writing prior to leaving the evaluator’s office, <u>or on the employee’s attorney, if any;</u>”</p> <p>.....</p> <p>“(k) In the event the injured worker declines or refuses or fails to designate any a physician in writing to be listed on either QME Form 120 or QME Form 121, the evaluator’s report shall be served the report as appropriate under section 36 <u>or section 36.5</u>, and within the time periods under section 38, of Title 8 of the California Code of Regulations, <u>except that the injured worker’s copy of the report which is subject to a finding under Health and</u></p>
--	--	--	--	--	---

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

					<u>Safety Code § 123115(b) shall then be served only on the injured worker's attorney, if represented, or if not represented on the injured worker's primary treating physician."</u>
36.5(k)	Commenter is concerned with the recommendation that the QME obtain an authorization for the release of medical information. It is his belief that the QME is required to file his/her report with or without this authorization. It would seem that requesting the injured employee's signature could indicate that the report will not be sent if he/she does not sign, thus creating a false impression. Commenter recommends deleting this recommendation and the Form listed in Sec. 125 because it is unnecessary and could easily be misleading.	20G	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Accepted in part to avoid creating a false impression in the injured worker's mind.	The sentence in subdivision 36.5(k) and proposed QME Form 125 are being deleted.
36.5(k)	Commenter recommends the following revised language: (k) In the event the injured worker declines or refuses to designate any physician in writing to be listed on either QME Form 120 or QME Form 121, the evaluator's report shall be served as appropriate under section 36, and within the time periods under section 38, of Title 8 of the California Code of Regulations. It is recommended that the evaluator serve the medical legal evaluation report with an authorization for release of medical information signed by the injured worker. A non-mandatory Authorization for Release of Medical	22G	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers' Compensation Institute November 6, 2008 Written Comments	Accepted for other reasons.	The language referring to the optional form and the proposed QME Form 125 have been deleted.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>Information form is available as QME Form 125 (Authorization for Release of Medical Information). (See, 8 Cal. Code Regs. Section 125.)</p> <p>It is inappropriate to ask an injured employee to sign a release of medical information form since the evaluator is <i>required</i> to submit the report to the claims administrator and, as applicable, to each party’s attorney, the PTP, and a designated physician. Offering the form may mislead the injured employee to believe that if s/he declines to sign the form, the evaluator need not send the report to the claims administrator and others.</p>				
38	<p>Commenter understands that the DWC supports QME/AME reports supported by substantial evidence and in compliance with current workers' compensation standards. Post reform AME reporting is exponentially complex, and usually accompanied by voluminous records. For the most part, the Panel QME rarely receives these complicated claims with multiple records and issues as most attorneys would rather appoint an AME. But if every report is devoid of consideration for complexity and has a rush thirty (30) day time frame with consequences of no payment or loss of QME status, most physicians may opt to do less medical-legal evaluations for status protection or continue this exodus. The unintended consequences of the rush time frame of less than sixty (60) days for complex cases would result in reduced appointments, lengthy wait lists for cancellations, or less QMEs/AMEs.</p> <p>Suggestion for §38: In view of exhaustive medical records, complex issues, and ‘good cause’ thresholds, a reasonable timeframe for AME reporting would be sixty (60) days to include Initial, Re-evaluation, and Supplemental QME/AME Reports. Commenter proposes</p>	2C	Janet Skiljo Haris, RN, MS – President MEDLink October 27, 2008 Written Comment	Rejected. Labor Code section 139.2(j)(1)(A) expressly provides and requires: “Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commended the medical evaluation procedure.” The section makes no exception for AMEs. The section directs the Administrative Director to adopt regulations governing extensions of this 30-day period when the evaluator has not received test results or consulting physician’s evaluations, or for good cause, which is defined as medical emergencies of the evaluator or evaluator’s family, death in the evaluator’s family or natural disasters or other community catastrophes. Accordingly, the	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>a thirty (30) day extension - total of sixty (60) days - for serving complex QME/AME Reports that meet 'good cause' thresholds.</p> <p>GOOD CAUSE THRESHOLDS FOR 30 DAY QME/AME REPORT EXTENSION: It is unclear as to what constitutes 'good cause' for the report extension as this is highly subjective. Also, there should be some flexibility that considers 'good cause' for significant case specific, professional, and personal emergencies. Consideration of realistic reporting time frames should be made based on the complexity of the claim. We understand that time frame extensions pose a difficult conundrum, and if too broad, the timelines becomes meaningless if everything constitutes "good cause."</p> <p>Good cause for a thirty (30) day QME/AME report extension post examination date may include: 1) Excessive voluminous medical records (more than 5 inches or 500 pages) submitted for review; 2) Multiple hours of surveillance films (more than 2-3 hours) submitted; 3) Numerous Dates of Injury (more than two) and Body Parts (more than two) to examine; 4) Complex Apportionment due to multiple dates of injury/body parts, and multiple co-defendants; 5) Failure to obtain timely authorization for diagnostic testing to finalize the issues; 6) Physician lengthy illness or lengthy sabbatical; 7) Physician personal, or professional emergency.</p> <p>Suggestions for Good Cause: Maybe there should be a higher fee to reward the extra burden of timely reporting, with fewer exceptions to the time limitations. Or, perhaps some type of appeal should be available for a "good cause" exception. Clearly, a case that involves</p>			<p>commenter's suggestion would require a statutory change.</p> <p>Moreover, failure of a QME to complete a report within these timeframes enables either party to request a replacement evaluator. (See, Lab. Code § 4062.5 and 8 Cal. Code Regs. § 31.5(a)(12).)</p>	
--	---	--	--	--	--

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	several thousand pages of records and multiple volumes of subrosa require more time than a standard exam. Delays can exist for additional testing, or additional records. Perhaps an initial report must still be issued within the deadlines summarizing the initial findings, but indicating what information is still needed for a final opinion? In conclusion, commenter suggests consideration of a thirty (30) day extension, total of sixty (60) day post date of examination, for submission of reports that meet 'good cause' thresholds.				
38	Commenter suggests that "good cause" be defined in clearer terms to prevent a subjective factor in the process. Commenter requests that the division consider allowing a thirty day extension under the following conditions pertinent to the individual case file under review: 1) voluminous medical records (over 300 pages); 2) more than 2-3 hours of surveillance films to review; 3) More than 2 dates of injury; 4) more than 3 body parts under review as well as apportionment determinations with more than 3 body parts; 5) awaiting additional diagnostic tests and 6) if the AME/QME examiner had an unexpected personal or professional emergency that prevented making the deadline.	15E	Tina Coakley, Legislative and Regulatory Analyst The Boeing Company November 5, 2008 Written Comments	Rejected. Each of those circumstances has existed throughout the many years that the time limits for completing evaluation reports have existed.	None.
38(h)	Commenter recommends the following revised language: (h) The time frame for supplemental reports shall be no more than sixty (60) days from the date of a written or electronically transmitted request to the physician by a party. The request for a supplemental report shall be accompanied by any new medical records that were unavailable to the evaluator at the time of the original evaluation and which were properly served on the opposing party as required by Labor Code section 4062.3. An extension of the sixty (60) day time frame for	22H	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers' Compensation Institute November 6, 2008 Written Comments	Rejected. The party agreement language was added in response to this commenter's comment on this subdivision in the preceding 15 day comment period. It is now clear that the commenter's intent is simply that there be no extension of time beyond 60 days even when both parties agree. That is not the intention of the Administrative Director.	To improve clarity, the Administrative Director will strike the party agreement process language added for the last 15 day comment period, as follows: “(h) The time frame for supplemental reports is

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p>completing the supplemental report, of no more than thirty (30) days, may be allowed without the need to request an extension from the Medical Director, as long as the evaluator contacts both parties at least fourteen (14) calendar days prior to the end of the sixty (60) day time frame and within seven (7) calendar days of being contacted, both parties agree to the extension in writing which is sent to the evaluator. Each party may send the evaluator their written agreement to the extension separately. However, if either party objects to the extension or if either party fails to respond to the evaluator at least seven (7) calendar days prior to the end of the sixty (60) day time frame, the evaluator must request the extension from the Medical Director by completing and submitting QME Form 112 (See, 8 Cal. Code Regs. § 112). The evaluator shall mail the completed QME Form 112 to the Medical Director no later than five (5) calendar days before the end of the sixty (60) day time frame above.</p> <p>This subsection is rather complex and confusing. Since no appointment for examination is involved and any new medical records are submitted with the request, 60 days provides a sufficient timeframe for the supplemental report.</p>				<p>unrepresented cases shall be no more than sixty (60) days from the date of a written or electronically transmitted request to the physician by a party. The request for a supplemental report shall be accompanied by any new medical records <u>that were unavailable to the QME evaluator at the time of the original QME evaluation and which were properly served on the opposing party as required by Labor Code section 4062.3.</u> in compliance with section 10160(f) of this Article. An extension of the <u>sixty (60) days time frame for completing the supplemental report, of no more than thirty (30) days,</u> may be agreed to by the parties <u>without the need to request an extension from the Medical Director.</u></p>
--	---	--	--	--	---

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
41(c)(7)	Commenter objects to the removal of the requirement that a consulting physician sign his/her report "under penalty of perjury and in compliance with Labor Code Section 4628". Commenter believes that a consulting physician must be held to the same standards as the QME and that it would be inequitable to expect the QME to attest in his/her report to the accuracy/veracity of another physician's examination/report.	20H	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Rejected. Consulting physicians may not be physicians who are familiar with the special declarations and attestations required of QMEs and AMEs in the workers' compensation system. Since the referring AME or QME must incorporate the consulting physician's report by reference into a report in which the evaluator discusses and comments on consulting physician's findings, and the referring evaluator must sign that report with the required declarations and attestations, the parties and the WCAB will have credible and admissible evaluation reports to rely upon.	None.
41(c)(7)	Commenter recommends the following revised language: (7) Write all portions of the report that contain discussion of medical issues, medical research used as the basis for medical determinations, and medical conclusions made by the evaluator. In the event more than one evaluator signs a single report, each signing physician shall clearly state those parts of the employee evaluation examination performed and the portions of the report discussion and conclusion drafted by the signing evaluator. Where a consultation report is obtained by an evaluator from a physician in a different specialty, the consultation report <u>shall be signed under penalty of perjury and in compliance with Labor Code</u>	22I	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers' Compensation Institute November 6, 2008 Written Comments	Rejected. Consulting physicians may not be physicians who are familiar with the special declarations and attestations required of QMEs and AMEs in the workers' compensation system. Since the referring AME or QME must incorporate the consulting physician's report by reference into a report in which the evaluator discusses and comments on consulting physician's findings, and the referring evaluator must sign that report with the required declarations and attestations, the parties and the WCAB will have	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	<p><u>section 4628(j), and</u> shall be incorporated by reference into the final report and appended to the referring QME's report.</p> <p>Commenter recommends that the Administrative Director retain the language deleted from the previous version, but change the Labor Code section form 4628 to 4628(j). Since the consultant's report will be incorporated into the evaluator's medical-legal report, the consultant's report should include the attestation from Labor Code section 4628(j), signed under penalty of perjury.</p>			credible and admissible evaluation reports to rely upon.	
QME Form 105	<p>Commenter requests that the Division replace "Claims Administrator/Employer" with "Claims Administrator."</p> <p>Only the unrepresented injured employer or the claims administrator may request a QME panel for an unrepresented employee. The definition of claims administrator in Section 1(j) encompasses situations where the employer is a self insured employer. If the employer is self insured, only the claims administration department of that employer may request the panel or otherwise handle the claim. Using the term "employer" as well as the term claims administrator may unwittingly result in a serious breach of the injured employer's medical privacy by the employer. A claims administration department of a self insured employer has a duty to safeguard the medical privacy of an injured employee and keep that information confidential from the rest of the employer organization. To avoid confusion and safeguard medical privacy, the term "claims administrator/employer," "claims administrator or if none, the employer," or other similar terms need to be replaced by "claims administrator."</p>	22J	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers' Compensation Institute November 6, 2008 Written Comments</p>	Rejected. As explained above in response to the objections to this phraseology, there are circumstances in which no claims administrator is involved but the employer is still legally obligated to act. The Administrative Director is aware that the workers' compensation insurers and third party administrators are quite effective and capable of informing their clients that they are administering a claim in order to avoid any duplication of efforts or confusion. Moreover, the Administrative Director believes these same insurers, third party claims administrators and in house claims administrators for self-insured employers have well established procedures in place to protect the personal medical information of the employer's	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

QME Form 106	<p>Commenter requests that the Division replace “claims administrator or employer” with “claims administrator”.</p> <p>Only the represented injured employer, the claims administrator or attorney representative may request a QME panel for an unrepresented employee. The definition of claims administrator in Section 1(j) encompasses situations where the employer is a self insured employer. If the employer is self insured, only the claims administration department of that employer may request the panel or otherwise handle the claim. Using the term “employer” as well as the term claims administrator may unwittingly result in a serious breach of the injured employer’s medical privacy by the employer. A claims administration department of a self insured employer has a duty to safeguard the medical privacy of an injured employee from the rest of the employer organization. To avoid confusion and safeguard medical privacy, the term “claims administrator/employer,” “claims administrator or if none, the employer,” or other similar terms needs to be replaced by “claims administrator.”</p>	22K	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers’ Compensation Institute November 6, 2008 Written Comments</p>	<p>injured employees.</p> <p>Rejected. This form applies when the injured employee is represented so it may be filed by the applicant’s attorney (or his or her client the injured employee) or the claims administrator or its defense attorney or the employer if there is no claims administrator or the employer’s attorney. The commenter appears confused in reference to this form.</p>	None.
QME Form 107	<p>Commenter requests that the Division delete “() 4061 and 4062” from the options for “Type of Exam.”</p> <p>Commenter can identify no occasion when this joint option would apply. If there is such an occasion, both the “() 4061” and “() 4062” option can be separately checked.</p> <p>Commenter thanks the Administrative Director for replacing “Ins./Adj./Agency” with “Claims Administrator” in this form.</p>	22L	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers’ Compensation Institute November 6, 2008 Written Comments</p>	<p>Rejected. QME forms 105 and 106 instruct the requesting party to check <u>one</u> reason for the panel request only. The references on this form correspond directly to the request that resulted in the panel being issued. This becomes especially helpful when the Medical Unit receives objections to a panel well after it has been issued.</p> <p>Further, this option may apply</p>	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

				when, for example, an defendant objects to the treating physician's opinion on the extent of permanent impairment, permanent disability or apportionment (under Lab. Code section 4061) and to the PTP opinion about the date the injured employee became permanent and stationary (under Lab. Code section 4062).	
QME Form 108	<p>Commenter requests that the Division delete the wording "at least" in the following sentence:</p> <p>a) Agree to wait, as long as the QME you selected is able to schedule your appointment at least within ninety (90) days of the date of your first call for an appointment; or</p> <p>"At least" is unnecessary, and confusing because "at least" implies 'no less than' and 'no more than' is the meaning intended.</p> <p>Commenter thanks the Administrative Director for replacing the term "claims adjuster" with "claims administrator."</p>	22M	<p>Brenda Ramirez Claims & Medical Director</p> <p>Michael McClain General Counsel and Vice President</p> <p>CA Workers' Compensation Institute November 6, 2008 Written Comments</p>	Accepted.	'At least' has been deleted.
QME Form 110	<p>Commenter recommends the following modification to make the last sentence conform with the language in the previous sentence and most of the other forms. Commenter appreciates that DWC has made this correction on most of the other forms and we believe the correction will significantly reduce potential confusion and the creation of a potential HIPAA threat.</p> <p>"To the Qualified Medical Evaluator: You are required by law to give notice on this form when an appointment</p>	20I	<p>Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment</p>	Rejected, for the reasons stated above in response to commenter's objection to this phraseology.	None.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	has been made with you to perform a QME comprehensive medical evaluation. Please complete this form in its entirety. You are legally required to include: the name and address of the employee, the name of the employer and claims administrator, and the appointment time and date. The Administrative Director also requires that you serve this appointment notification form on the employee and the claims administrator or, if none the employer,				
QME Form 110	Delete from the form "or if none the employer" in the introduction. The appointment notification should not be served on the employer if there is no claims administrator because to do so will breach the privacy of the injured employee for the reasons described in the discussion under QME form 106. Commenter thanks the Administrative Director for replacing the heading "INSURER or CLAIMS ADMINISTRATOR INFORMATION" with "CLAIMS ADMINISTRATOR INFORMATION" and replacing "CLAIMS ADMINISTRATOR/EMPLOYER (or attorney if known)" with "CLAIMS ADMINISTRATOR" on this form.	22N	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers' Compensation Institute November 6, 2008 Written Comments	Rejected, for the reasons stated above in response to commenter's objection to this phraseology.	None.
QME Form 111	The section heading "Claim Administrator" is spelled wrong. In addition, as this form is to be filled out whenever the QME serves each comprehensive medical-legal evaluation report, follow-up evaluation report, or supplemental report, commenter believes it would be helpful to include on this form a reference to the date(s) of any previous report(s) served by the QME in this case. A request for similar information could also be included on QME Form 122.	18C	Mark Gerlach for Todd McFarren, President California Applicants' Attorney Association November 5, 2008 Written Comments	Accepted in part.	The spelling of Claims Administrator has been corrected. In regard to QME Form 111, and to clarify the Event Dates section (items 9 – 12, item 12 will be re-lettered as '12A.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
					Date this QME Report Served on All Parties' and '12B. Date(s) of all Prior Reports Served by this QME'. Also on the instruction page, under Event Dates, the text is clarified by: "and date(s) report(s) served on all parties."
QME Form 111	Commenter requests that the words "or if none the employer" be removed in the Claims Administrator section. This is crucial in this case as the actual QME report could be submitted directly to the employer violating the HIPAA statute.	20J	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Rejected, for the reasons stated above in response to commenter's objection to this phraseology. The employer information is needed for other reasons.	None.
QME Form 111	Delete from the form "if none, enter Employer information" and delete from the instructions "or if none the employer." The evaluator report and summary form should not be served on the employer if there is no claims administrator. To do so will breach the privacy of the injured employee for the reasons described in the discussion under QME Form 106.	22O	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers' Compensation Institute November 6, 2008 Written Comments	Rejected, for the reasons stated above in response to commenter's objection to this phraseology. The employer information is needed for other reasons.	None.
QME Form 112	Commenter states that there are a number of problem areas in this form. First the form refers to Sec. 34 (h), but commenter believes that it should refer to Sec. 38 (h). Second, the request for a 30 day extension gives a reason of a delayed Consulting Report, yet Sec. 32 (f) states that a Comprehensive report should not be delayed for this reason. Third, commenter finds Sec. 38(h) to be quite convoluted and would recommend placing the	20K	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Accepted in part.	The reference to "34(h)" has been changed to " Review 8 Cal. Code Regs. § 38(h) regarding extension of time for supplement report." Also, after "Request

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	period of time allowed for the Supplemental Report extension and some reason examples on the form to assist the requestor.				Extension for Supplemental Report” the following is added for clarity “(maximum 30 days)”
QME Form 112	Commenter requests that this form be deleted and refers to their comments made in reference to section 36.5(k).	22P	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers’ Compensation Institute November 6, 2008 Written Comments	Rejected.	None.
QME Form 120	In the first check box option, it indicates that the cost of the office visit will be paid by the “employer.” Commenter recommends changing this to Claims Administrator for reasons previously stated.	20L	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Accepted in part.	For clarity and consistency, the phrase “claims administrator, or if none by” will be restored before the word “employer.”
QME Form 120	Commenter recommends the following revised language: By sending my copy to the following physician who will review it with me and will be paid <u>by the claims administrator</u> for an office visit for this purpose by my employer . The physician I name below can be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician named below will give me my copy of the report;	22Q	Brenda Ramirez Claims & Medical Director Michael McClain General Counsel and Vice President CA Workers’ Compensation Institute November 6, 2008 Written Comments	Accepted in part.	See response immediately above.

Section	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD	ID NO.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
---------	---	-----------	--------------------------------	----------	--------

	The office visit will be paid by the claims administrator rather than by the employer.				
QME Form 125	<p>The instructions do not apply in the Workers' Compensation setting and give the injured employee a wholly false impression.</p> <p>“By signing this form, you are giving permission for this physician and this medical group to release your confidential medical information. It is important to fill out the entire form to make clear what information you agree to release, to whom it may be released, the purpose(s) the person receiving the information may use it for, and how long this authorization to release your medical information will remain valid. If you do not sign an authorization such as this, the Confidentiality of Medical Information Act (and other statutes) require the physician or medical group to keep your medical information confidential, unless they are required to disclose it by law.”</p> <p>Please refer to his comments under Sec. 36.5 (k) for the rationale for recommending that this form be deleted in its entirety.</p>	20M	Steven Suchil Assistant Vice President American Insurance Association November 6, 2008 Written Comment	Accepted in part.	Form 125 and the references to it in the regulations have been removed.