

**ALPHA Fund**  
**Association of California Healthcare Districts**  
**Association of California Insurance Companies**  
**California Association of Joint Powers Authorities**  
**California Chamber of Commerce**  
**California Coalition on Workers' Compensation**

June 17, 2013

Maureen Gray  
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Department of Industrial Relations  
Division of Workers' Compensation, Legal Unit  
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**SUBJECT: COMMENTS REGARDING PROPOSED CALIFORNIA CODE OF REGULATIONS, TITLE 8, DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS: CHAPTER 1. DIVISION OF WORKERS' COMPENSATION: QUALIFIED MEDICAL EVALUATOR REGULATIONS: 15 DAY REVISION**

Dear Ms. Gray:

The above-listed organizations thank you for the opportunity to provide additional comments on the draft regulations on the Qualified Medical Evaluator (QME) requirements. Combined, our organizations represent tens of thousands of insured and self-insured public and private California employers and insurance companies.

As you are aware, SB 863 (Chapter 363, Statutes of 2012), set out a process that permitted certain workers' compensation benefits to increase while setting out a series of system reforms to fund the increased benefits. All employers, public and private sector, insured and self-insured, realize that the anticipated savings from SB 863 depends in large part on regulatory implementation by the Department of Industrial Relations, the Division of Workers' Compensation (DWC), the Office of Self Insurance Plans, and the Workers' Compensation Appeals Board.

The above-listed organizations (hereafter "Coalition") are dedicated to working collaboratively with regulators throughout the implementation process to ensure that employers across California receive the relief anticipated during the passage of SB 863 (De Leon, 2012).

### **Qualified Medical Evaluators**

As part of the reform package, SB 863 made certain changes to the qualified medical evaluator (QME) requirements. First, the new law places a reasonable limit on the number of offices a QME could operate. Instead of unlimited locations, a QME is limited to conducting qualified medical evaluations at no more than ten office locations.

Additionally, SB 863 set out that in cases in which the injured worker is represented by an attorney, there is no longer a requirement that the parties try to reach an agreement on an Agreed Medical Evaluator (AME) before seeking a QME panel. Additionally, in cases in which the injured worker is represented, the parties may agree to use an AME.

The intent language of the SB 863 noted, in part, in subsection (f)... *“The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time-consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of qualified medical evaluators can bias the outcomes. Timely and medically sound determinations of disputes over appropriate medical treatment require the independent and unbiased medical expertise of specialists that are not available through the civil service system.*

The comments below are made in response to the Division’s call for additional comments under the 15-Day Notice of Modifications, but again in the spirit of the intent language of the enacting statute, SB 863.

### **Article 1: General: Section 1: Definitions**

**Subsection (t): Future Medical Care:** (t) “Future medical care” means medical treatment as defined in Labor Code section 4600 that is reasonably required to cure or relieve an injured worker of the effects of the industrial injury after an injured worker has reached maximum medical improvement or permanent and stationary status including a description of the type of the medical treatment which might be necessary in the future. This opinion is not binding in any proceeding concerning an injured worker’s need for medical treatment which might be necessary in the future after maximum medical improvement status. The AME/QME opinion shall only be considered on the issue of future medical care which might be needed and shall not be considered on any past, current or continuing care treatment recommendations.

**Coalition Comment:** Agree with the modification to insert “as described in section 10606(d) of title 8 of the California Code of Regulations” at the end of the first sentence of the subdivision.

**Subsection (cc): Request for Factual Correction:**

(cc) “Request for factual correction” means a request by an unrepresented injured worker or a claims administrator, or their representative, to a panel QME:

- 1) to change a statement or assertion of fact contained in a comprehensive medical-legal evaluation that is capable of verification from written records submitted to a panel QME pursuant to section 35 of title 8 of the California Code of Regulations.
- 2) to address specific issues completely
- 3) to follow regulatory procedures for reporting established by the administrative director.

**Coalition Comment:** As noted in prior comments, the Coalition strongly urges the Division to take note of authorizing statute Labor Code section 4061 subsections (d)(1) The statute states that the parties may each request one supplemental report “seeking correction of factual errors in the report.” The Coalition believes the Request for Factual Correction process should support the correction OR clarification of factual errors regarding an issue that pertains to any/all benefits provided under workers' compensation.

The purpose of the reform of this statute by SB 863 was to allow the parties to obtain a **complete and accurate** report from the QME, on which all determinations of workers' compensation benefits are made. If this medical opinion fails to address all issues completely and accurately, an injured worker's benefits are then delayed and employer costs increase –both results are contrary to the intent of the stakeholders involved in the reforms discussions.

In fact, corrections or additional reports are permitted in every section of this rulemaking package, with the exception of Regulation 37. The Coalition does not understand why, in this critical area alone, corrected or updated medical information is barred. If this section is left unchanged, it begs that question of why bother seeking the permanent disability rating if the request will be rejected as incomplete. It makes no sense to be required to use a defective report when simple communication, as authorized by statute, could clarify relevant issues. Parties should be able to append medical reports or medical evaluations not previously sent to these report in order to cure a defective QME report in the most expeditious means available. This means the injured employee obtains benefits faster and reduces cost of the claim paid for by the employer.

To that end, the Coalition continues to strongly recommend that subsection (cc) be revised to include the requirements to 1) address specific issues completely as possible, as well as to 2) follow the reporting procedures set out by the Administrative Director of the Division of Workers' Compensation. Coalition recommendations are in **bold/underline/italics**.

**Section 31.7: Subsection 2: Obtaining Additional QME Panel in a Different Specialty**

~~(2) The AME or QME selected advises the parties and the Medical Director, or his or her designee, that she or he has completed or will complete a timely evaluation of the disputed medical issues within his or her scope of practice and areas of clinical competence but recommends that a new evaluator in another specialty is needed to evaluate one or more remaining disputed medical conditions, injuries or issues that are outside of the evaluator's areas of clinical competence, and either the injured worker is unrepresented or the parties in a represented case have been unable to select an Agreed Medical Evaluator for that purpose **Where an acupuncturist has referred the parties to the Medical Unit to receive an additional panel because disability is in dispute in the matter ;**~~

**Coalition Recommendation:** The Coalition continues to believe the regulatory section should be amended to delete the second reason listed to obtain an additional QME panel as it pertains to an acupuncturist QME needing a different specialty to evaluate disability. The Coalition believes that effective, July 1, 2013, acupuncture as a viable QME specialty is not likely to occur, making this section unnecessary and confusing.

The Coalition continues to be concerned that it is too easy to obtain multiple QME panels. Multiple panels are very expensive and add additional costs for employers. Multiple panels also delay claim resolution. The Coalition believes the Division should require an identified good cause as the basis for an additional panel and language be added to allow for the other party to object to any order issued if those factors are not met. For that reason, the Coalition recommends that language be added to allow a party to object to an Order issuing a QME Panel. Alternatively, delete 31.7(b) (3). The above again reflects the language strikeout recommended by the Coalition.

**Section 32: Subsection (a): Consultations**

**Consultations-Acupuncture Referrals**

~~**In any case where an acupuncturist has been selected by the injured worker from a three-member panel and an issue of disability is in dispute, the acupuncturist shall, notify the parties to the examination that another specialty is required to determine disability and refer the parties to the Medical Unit to**~~

~~request and additional panel pursuant to section 31.7(b) (2). request a consult from a QME defined under section 1(z) to evaluate the disability issue(s). The acupuncturist shall evaluate all other issues as required for a complete evaluation. If requested by the QME acupuncturist to obtain a QME to provide the consulting evaluation the Medical Director shall issue a panel within fifteen (15) days of the request in the specialty selected by the QME acupuncturist.~~

- (a) ~~(b) Except as provided in subdivision 32(a) above, n~~ No QME may obtain a consultation for the purpose of obtaining an opinion regarding permanent disability and apportionment consistent with the requirements of Labor Code sections 4660 through 4664 and the AMA Guides .

**Coalition Comment:** Coalition reiterates prior our comment made to the Divisions on this section. All references in Section 32 to acupuncturists should be eliminated. An acupuncturist is not now able to address disability issues. Per Regulation 35(g) (2), effective July 1, 2013, they cannot opine on disputed medical treatment issues. Therefore, as of July 1, 2013 there is no functional need to retain acupuncture as a QME specialty. The above reflects the language changes recommended by the Coalition.

**Section 37: Subsection (a) Request for Factual Correction of a Comprehensive Medical-Legal Report From a Panel QME .**

(a) An unrepresented employee, or the claims administrator may request the factual correction of a comprehensive medical-legal report within 30 days of the receipt of a comprehensive medical report from a panel Qualified Medical Evaluator.

(b) A request for factual correction ~~using the form in section 37(f) of title 8 of the California Code of Regulations~~ shall be served on the panel Qualified Medical Evaluator who examined the injured worker, the party who did not file the request and the Disability Evaluation Unit office where the comprehensive medical-legal report was served. If the request for factual correction is served by the claims administrator, the injured worker shall have five (5) days after the service of the request for factual correction to respond to the corrections mentioned in the request. The injured workers' response shall be served on the panel Qualified Medical Evaluator and the claims administrator.

(c) If the request for factual correction is ~~filed~~ made by the injured worker the panel Qualified Medical Evaluator shall have ten days after service of the request to review the corrections requested. ~~in the form and determine if factual corrections are necessary to~~ and ensure the factual accuracy of the comprehensive medical-legal report. If the request for factual correction is ~~filed~~ made by the claims administrator or by both parties, the time to review the request for correction shall be extended to 15 days after the service of the request for correction.

(d) At the end of the period for the panel QME to review the request for factual correction in subdivision (c), the panel QME shall file a supplemental report with the DEU office where the original comprehensive medical-legal report was filed. ~~indicating whether the factual correction of the comprehensive medical-legal report is necessary to ensure the factual accuracy of the report and, where factual corrections are necessary, if the factual changes change the opinions of the panel QME stated in the report.~~

(e) ~~In no event shall a party file any documents with the panel QME other than the form indicating the facts that should be corrected; nor shall the panel QME review any documents not previously filed with the panel QME pursuant to Section 35 of these rules.~~

(f) ~~Request for Factual Correction of a Unrepresented Panel QME report form. [Form 37]~~

NOTE: ~~Form referred to above are available at no charge by downloading from the web at <http://www.dir.ca.gov/dwc/forms.html> or by requesting at 1-800-794-6900.~~

[QME Form 37]

**Coalition Comment:** The Coalition would like to reiterate the concerns raised in prior comments. Labor Code section 4061, subsection (d) (1), which provides the statutory basis for this regulation, simply states that the parties may request a supplemental report “seeking correction of factual errors in the report.” The purpose of this procedure is to allow the parties to obtain a complete and accurate report from the QME, on which determinations of workers’ compensation benefits are made. If this medical opinion fails to address all issues completely and accurately, an injured worker’s benefits are delayed. It is in the best interests of the injured worker to cure a defective QME report in the most expeditious means available. If the report can be corrected by a supplemental report, then that is the preferred method.

The ability to correct factual errors by requesting a supplemental report by way of a written letter is allowed. Supplemental reports obtained in this manner are permitted when clarification or correction pertaining to LC 4060 issues (AOE/COE) and LC 4062 issues (nature and extent, parts of body) are needed. Parties can simply make the request in writing and submit relevant documentation for the QME's consideration. This same straightforward procedure should be used to address LC 4061 issues (apportionment) and should be used to cure an evaluator's failure to address and/or properly articulate an opinion on the issue of apportionment.

The regulatory requirement to complete Form 37 in order to request correction of an inaccurate or incomplete QME report does not expedite this process. The Coalition is also concerned that Form 37 unnecessarily limits access to information the QME may need to issue a corrected report.

In fact, corrections or additional reports are permitted in every section of this rulemaking package, with the exception of Regulation 37. The Coalition does not understand why, in this critical area alone, the provision of relevant medical information is barred. If this section is left unchanged, it begs that question of why bother seeking the permanent disability rating if the request will be rejected as incomplete. It makes no sense to be required to use a defective report when simple communication, as authorized by statute, could clarify relevant issues.

Parties should be able to append medical reports or medical evaluations not previously sent to these reports in order to cure a defective QME report in the most expeditious means available. Making this change will mean the injured employee obtains benefits faster and reduces cost of the claim paid for by the employer.

As written, the Coalition continues to believe proposed Section 37 and the accompanying Form 37 are certain to create additional delays in the payment of benefits, compel unnecessary litigation and waste scarce resources. The Coalition believes the Request for Factual Correction process should support the correction OR clarification of factual errors regarding an issue that pertains to any/all benefits provided under workers' compensation. The above reflects the language changes recommended by the Coalition to Section 37 and the recommendation of the deletion of Form 37.

## **Conclusion**

To summarize, the Coalition continues to recommend:

1. Revising the definition of Future Medical Care to ensure alignment with Labor Code 4600.
2. Revising the Request for Factual Correction to cure a defective QME report in the most expeditious means available;
3. Deleting of Acupuncture as a QME specialty to comport with current law;
4. Revising Form 31.7 to remove reference to acupuncture as basis for additional QME;

5. Revising Regulation 37 text to allow supplemental reports be requested via written letter and without Form 37;
6. Deleting Form 37.

The Coalition offers all of the above comments and clean up recommendations in the interest of helping the Division meet the primary goals of SB 863. These goals, strongly supported by the public and private sector employer community, are to reduce litigation, eliminate unnecessary or unreasonable barriers to claim resolution and unnecessary delays in the delivery of benefits to injured workers, and of high importance, to save employers sufficient dollars needed to fund scheduled benefit increases. We urge their incorporation to the regulatory package concerning Qualified Medical Evaluators by the Division.

Thank you once again for the opportunity to provide commentary on the proposed regulations.

Sincerely,



Julianne Broyles  
California Association of Joint Powers Authorities

cc: David Lanier, Chief Deputy Legislative Secretary, Office of Governor Edmund G. Brown  
Christine Baker, Director, Department of Industrial Relations  
Destie Overpeck, Acting Administrative Director, Division of Workers' Compensation