**Jason Schmelzer** May 14, 2021

California Coalition on Workers’ Compensation

The California Coalition on Workers’ Compensation (CCWC) is an association of California’s public and private sector employers that advocates for a balanced workers’ compensation system that provides injured workers with fair benefits, while keeping costs low for employers. Our members include not only businesses of every size, but also cities, counties, schools and other public entities. Thank you for the opportunity to submit comments on the draft regulations.

The proposed Medical-Legal regulations addresses several key issues surrounding the quality of qualified medical evaluators. We embrace the DWC’s desire to increase effort to ensure quality medical reports in a timely manner and our comments offer additional recommendations to accomplish this. High quality medical reports are critical to the efficient operation of the workers’ compensation system, and untimely low-quality reports can delay medical treatment and other benefits, increase friction and litigation, and drive-up costs for employers.

If a physician is objectively identified as providing substandard reports, then the DWC needs to have a formal process in place to take appropriate action. It is important for system stakeholders to have confidence in the QME process and the work product that is produced, and poor-quality reports shake that confidence. Employers, insurers, and claims administrators all have performance evaluations that hold them accountable and create an incentive for compliance. It is time for other system participants with critical roles to be held accountable for their adherence to standards.

Financial incentives drive outcomes. The current QME fee schedule does not encourage quality or timeliness. For example, the high fees paid for supplemental reports under the fee scheduled actually provide an incentive to provide an initial report that doesn’t resolve the claim. It is out experience that many QME’s do not find MMI recommending specific treatment be provided, specialist evaluation or diagnostics are needed. The Pre-Eval Communication section below addresses the need for diagnostics. Unfortunately, not having the right specialist evaluating the injured worker as a QME is limited by case law decisions. QME recommending specific treatment remains a concern.

The goal of the quality QME report is to be able to settle or bring the case to conclusion without requiring supplemental reports or depositions.

# **Availability of QME/Delays:**

The current method of selecting a QME has inherent delays and is particularly problematic as it does not account for the availability of the QME. As noted during the stakeholder meetings on this issue, many QME’s are continuously selected and thus their schedule is filled limiting them to appointments beyond the 120 days. This results in replacement panel requests, adding to the delay in resolution of the issues, delay of benefits to the IW and increased costs. All Stakeholders agreed that the QME should be able to advise of availability based on a full schedule in order that the selected panel is one that can avoid replacement due to unavailability. We recommend the DWC utilize a scheduling program of when the doctors are available as it may change the selection or at a minimum require the QME to notify of they are unavailable due to lack of full calendar.

# **QME Education:**

We agree with the increase in education for physicians, although we maintain that the required training, even with the increase remains insufficient to address the issues of quality reporting and consistency. We support the recommendations made by CWCI with respect to increasing the educational requirements to drive up the quality of QME reports.

We disagree with the proposal to reduce the training of chiropractors from 44 hours to 25 hours. Chiropractors as a whole require far less education to achieve their credentials as a chiropractor. Many lack understanding of basic medical terminology and abbreviations resulting in misinterpretation of medical reporting. Since chiropractors are now permitted to comment on injuries for which they are not specifically trained to treat, it is essential that they receive increased training in order to provide quality and consistent report in their roles as a QME. To this end we agree with the recommendations made by CWCI with the one deviation, that the training should include training in medical terminology and common medical abbreviations.

# **Bias Training:**

We support the anti-bias training contained in the proposed regulations. The elimination of bias of evaluating physicians will produce more accurate reports consistent with the AMA Guides. We further recommend you require physicians to provide proof of compliance with Business and Professions Code Sec. 2736.5 at the time of their reappointment as QMEs. To that end, we recommend adding a paragraph (7) to subdivision (c) of Section 50, to read:

(c)(7) attesting that the physician, if applicable, has completed course work on the understanding of implicit bias as required by Business and Professions Code Sec. 2736.5.

# **Electronic Service:**

We have no objections to electronic service and electronic reports by the QME and support that delivery so as to expedite to provision of benefits.

# **Quality Control:**

We believe as part of the quality control regulations that all reports should be produced within 1 week of the evaluation. We believe any delays between time of evaluation and report result in the QME forgetting important details. The closer in time to the evaluation that the report is drafted the better the quality of the report. Similarly, the immediate report preparation is less likely to result in a supplemental report to address the issues and inquiries previously raised by the parties. There is also a healthy precedent in that employers, insurers, and claims administrators have myriad requirements to complete tasks within specific periods of time. There is no reason that physicians shouldn’t be required to do the same when there is a good reason.

The QME evaluators need accurate and timely feedback in regards to the quality of their report. The current system does not provide that. In fact, the ex-parte issues forbid timely feedback to the physicians until the claim is completely resolved. Nevertheless, there should be some feedback to the QME, at least once the case is concluded.

A foundation of quality in any system is standardization of report formats and content. It allows the parties to know where to look to determine if issues raised have been addressed. Therefore, strongly recommend the DWC adopt a standardized format for QME reports that adheres to the Compliance Checklist periodically reviewed by the DWC for quality of evaluations performed by the QME (see proposed QME report format attached).

Standardization will allow the DWC a checklist to document compliance. As such, we highly recommend that a quality checklist be produced for all parties to utilize identifying the issues in dispute. However, it is essential that the QME be advised that the issue list is subject to more detailed explanation in the cover letters of the parties.

A standardized format for the cover letter will help the entire industry as the QME would then clearly know what they are looking for and where in the cover letters. To achieve higher quality, we recommend a cover letter should include all of the following in this order:

* Accepted body parts, injury.
* Has the IW been declared MMI by the primary treating physician or a secondary physician?
* If TPD what kind of transitional work restrictions should apply.
* Questions concerning PPD and apportionment.
* Need for future medical.
* The current employment status.
* Has the injured employee returned to work? Are there permanent work restrictions?
* A copy of the DWC RTW form, completed by the primary treating physician or secondary physician should be attached.
* Authorization for diagnostics:
	+ Either with a provider (and telephone number) to coordinate provision; or
	+ Permitting the QME to self-refer for diagnostics.

As part of a formalized cover letter format, we recommend the physician document the date the cover letter was received.

# **Complaint Form and Process**

There is an existing process concerning formal complaint process. Nobody knows how to complete a complaint as the DWC has failed to provide education on how to file a complaint.The existing process is cumbersome and labor intensive. Further, the DWC may not be aware that the practice has been to avoid providing physician “complaints” for fear of retaliation from the QME in the form of refusing to see the injured worker for this payer in the future. We submit that rather than focus strictly on complaints, we strongly recommend the form be revamped to a feedback report that offers opportunities for ongoing improvement. The Feedback form should be sent within 10 days of receiving the QME report in order to provide accurate and timely feedback to the QME to the quality of their report. Having a more ‘check list’ rating form will serve the payers and the providers with more objective feedback. The current system does not allow for this.

The DWC should offer on line training for how to complete the new Feedback form as well as the process for review and action to be taken with the QME. (or not)

Feedback on ex-Partee issues are even rarer. One of the things we recommend, at case conclusion is for the DWC to send the final determination of PPD to the evaluator with a copy of the feedback report.

# **New Appointments**

All new QME should have their initial five reports reviewed with feedback by DWC for their quality and accuracy to ensure that they are producing a quality and accurate report. Providing feedback to the new QME is essential to their development and to insuring they produce quality reports.

# **Re-appointment**

§50 (g) We request the DWC clarify the regulation to be more specific. Will the reports be read? Is there a feedback loop?

We recommend an addition to rule §51 by requiring the DWC to track all complaints by party. The DWC would also be required to review those complaints when they come in and before re-appointment. (see complaint form referenced below)

If there have been questions concerning quality or timeliness of evaluations, there should be a higher standard for review and re-appointment. For example, the number of complaints, level of complaints and demonstration of improvement to the respective complaints.

# **Quality Assurance**

In most every system there will be outliers, those whose reports do not provide the quality or consistency needed by an evaluator. Therefore, we suggest DWC consider utilizing an analytics tool to determine the outliers and take appropriate action.

The process for filing a QME complaint is time consuming and as such many are not filed. We previously suggested that page two of the complaint includes several drop-down boxes that note the regulation under which a complaint can be filed (a third page or attachment will be needed for the complainant to list supporting facts). This will enable the user to ensure that their complaints are based on regulations that permit the DWC to take actions and will permit the user to ensure that the facts support those allegations. This will streamline the process for the complainant and will likely minimize erroneous complaints.

It should be noted that many employers and claims are afraid to make comments for fear of retribution in the next reporting from the QME. We recommend the complaint form/process be renamed as a Feedback form to report the positive and negative feedback. There should be a formal process when complaints are submitted with a timeline for DWC to provide direction to the QME.

An alternative to the Complaint form might be to rename the form as a QME feedback form, allowing the form to contain both positive and negative feedback. Perhaps one way to ensure quality physicians is to identify those providing the best quality reports and to provide recognition to these physicians.

If there is an aggregator (QME management company) involved in the process, the aggregation companies should be held accountable for the quality and timeliness. We recommend that these aggregators should be required to share all their quality assurance programs with the DWC.

# **Pre-Eval Communication**

If there is going to be a need for diagnostics by the QME, it is highly recommended the following:

* The QME communicate the need prior to the eval to both parties, based on early review of the records.
* If during the eval, the need for additional diagnostics is found to fully address impairment, then there should be an easy process to request/authorize that request in an expedited fashion (i.e. pre- authorization within defendants cover letter with a number of the provider to be contacted for scheduling of the diagnostics).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gabor Vari, MD, Chief Executive Officer** May 14, 2021

California Medical Evaluators

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

(1) We recommend that the increased requirement of 16 hours of education required for initial appointment or reappointment not go into effect until 2022. Education course providers will need to time to update courses to come into compliance with the increased requirements.

Additionally, there are many prospective QMEs who have recently taken the April 2021 QME competency exam and have successfully completed their 12 hour report writing course certificates. These prospective QMEs have not yet received their examination results and therefore are not yet eligible for appointments as QMEs. They should not be required to fulfill this increased requirement in order to become appointed as QMEs. First, there is the practical issue of a lack of currently available courses which conform to these increased requirements. Second, these physicians should not have a last minute barrier to entry into the QME system placed in front of them. A future implementation date for these increased requirements would avoid such an outcome.

(2) In subsection 31.3(f), we recommend that the terms "initial examination" and "supplemental examinations" be replaced with the terms "Comprehensive medical-legal evaluation" and "Follow-up medical-legal evaluation" as defined in CCR 9793 in order to maintain consistency of terminology throughout the regulations.

(3) Regarding regulation 36.7, we applaud the Division for creating a framework for QMEs to compliantly serve their medical-legal reports electronically. This regulation will help injured workers and employers move their workers’ compensation claims toward resolution by avoiding delays or disputes associated with service by mail. However, in our eyes, the regulation does not go far enough as it requires each party to "opt-in" to accept electronic service.

We recommend that electronic service be allowed unconditionally similar to electronic billing.

Claims administrators have been required, by statute, to accept electronic medical bills since 2012. Claims administrators should be required to accept electronic medical reports today. Millions of pages of paper are needlessly wasted each year due to California's byzantine requirement to serve medical-legal reports by mail. In our experience, "opt-in" simply does not work and we are concerned that mail service will remain the norm so long as DWC does not require carriers to accept electronic service of medical-legal reports.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Suzanne Honor-Vangerov, Esq., CPC, CPC-I** May 14, 2021

Thank you for giving us an opportunity to comment on the proposed regulations.

I have only one comment related to the section below. In the newly added section "f" the language indicates "supplemental examination". I believe the terms "follow-up" or "subsequent" evaluation is better based on the structure of the medical-legal fee schedule language and to keep the two sections consistent. Under the fee schedule "supplemental" refers to an evaluation which doesn't involve an appointment or a physical examination of the patient. It also keeps it consistent with section "e".

**ARTICLE 3. ASSIGNMENT OF QUALIFIED MEDICAL EVALUATORS, EVALUATION PROCEDURES
§ 31.3. Scheduling Appointment with Panel QME.**

(e) If a party with the legal right to schedule an appointment with a QME is unable to obtain an appointment with a selected QME within sixty (60) days of the date of the appointment request, that party may waive the right to a replacement in order to accept an appointment no more than ninety (90) days after the date of the party's initial request for an appointment ~~request~~. When the selected QME is unable to schedule the evaluation within ninety (90) days of the date of that party's initial request for an appointment ~~request~~, either party may report the unavailability of the QME and the Medical Director shall issue a replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations upon request, unless both parties agree in writing to waive the ninety (90) day time limit for scheduling the initial or subsequent evaluation.
Note: Authority cited: Sections 133, 139.2 and 5307.3, Labor Code. Reference: Sections 4060, 4061, 4062, 4062.1, 4062.2, 4064 and 4067, Labor Code.

(f) The provisions of subdivision (e) of this regulation apply to both requests for an initial examination by a QME and requests for supplemental examinations by a QME.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Jackie Secia, Claims and Medical Director** May 14, 2021

California Workers’ Compensation Institute (CWCI)

The California Workers’ Compensation Institute offers the following comments:

The Institute recommends that the Division follow the lead of the WCAB in its recent revision to its Rules of Practice and Procedure by also adopting the use of the singular “they” as a gender-neutral pronoun where appropriate. This would be in keeping with Assembly Concurrent Resolution 260, which encourages state agencies “to use gender-neutral pronouns and avoid the use of gendered pronouns when drafting policies, regulations, and other guidance[.]” As the WCAB pointed out in its FSOR, many other organizations have adopted the singular they as a gender-neutral pronoun. Most of the major style guides accept the use of the singular they as a gender-neutral pronoun. The Associated Press, for example, approved of the singular they as a gender-neutral pronoun in 2017, noting that “[t]hey/them/their is acceptable in limited cases as a singular and/or gender-neutral pronoun, when alternative wording is overly awkward or clumsy.” The MLA style guide followed suit in 2018, noting that “constructions such as “his or her” are often cumbersome, and some writers may find singular, gender-specific constructions insufficient, given that many people do not identify with a particular gender. Using plural constructions, if possible, is often the best solution—and the most inclusive one[.]” More recently, Merriam-Webster expanded its definition of “they” to specifically include usage as a singular, non-gendered pronoun. The use of “they” as a singular, non-gendered pronoun is so widespread both in print and in speech that it often passes unnoticed. In order to avoid the cumbersome “he, she, or they” the Institute recommends that less grammatical damage will be caused by the use of “they” in these and other forthcoming regulations.

**Section §1(o):**

Rather than limiting the role of the DEU to “issuing summary ratings,” we recommend that the definition should read, “DEU is the Disability Evaluation Unit under the Administrative Director pursuant to §10150 of Title 8 of the California Code of Regulations.”

**Section §1(s):**

Reference to “Section 9793(f)” should be corrected to “Section 9793(g),” consistent with the Medical Legal Fee Schedule that took effect April 1, 2021.

**Section §1(ff):**

Reference to “Section 9793(l)” should be corrected to “Section 9793(m),” consistent with the Medical Legal Fee Schedule that took effect April 1, 2021.

**Sections §§11(a)(4) and (b)(1):**

Oversight of the initial appointment of a QME is essential to furthering the stated goal of the Division to improve the quality of evaluators and their written reports. The Institute recommends that these sections should also require first-time applicants to be granted a “provisional,” rather than permanent, appointment status for a period of two (2) years. During this time period, the provisionally appointed QME applicant shall be required to serve a redacted copy of each report on the Director of the Medical Unit (MU), concurrent with service on the parties, after having been selected as a QME from an assigned panel under §4062.1 or remaining on the panel after the striking process has been completed under §4062.2. The Medical Director and the investigative division of the MU would then be required to continuously review submission of reports for content and quality and provide feedback to the provisional QMEs when the reports are determined to be insufficient. At the conclusion of the provisional appointment period, the QME may seek reappointment and permanent status pursuant to section 50. Conversely, if during the provisional period, the Medical Unit has determined that reports are insufficient as to content and quality and/or complaints have been received pursuant to section 60(c), the provisional QME applicant may be denied reappointment pursuant to section 51.

We believe that an initial “provisional” status is critical to ensuring quality of medical-legal reports and is within the regulatory authority of the Division since it is vested with the authority to implement “any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator,” under §§139.2(b)(7) and (j)(6). Likewise, pursuant to §139.2(i), the Medical Director is required to “continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted.”

**Section §11(f)(9):**

The Institute recommends changes to this section as follows:

“An applicant who fails the exam one time shall show proof of having completed eight (8) hours continuing education from a course approved by the Administrative Director prior to taking the examination again.”

**Section §11.5(i):**

It has been the Division’s stated intention to reduce frictional disputes and improve the quality of report writing when proposing amendments to regulations applicable to the QME or Medical Legal Fee Schedule process. The quality of instruction and the duration of training required of new QME applicants necessarily impacts the quality of the evaluator’s report, which is critical to the efficient functioning of the California workers’ compensation system. Yet, the Division proposes only to increase the required completion of course training preceding appointment as a QME by 4 hours (*i.e.*, from 12 to 16 hours) under proposed §§11(b)(1) and 11.5(i).

Because improvement of quality report writing and consistency of instruction by accredited education providers covered in §11.5(a-h) is the desired outcome, it must be recognized that the detailed curriculum covered in §11.5(i)(1-10) cannot reasonably be included or adequately instructed within the proposed 16-hour requirement.  As such, insufficient training may continue to be a contributing factor to the poor quality of medical legal reports.  Moreover, we believe that initial educational requirements for a new QME applicant should be substantially greater than the continuing education requirements for established QMEs as set forth in §55.

We urge the Division to increase the minimum course requirement to thirty (30) hours. Other key industry participants are required to complete much more extensive curriculum training on similar topics in order to meet their basic qualification standards. For example, Workers’ Compensation Claims Adjuster certification requires 160 hours of initial training followed by 30 hours of continuing education every 2 years (§§2592.02 and .03). Medical-Only Adjuster certification requires 80 hours of initial training followed by 20 hours of continuing education every 2 years (§§2592.02 and .03). Likewise, Medical Bill Reviewer certification requires 40 hours of training followed by 16 hours of continuing education every 2 years (§2592.04). The State Bar of California requires 45 initial and 36 hours of continuing education (MCLE) training every 3 years for attorneys who have satisfied the requirements for legal specialization in workers’ compensation.

The number of hours required for claims adjusters and bill reviewers is indicative of the complexity of the California workers’ compensation system.  In order for a physician to become familiar with the requirements that will enable them to perform adequate evaluations and create reports that provide the basis for impairment ratings and disability compensation, more training must be required. We have the following proposal.

**Section §11.5(i)(1-9):**

To promote consistency and quality of instruction offered by different accredited education providers described in §11.5(a-h), the Institute recommends re-organization of this section with mandatory completion of instruction according to specific core topics to satisfy course requirements. As currently constructed, the proposed section would not ensure uniformity of instruction by accredited education providers for all QME applicants. Instead, we recommend that the minimum thirty (30) hours of instruction in disability evaluation report writing should be structured to adequately address the proposed curriculum of training as follows:

* Four (4) hours of instruction [2 hours mandatory] – The QME Process and the Role of the Evaluator
* Eight (8) hours of instruction [4 hours mandatory] – Medical Legal report writing and the Anatomy of a Medical Legal Report
* Two (2) hours of instruction – The Medical Treatment Utilization Schedule (MTUS), adopted by the Administrative Director pursuant to Labor Code §5307.27 and §9792.20 et seq. of Title 8 of the California Code of Regulations
* Two (2) hours of instruction [2 hours mandatory] – Anti-bias training which satisfies the content requirements set forth in §11(h)
* Eight (8) hours of instruction [8 hours mandatory] – Evaluation of disability in California pursuant to §§4660 and 4660.1 allocated as follows:

	+ Two (2) hours of instruction for dates of injury not subject to AMA Guides impairment rating
	+ Six (6) hours of instruction for dates of injury on/after 01/01/05 and exceptions that apply for dates of injury prior to January 1, 2005 - *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*
* Six (6) hours of instruction [3 hours mandatory] – Review of workers’ compensation case law and apportionment of disability pursuant to §§4663 and 4664

**Section §11.5(i)(10):**

The Institute recommends that §11.5(i)(10) should not be included in or credited toward the hourly curriculum requirements set forth in §11.5(i), but rather submission of a medical-legal report and critique by an accredited education provider should be added to §11 as a condition of eligibility for initial appointment as a QME.

**Section §11.5(i)(5):**

This section recommends training covered in “§§9725 through 9727 of title 8 of the California Code of Regulations.” We suggest that there should be conformity with concurrent DEU proposed regulations (1st Forum comment period closed 04/07/21) that intend to repeal and replace these same sections with new proposed §§10145 through 10147.

**Section §14:**

All chiropractors are subject to the workers’ compensation evaluation certification under §§11(a)(4) and 14(a) as a condition for QME appointment. While the type of chiropractic training and instructors who provide it may be exempt under §11(b)(1), we are not clear as to which section of §11.5 the Division is referring, since the section also includes requirements for accreditation of education providers. As such, the Institute would recommend that this section specifically refers to §11.5(i).

The Institute is concerned that the Division has chosen to reduce required course hours from 44 to 25 hours and anticipates that this may result in loss of competency of chiropractic evaluators who are also assigned to QME Panels. For this reason, we recommend that there be no reduction or adjustment to the current 44-hour education requirement.

We also recommend revisions to proposed §14(b)(4) such that in addition to the 8 hours of overview training in workers’ compensation [§14(b)(3)] and 2 hours of mandatory anti-bias instruction (§14(b)(4)(E)], the remaining course hours at a minimum shall include the following mandatory training:

* Four (4) hours of instruction – Review of workers’ compensation case law; and
* Eight (8) hours of instruction – Evaluation of disability in California pursuant to §§4660 and 4660.1 allocated as follows:
	+ Two (2) hours of instruction for dates of injury not subject to AMA Guides impairment rating
	+ Six (6) hours of instruction for dates of injury on/after 01/01/05 and exceptions that apply for dates of injury prior to January 1, 2005 - *AMA Guides to the Evaluation of Permanent Impairment, 5th edition*

The Institute also recommends that submission by the chiropractic applicant of a medical-legal report and critique by an accredited education provider should be required as an additional condition of eligibility for initial appointment as a QME pursuant to §11(a)(4) and should not be included in or credited toward the required 44 education hours to satisfy course completion.

**Sections §33(a) and §51(a)(3):**

Proposed §51(a)(3) provides a discretionary opportunity for the Medical Director to deny reappointment to physicians who list themselves as unavailable in excess of 90 days during the calendar year.  The Institute understands the tension between the Division’s need to ensure that the QME physicians are actually making themselves available as part of the system, and the need of those physicians to ensure that they are not over-promising their availability to the point that they end up doing a disservice to the system in the long run.  In hopes of reconciling the competing interests, the Institute suggests that language be added to §33(a) to include fully booked schedules as a “good cause” justification for the unavailability.  Clearly stating that lack of availability due to medical-legal evaluations already on calendar will permit conscientious (and fully participating) physicians from becoming overextended without facing the risk of a denial of reappointment.

**Section §51:**

The QME Investigations and Enforcement Section reviews complaints regarding QME physicians to determine qualifying and disqualifying factors relevant to QME certification. At the time of reappointment, all such complaints received by the Medical Director should be included in the review to determine if the reappointment of the QME is supported or should be denied.

Therefore, the Institute recommends adding new subsection §51(a)(15) that states, “upon referral of a credible complaint or complaints filed by the public on QME Complaint Form (rev. 12/08) or referred by the Medical Director pursuant to §60(c) of Title 8 of the California Code of Regulations.”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Peter Spalding, Network Specialist** May 13, 2021

Liberty Mutual Insurance

On behalf of Liberty Mutual Insurance, we very much appreciate the Division’s work to improve the Qualified Medical Evaluator (QME) regulations. We welcome the opportunity to help spur improvements benefiting California’s injured workers and employers.

In short, we view the proposal as a step in the right direction, though it stops short of addressing some of the concerns we had previously identified. (Please see our prior letters regarding the Medical-Legal Fee Schedule, specifically our DWC Forum comments dated July 9, 2020, as well as our formal public comments dated December 4, 2020.) **[Available upon request.]** We support the current proposal but recommend expanding it to include additional reforms.

Our data continues to show that California’s Workers Compensation medical-legal evaluations are unusually costly compared to other states. This remains the case even after accounting for California’s large population.

In 2020, our data showed that the costs of California medical-legal evaluations accounted for more than 30.6% of the costs of medical-legal evaluations throughout the United States.[[1]](#footnote-1)

California’s costs were more than triple those of the next-costliest state, namely New York, which constituted 9.2% of the national total. In 2019, the discrepancy was even more extreme though the pattern was the same: California accounted for more than 54.4% of the nationwide total, followed by New York at 5.2%.

Even those numbers are likely conservative, since they don’t include other medical-legal expenses such as copy services, which are also unusually high in this state. California’s costs are also likely to increase in the future, given the higher reimbursement rates under the new Medical-Legal Fee Schedule effective April 1, 2021.

Unfortunately, these added costs have not resulted in higher-quality reports. We define quality reports as those that constitute substantial medical evidence, comply with all applicable rules and regulations, and minimize the need for supplemental reports, depositions, or other forms of discovery. In fact, poor-quality reports are common cost drivers, since they increase litigation expenses and other frictional costs.

With that in mind, Liberty Mutual Insurance recommends the following improvements:

# We support the proposal’s more rigorous continuing education requirements as outlined in the proposed 8 CCR 55(b), though we recommend instituting additional requirements.

* + Continuing education is one of the most important tools to ensure that QMEs are well-informed and that they are prepared to write high-quality reports. This is especially true now that the new Medical-Legal Fee Schedule has increased QME reimbursement rates; i.e., if the costs go up, the quality should go up accordingly.
	+ We recommend increasing the minimum continuing education requirement to at least 20 to 25 hours of instruction for each two-year QME appointment. The current proposal increases the requirement from 12 to 16 hours every two years, but that remains well below the continuing education requirements for other system stakeholders. For example, California Workers Compensation claims adjusters must complete 30 hours of continuing education every two years, and attorneys must complete 36 hours of Minimum Continuing Legal Education (MCLE) every three years. QMEs should be subject to similar requirements.
	+ We also recommend requiring QME continuing education to include at least one hour of instruction regarding changes or updates to California’s Workers Compensation system. For example, we continue to encounter QMEs who are unfamiliar with the reforms in Senate Bill 863 (2012) even though those provisions were enacted more than eight years ago and were widely publicized throughout the industry. The current proposal touches on this issue by requiring instruction in “case law” but the language is so broad that it may not have its intended effect.

# We continue to recommend more clearly defining the rules around which records should be sent to the medical-legal examiner.

* + This issue came up repeatedly during the rulemaking process for the new Medical-Legal Fee Schedule, including informal stakeholder meetings as well as formal public comments. The current proposal presents a prime opportunity to resolve those concerns and lay out clear ground rules for all parties.
	+ As noted in our prior letters, the language in Labor Code 4602.3 is so broad that it often leads to disagreement, and the underlying regulations in 8 CCR 35 provide little or no clarification. In practice, this often results in the parties sending all available records to the examiner for review, which can amount to thousands of pages. Under the new Medical-Legal Fee Schedule, those record reviews are now billed at $3 per page above a certain threshold (usually 200 pages).
	+ We recommend modifying 8 CCR 35 to clarify these requirements.
		- By definition, a medical-legal examination exists for the purpose of proving or disproving a contested claim, pursuant to Labor Code 4620. Therefore, the records sent to the examiner should be treated similarly to trial exhibits: they should be organized and curated to illustrate the issue(s) in dispute, and avoid duplicate or irrelevant information.
		- Certain records should be presumed irrelevant absent evidence to the contrary. The parties should only be allowed to send them upon mutual agreement, or when ordered by the Workers’ Compensation Appeals Board or the Administrative Director. Examples include, but are not limited to, billing records, fax cover sheets, or other administrative records; physical therapy notes; reports of follow-up appointments that show no change in diagnosis, prognosis, work status, or treatment plan; and medical history that is unrelated to the contested issue(s) on the claim.
	+ We also recommend instituting a cap around the amount of records sent. The above-noted 200-page threshold should suffice for the vast majority of Workers Compensation cases. The parties should only be allowed to send additional records upon mutual agreement, or when ordered by the Workers’ Compensation Appeals Board or the Administrative Director.

# We continue to recommend clarification around when a treating physician can bill a medical-legal code, as opposed to a treatment report code such as WC004.

* + The proposed regulations contain no language around this. The main legal authority on this issue is the above-noted Labor Code 4620-4621. However, that language is also very broad and is difficult to apply in practice.
	+ We often see a small subset of physicians billing medical-legal codes for things like Utilization Review (UR) disputes. This contradicts Labor Code sections 4061 and 4610.5, which expressly state that UR disputes are to be resolved through Independent Medical Review (IMR) instead of medical-legal examinations. We also see certain physicians providing ongoing treatment on denied claims and billing for a separate medical-legal examination for each visit.
	+ This risks becoming a significant area for abuse, given the increased reimbursements under the proposal. Under the current fee schedule, the maximum reimbursement for a treatment report code, absent mutual agreement, is $181.48 for code WC004, while the reimbursement for a medical-legal examination is $2,015.00 for code ML201.
	+ To avoid these abuses, we recommend adding language to the medical-legal fee schedule stating that treating physicians can only bill medical-legal codes only in limited circumstances to prove or disprove a disputed claim. They should be expressly barred from billing medical-legal codes for UR disputes or other issues that cannot be resolved through medical-legal examinations, and they should be similarly based from billing those codes for ongoing treatment. When treating physicians do bill medical-legal codes, only the initial medical-legal evaluation should be billed as a comprehensive medical-legal evaluation.

We also see opportunities for improvement in other aspects of medical-legal evaluations, such as a more streamlined process. We recognize that some of those reforms would require legislative action, which we would support, as they would be a win-win for both injured workers and employers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diane Przepiorski, Executive Director** May 12, 2021

California Orthopaedic Association

The California Orthopaedic Association always appreciates the opportunity to provide input into the Division’s proposed regulations.  These comments are on the proposed QME Regulations.

## QME CME Requirements

COA supports educational efforts to improve the quality of QME reports.  At the Task Force meetings, we heard loud and clear that some QME reports are not ratable and do not provide a rationale for their conclusions.  We very much support and continue to look forward to participating in the Medical-Legal Report Quality Task Force in which experts are reviewing actual QME reports and commenting on their content and ratability.

Thus, we believe that changes in the topics and hours required of QMEs either for the Mandatory Report-Writing course or a QME’s on-going CME requirements are premature.

We believe that the Division should wait for input from the Quality Task Force in identifying areas of concern before making changes to the QME CME requirements.  For example, if we find that QMEs do not understand how to handle and evaluate causation issues, then QME CME providers should be asked to add education in this identified educational gap.  This will likely change from year-to-year, so we also question mandating required topics in regulation.  A mandate for certain topics and recommended time for the topic, will make it more difficult for CME providers to incorporate any newly identified educational gaps in their course materials.  The available time will already be taken up by the mandated topics.

Also, arbitrarily adding 4 hours every two years and adding required topics to be covered in the courses may only create additional obstacles for physicians to become a QME without improving the report quality.

## COA Recommendations:

1. Leave the Mandatory Report-Writing CME hours at 12 hours and the on-going QME CME requirement at 12 hours every two years.
2. When the Medical-Legal Report Quality Task Forces has recommendations for improving report quality that the Division re-evaluate the required CME hours.

**Topics – Required for the Mandatory Report-Writing Course** are already very much prescribed in the regulations – down to even the amount of time that is recommended be spent on each topic.  The proposed regulations add case law and anti-bias training of at least two hours for each topic or a total of four additional hours.  For the anti-bias training, courses would be required to cover two examples – one related to the injured worker’s gender and the other related to industrial breast cancer.

It seems that there may be examples of potential anti-bias in the evaluation of an injured worker, so we support adding this topic to the Mandatory Report-Writing course.  We object to the recommendation that two hours be spent on the topic.  We also see little need for an orthopaedic surgeon to be knowledgeable in anti-bias in industrial breast cancer.  Even if breast cancer was a factor in an industrial injury, it is doubtful that the courts/parties would rely on the opinion of an orthopaedic surgeon for an impairment rating for breast cancer.  What about other important potential areas of bias such as:  obesity, race, sexual orientation, etc.?

## COA Recommendations:

1. Regulation 11 Section (h)

We support subsection (1).

(1) Instruction designed to increase awareness and understanding of differences in human experience, as well as awareness of implicit or unconscious bias, stereotyping, and discrimination, and the ways in which unconscious bias can unintentionally impact perceptions and decision-making, including in medical evaluations and reporting, and lead to disparities in health care strategies, to help eliminate or reduce implicit bias in medical evaluations and report

We recommend deleting subsection (2) and (3) and substituting the following new subsection (2)

(2)  At least one or two examples relating to an evaluation and rating of permanent disability of potential anti-bias related to the injured worker’s injury.

2.  We recommend the deletion of the two-hour mandate for anti-bias training and would instead ask that the regulations encourage QME CME providers to include anti-bias training in their courses with no prescribed time requirement.

At the Medical-Legal Task Force Meetings, it was recommended that if the number of CME hours was increased, that the QME be allowed to count no more than one hour of billing and coding training per year to meet their CME requirement.  This is particularly important at this time as physicians are learning how to bill and code the new Medical-Legal Fee Schedule.  We don’t see this change noted in the regulations.

## COA Recommendation:

That the Division clarify that a QME may count no more than one hour per year in instruction in billing and coding issues.

**Mandatory Report-Writing Course – on-line/in-person education**

COA currently offers an in-person Mandatory Report-Writing course – typically in the Fall 2-3 weeks prior to the DWC’s Fall QME Test.  Other times of the year, we offer an on-line course.

We believe that the requirement that at least 6 hours of the course be in-person is impractical.  This requirement effectively stops all Mandatory Report-Writing course at this time and prevents physicians from completing the QME application process.

We know of no statistics to say that in-person training is more effective than on-line education.  In fact, physicians taking COA’s Mandatory Report-Writing course have a high pass rate – whether they attended an in-person course or took the course on-line.  Younger COA members who we are encouraging to become QMEs, also seem to prefer on-line courses, so this requirement discourages younger physician participation.

We also note that the Division itself has not returned to in-person meetings.

If the Division moves forward with the requirement that at least 6 of the hours be in-person training, it will delay physicians completing the application process as they search out an in-person course.  Thus, COA is opposed to requiring 6 hours of in-person training.

## COA Recommendation:

We recommend that the Division delete the requirement that 6 hours of instruction must be an in-person lecture and allow the entire course to be taken on-line.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daniel Buch, DC, QME** May 7, 2021

As a DWC approved provider of QME continuing education and report writing courses, I understand the importance of educational preparation for appointment as a QME. I also understand the desire of the DWC to improve the overall quality of QME reports. However, I believe that adding 4 additional hours to the report writing course, and adding an in-person 6-hour lecture component to report writing course will not result in improved QME report quality.

The 12-hour distance learning course I have been providing for the past four years is comprehensive and has met with considerable positive feedback from the physicians who have completed the course. It is my understanding as a course provider that additional hours of course material will not improve report quality. It is however my opinion the additional hours would best be employed by physicians in the preparation of the required sample QME report which must be completed to pass the course. I often have to ask highly educated physicians to resubmit their sample reports to correct flaws and misunderstandings. Sometimes three drafts of a sample report are required before a report is satisfactory. The synthesis of the complex topics presented and the preparation of the sample report takes a great deal of time, well above the current 12 hour course requirement. Adding course content will not serve to improve report quality and will, in my opinion, serve to discourage physicians and result in FEWER hours devoted to composing the required sample QME report.

Even more importantly, I believe that report quality will not be improved by requiring that 6 hours of the course requirement be performed in person. I will remind the parties involved that the COVID-19 pandemic and its effects are still with us. Requiring additional in-person course work to the report writing course is imprudent in my opinion. While in-person courses are not without merit, I have found that distance learning is an ideal method to convey the complex and varied topics required of the Report Writing Course. Some of the advantages of distance learning include:

- Distance learning via video streaming allows physicians to rewind and review complex topics and calculations.

- Complex topics can more accurately be developed and presented by the lecturer. This allows course registrant physicians to gain a clear and concise understanding of the topics presented.

- Physicians, by nature of their profession, work long hours. While utilizing distance learning, physicians can learn at their own time and their own pace. Complex topics are easier to comprehend when the mind is receptive and rested. Distance learning allows physicians to complete the required course work at times when they are best able to comprehend and retain the material presented.

By altering the QME Regulations to require that 6 hours of Report Writing course work be performed in person, the DWC will be removing the advantages of distance learning I have just outlined. Furthermore, this will also result in added expense of time and money to physicians who choose to serve as QMEs. This will no doubt result in a decrease in the number of new physicians willing to complete the requirements to be appointed as a QME. In short, at a time when the QME system needs to encourage new physicians to participate as QMEs, this new 6-hour in person requirement will likely discourage such participation.

In addition, by requiring 6 hours of in person time to the Report Writing course, the DWC will essentially render distance learning courses obsolete. This is because physicians will, by virtue of economy of effort, opt to complete a single in-person 16-hour course rather than complete a 10-hour distance learning course and THEN register for a separate 6-hour in-person course. Again, this will not result in improved report quality.

Finally, the proposed amendments to the QME Regulations contain no instruction as to which educational provider will be responsible for reviewing the required sample QME report which must be completed by physicians registered for the Report Writing course. Will the sample report review be the responsibility of the 6-hour in-person provider? The 6-hour in-person requirement serves to add confusion to the Report Writing course process.

I respectfully urge the parties involved to remove the proposal to add 4 additional course hours to the Report Writing course. I also urge, most strongly, to remove the proposal to require 6 hours of in-person lecture from the Report Writing course.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Jonathan Brand** May 6, 2021

I am writing to express my concern about the proposed regulations. In particular the provision requiring six hours of in person learning. As an applicant attorney in practice for over 35 years, I most certainly agree that report quality is an issue in workers’ compensation. The proposed rule, however, creates the appearance of positive change without actual change. In fact, the rule would do the opposite.

Although there is ample evidence that medical-legal reporting needs improvement, there is no evidence that remote learning is in any way responsible for poor report writing.

The key to success should be the quality of the course presented – either in person or remotely. I would suggest that we focus on making sure the programs offered provide quality education. This of course is a bit more complicated than simply requiring six hours of in person learning. Quality remote learning is better than poor in person learning. Shouldn’t this be our focus?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Jim Plato** May 2, 2021

I see that in the proposed changes that the required hours for QME continuing education every 24 months will go from 12 hours to 16 hours and that additional mandatory subjects will be added, including items like ‘medical-legal billing,’ ‘bias training,’ etc.

I am currently an approved educational provider for the DWC Medical Unit until 7/6/22. If the proposed QME regulations are approved by OAL, will my current continuing education course approval remain in effect until 7/6/22 or will I have to re-apply to expand the number of hours and include the mandatory subjects prior to 7/6/22? And, if I am not required to do that until my course renewal date on 7/6/22, will QMEs who take my currently approved course have to take other approved courses for the additional 4 hours than contain the proposed mandatory subjects?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Jo C. Stroud, MD** May 1, 2021

I served as a QME from the onset until 2016, when I retired and moved to Hawaii. The proposed changes are very reasonable and should proceed. It’s very important to have bias training, as well as enough training hours before appointment. Recertification and reappointment CEU hours need to be increased as well. It’s quite easy to do most of this online. Sending in one’s recent reports will give the review board an opportunity to review the quality of the QME report writing. It was a pleasure to serve the DWC form 1989 to 2016. Thank you for the honor.

1. Based on payments made by Liberty Mutual Insurance and its affiliates in calendar year 2019 and 2020. Note that the codes in the Medical-Legal Fee Schedule are unique to California, so the state’s costs are being compared to equivalent codes in other states. [↑](#footnote-ref-1)