

Date: October 30, 2017

To: Commission on Health and Safety and Workers' Compensation (CHSWC)

From: Diane Worley, Director of Policy Implementation
California Applicants' Attorneys Association

RE: Qualified Medical Evaluators: Updating Trends in Evaluations, Availability, and Equity : Report to the Commission on Health and Safety and Workers' Compensation
by Frank Neuhauser : University of California, Berkeley October 2017

The 2017 QME study authored by Frank Neuhauser presents a challenge to the Commission.

The main focus of the prior 2010 QME study prepared by Mr. Neuhauser(to which the current study is an update) was on how to improve equity and timeliness in the QME reporting process. The 2010 report recognized that QME evaluations are at the heart of the California workers' compensation dispute resolution process. One of the recommendations of this prior study was that the DWC should conduct outreach efforts to specific specialties (orthopedic, pain, and psych, for example) to increase the registration of these providers as they were underrepresented compared to the frequency at which the specialty was requested. The goal was to increase access to appropriate specialties in the QME evaluation process.

The 2017 QME study unfortunately seems to not focus on solutions to these continuing access issues. The study also makes many assumptions in its' findings not anchored in data. Part of this may be due to the fact that no participants in the QME process (injured workers, attorneys, doctors) were interviewed to allow a better understanding of how the QME process works and what the current problems are. Part of it may be that the researcher used "summary data from various sources" which are not identified to help explain these findings (p. 2).

To highlight other significant problem areas in the report:

- QME "bias" is not objectively measured or defined in the research for this report . Higher PD ratings, or the use of the Almaraz/Guzman case by a QME (as suggested in the study) are not valid measures of bias. There are so many factors which go into a QME evaluation and each injury and the disability which results therefrom are unique for each worker as well as the quality of the evaluation for that injury.
- Reviewing data "in a vacuum" results in a lot of speculation on how the QME process works.
- The lack of availability of certain specialists is increasing. Will this be studied more? The main shortage based on the study are orthopedists and pain specialists (based on the # of requests and # of doctors in specialty). However it is also very difficult to get certain specialists such as oncologists, urologists, etc. particularly in Northern California.

- We agree that the DWC should look at making the process easier for unrepresented applicants to ask for a panel QME because of the significant decrease in these requests since SB 863.(p.28)
- The report recognizes the difficulty with access to pain management specialists and that this has increased as many of the doctors suspended or restricted from the system are in this specialty. Yet the report “tars” all doctors in the pain management specialty who have always operated in an ethical manner by suggesting the DWC could examine the cost-benefit of even maintaining separate pain specialties in the QME system. There is now a process in place for getting the “bad actors” out of the QME system. This updated report should be focusing on how to recruit and keep the “good” doctors to address the chronic problem with access to certain specialties, including pain management.

The Commission quickly recognized that the 2017 QME report raised many questions and so you did not approve the study.

That brings us to the question: what should be done now?

The challenge facing the Commission is how to address these complex issues while preserving the availability of QMEs in a wide range of specialties which is “the heart of the California workers’ compensation dispute resolution process.”

CAAA strongly agrees with Commissioners Kessler, Bloch, Bouma and Wei who called for further study and public input from stakeholders to focus on the multitude of issues and questions that the report raises.

From: Steve Ounjian <steve@cmlsllc.com>

CHSWC-

Thank you for the opportunity to make comments on the new QME study. I will keep my comments focused upon a few topics/areas versus touching upon the study in general.

First, my name is Steve Ounjian. I am one of the owners of CMLSllc. CMLS is a management company that supports the administrative and front office functions of QMEs within California. We have been in business since 1985 and have worked with hundreds of QMEs throughout that time. Additionally we have spoken with and interacted with thousands of QMEs during that time as well. I feel we have a good sense of how QMEs (single office and multi office) view the system and their desire to participate within it.

My comments are as follows:

Pages 30-32 of study-Concentration of Assignments among a Limited Proportion of High Volume QMES.

COMMENT: The study identifies a percentage of QMEs that are willing and capable of serving the system at a higher level. Namely "10 site" doctors. These QMEs are producing at a higher level than others in the system. There seems to be a concept floated that these highly productive doctors somehow discourages single site doctors from being QMEs or participating long term in the system. That even non QMEs are discouraged from becoming licensed and participating because of them.

All QMEs within the system have the right and capability to serve at a higher level IF they wanted to. There are no restrictions upon single site doctors to do so. They have the same right to add additional clinic sites and serve at a higher level IF they wanted to. They choose not to. I have personally spoken to thousands of these QMEs over the course of almost 20 years. I find that many single site doctors are very happy spending their time doing the thing they went to medical school for- actually treating. As an example: with all things being equal, most Orthopedists in a surgical practice would prefer doing surgery versus doing a QME report. They enjoy treating and doing surgery. They enjoy that process of making a significant difference for their own patients. In their minds that is their highest and best use. That is what they sacrificed time and money to be able to do throughout their lives. We should be grateful for this mindset and type of person in our society. They did not go to medical school to be a QME. They are not required to do QME work. For some of these physicians QMEs are a distraction.

I have heard countless times from single site QMEs the following:

1. I am too busy in my current practice. Maybe when I slow down I will do more.
2. I don't like doing QMEs. The requirements are too complex and I feel unjustly scrutinized. It's just not fun work. I prefer surgery.

3. I have better things to do with my time than doing more QMEs.
4. My staff doesn't have the time or resources to keep me compliant with all the regulations upon the QME.
5. Reimbursements are too low for the amount of time I'm expected to invest to complete these reports.

Imagine trying to adjust system algorithms to push more work onto a single site QME with the mindset above. What kind of expeditious appointment or well thought out report will be produced? It won't and the examinee and participants will suffer from it.

Not once have I heard physicians tell me that the reason they DON'T want to participate is because they aren't getting enough work. That somehow there are these productive "10 site" QMEs that discourage them from participating. Physicians can be bold and forthright. If this was the case I would have heard about it long ago directly from the QMES or indirectly through other means. It's just not in the thinking or motivations of the non QME physician or single site QME.

The study goes on to opine that single site doctors are at a disadvantage to 10 site QMEs. This is false. The single site doctor doesn't want an advantage that they can't have. They have the freedom to take the opportunity. The productive QME is mutually exclusive from them. They both have the same freedoms and rights within the system. The single site QME typically doesn't care for substantially more work. If they did want more work there are multiple opportunities for them to serve the system at a higher level. Many QMEs (multi site) currently do this because their motivation, desire and values align with serving the QME system at a higher level. The system should be grateful that these physicians even exist as they aren't commonplace. I would further opine that they are critical and act like a safety net to ensure QME system efficiencies and timeliness remain.

It is important to note that it's conceivable that QMEs who are better and more skilled report writers are sought out or picked more frequently. Reputation on skill of report writing is nothing anyone can take away from a single site QME. Not even a QME who serves 10 sites has an advantage against that valuable element in any given city. It is my belief that the current system has a flight to quality element when participants pick QMEs. The QMEs who write better more comprehensive reports are agreed upon or stand through the striking process. This concept alone is real and further hinders the argument that 10 site QMEs somehow have an all encompassing capability of hurting single site QMEs.

The study points out that there is a significant investment of time and resources to become a QME. This is true. But that somehow this new physician assesses the cost in time and money to become a QME against projected future work. That somehow these physicians are starting to act like calculating businessmen realizing (without ever participating in the system) that their investment won't be worth it. The study assumes this physician forecasts the future work and income from being a QME as low because of these highly productive 10 sites QMEs and the apparent advantage they have. This is false. I know because I have spoken with and helped

hundreds of physicians become QMEs. Physicians don't have access to data to do high level analysis of an opportunity such as becoming a QME. It isn't their focus.

The reality is that many physicians who aren't QMEs prefer doing what they are comfortable with and that's surgery/treatment. Many of these physicians are given volumes of study material to prepare to become a QME. Most of the time many of them are shocked at the amount of regulations and complexity the QME system imposes upon them and their practice. To bring clarity - many physicians don't proceed to be QMEs because of this singular reason.

The next section of the study points out the role of what's called an "aggregator." I will assume that's the term coined for the management companies that boost production and efficiency in the system.

Many of the high volume QMEs are with aggregators. This is true. Although, it should be noted, there are many QMEs that have built up their own 2-10 clinics and manage it through their own office. Therefore not ALL highly productive QMEs work exclusively through aggregators. The aggregators have focused on and are devoted to delivering services specifically to help these QMEs be more productive without burdening their own offices with the complexities of managing higher work volume. This is the role that CMLS has filled in serving the QME system for 30+ years. I would like to add that aggregators act as a bridge to efficiencies and simplification for QMEs to become more productive. We believe the right QMEs operating in that system of efficiency and higher productivity are extremely valuable to this system.

I have come up with a brief short list of quick fixes to reduce QMEs exiting the system and help bolster more physicians participating:

1. Administer QME tests more frequently. Monthly or quarterly versus just twice a year.
2. Prepare a free online QME prep course that can easily train and guide new physicians. This course could showcase the benefits to the physician to participating in the system. This structure could simplify the process to study for the exam as well.
3. Protect the QME by eliminating situations where the fee schedule discounts the physicians time down to working for substantially discounted rates.
4. Consider eliminating outdated and onerous regulations hurled onto the QME.
5. Develop a program to help the QME pool feel that their role is appreciated and they are dealt with fairly when complaints arise. QMEs need to know the system in which they work is reasonable and deals fairly with them.

6. Help the QMEs efficiently get paid for services. Currently there are many hurdles to overcome to get paid and IBR is too unreliable for the QMEs to feel comfortable utilizing.

We, at CMLS, would welcome the opportunity to participate with stakeholders and the CHSWC committee to help better understand the role of management companies. Additionally, we would be available to help develop ways for management companies to work with CHSWC and DWC for the betterment of the system.

Lastly, I want to thank Frank Neuhauser for his great work on the QME study and CHSWC for the opportunity to share my comments on it.

If I may be of further help or assistance please contact me directly 559-704-2915.

Sincerely
Steve Ounjian