Research Report

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Qualified Medical Evaluators and the Medical-Legal Process in California Workers' Compensation

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About This Report

In California, Qualified Medical Evaluators (QMEs)—physicians who have been certified by the California Division of Workers' Compensation to assess injured workers and write reports—play a critical role in California's Medical-Legal process and in dispute resolution. In this research, we analyze data provided by the California Department of Industrial Relations (DIR) and conduct interviews and focus groups with stakeholders across California's Med-Legal system. The purpose of this research is to assess whether the system is meeting its intended purpose, is sustainable in its current form, and could be improved to better meet its stated goals, with a focus on the role of QMEs in the system.

This work was conducted in the Financing and Organization Program of RAND Health, a division of RAND that strengthens health care systems and the societal conditions that support health. For more information, visit www.rand.org/health or contact Health@rand.org.

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Summary

Background and Purpose

In California, Qualified Medical Evaluators (QMEs)—physicians who have been certified by the California Division of Workers' Compensation to assess and write reports on injured workers—play a critical role in resolving workers' compensation disputes. QMEs evaluate injured workers and write reports to address Medical-Legal (Med-Legal) questions to help resolve the cases. The California Division of Workers' Compensation in the Department of Industrial Relations (DIR) is responsible for the appointment and reappointment of QMEs and for administering the process through which QMEs are assigned to cases.

California DIR contracted with RAND to better understand whether the Med-Legal process is meeting its purpose, whether it is sustainable, and how it could be improved, with a focus on the role of QMEs in the Med-Legal process. Specifically, this report addresses ten high-level research questions:

1. Is there a mismatch between the supply and demand of QMEs across specialties and geographic areas?
2. What is the best way to recruit and retain QMEs?
3. How have recent changes to the QME reimbursement structure impacted overall costs to the workers' compensation system, and should additional changes be considered?
4. What have been the impacts of structural changes to QME selection, and should additional changes be considered?
5. How can medical record delivery to QMEs be improved?
6. How has the quality of Med-Legal reports changed since 2012, and what is the best way to ensure the quality of QME reports?
7. Are the time frames built into the QME process appropriate and being met?
8. Are remote telehealth/remote health evaluations being used appropriately, and should any changes regulating their use be considered?
9. How have litigation practices in the Med-Legal system changed since 2012?
10. What role have medical management companies (MMCs) played in the Med-Legal process?

Methods

To answer the above research questions, we used both qualitative and quantitative methods. Our qualitative analyses included a review of related policies from other states; interviews with applicants' attorneys, defense, employer, or insurance representatives; MMC representatives;

injured workers; and representatives from other states' workers' compensation agencies. We also conducted focus groups with active and former QMEs. Our quantitative analyses included an analysis of data sources maintained by California DIR, including data on QMEs and panel assignments, all-payer workers' compensation claims data, and case status data.

Results

A summary of our review of state policies from 17 other states is shown in Table S.1. This review focused on the role that independent medical examinations (IMEs) or similar types of Med-Legal evaluations play in resolving Med-Legal workers' compensation disputes in other states. Overall, we found substantial variation in the role that state workers' compensation agencies play in Med-Legal evaluations in their states. Of the states we reviewed, there were no other states that used the exact same system that California does. However, like California, some state workers' compensation agencies took a more active role in aspects of the Med-Legal process, such as evaluator selection, accreditation, discipline, and quality review. Also like California, some states set evaluation rates according to a state fee schedule and required employers or payers to pay for evaluations. We spoke with two of these states—Colorado and Texas—as part of our qualitative interviews.

Table S.1. Summary of Other State Results

Feature of IME and Related Processes	Applicable States
Requestor selects evaluator	FL, GA, HI, MD, NC, NV, NM, NY
Only defense can select evaluator	AZ, IL, MI, NJ, OH
State workers' compensation agency can select evaluator in some circumstances	CO, FL, GA, HI, NV, NM, NY, OH, PA, TX, WA
State-specific accreditation requirements for some types of evaluators	CO, FL, NM, NV, NY, OH, PA, TX, WA
State workers' compensation agency has role in evaluator discipline	CO, FL, NV, NY, OH, TX, WA
State workers' compensation agency has explicit role in reviewing and enforcing rating or report quality	CO, NV, OH, TX
Employer or payer must typically pay for evaluations (with limited exceptions)	AZ, FL, GA, MI, NC, NJ, NM, NV, OH, PA, TX, WA
Evaluation rates set by a state fee schedule (as opposed to agreed upon by parties)	CO, GA, HI, MD, NV, NY, OH, TX, WA

SOURCE: Authors' review of workers compensation policies from 17 states: AZ, CO, FL, GA, HI, IL, MD, MI, NC, NJ, NM, NV, NY, OH, PA, TX, WA.

Select themes from our qualitative interviews corresponding with key research questions are presented in Table S.2. All themes were endorsed by multiple participants, although there was a considerable diversity of perspectives.

Table S.2. Summary of Select Themes from Qualitative Interviews and Focus Groups

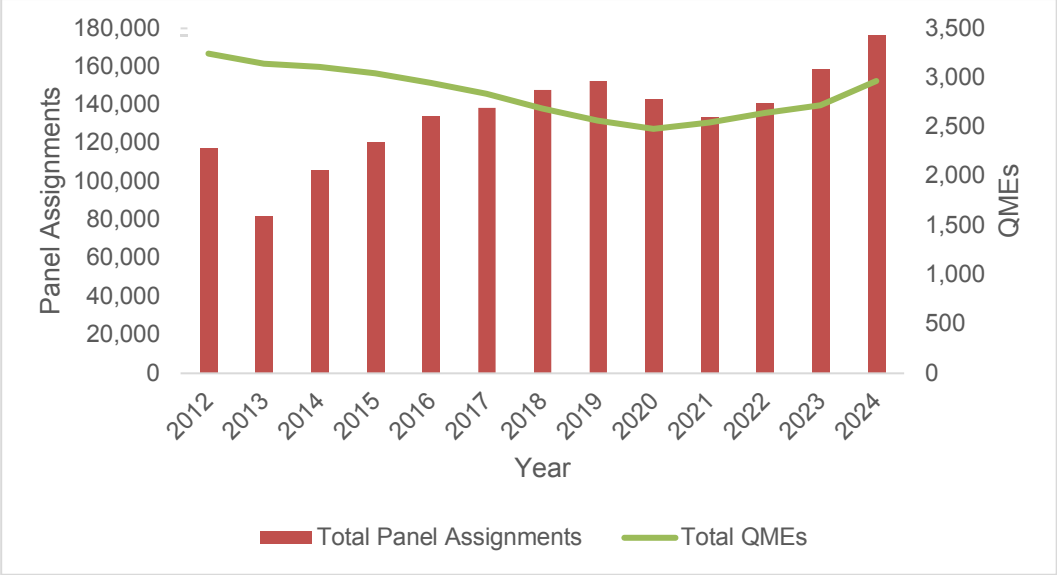
Research Question	Summary of Select Themes
Is there a mismatch between the supply and demand of QMEs across specialties and geographic areas?	• There are enough QMEs overall but not in certain specialties and geographic areas. • The ten-office limit made QME selection fairer but may have decreased access.
What is the best way to recruit and retain QMEs?	• QMEs appreciate the intellectual stimulation, extra income, and flexibility of the job. • Reasons for leaving the QME system include time pressures, delays in payment, and frustrations with medical record delivery and prohibition on commenting on treatment.
How have recent changes to the QME reimbursement structure impacted overall costs to the workers' compensation system and should additional changes be considered?	• Overall, 2021 fee schedule changes increased Med-Legal payments and attracted new QMEs. • Participants prioritized adding a cost-of-living adjustment to the fee schedule. • The simplification of the fee schedule was easier to navigate and reduced gaming but may also encourage poor work and be difficult for new QMEs who take longer to write reports.
What have been the impacts of structural changes to QME selection, and should additional changes be considered?	• It is difficult to create a fair process for selecting a specialty. • The removal of the neuropsychology specialty has led to difficulties. • The current panel system has advantages over the "dueling QME system."
How can medical record delivery to QMEs be improved?	• Medical records should be available prior to the evaluation, but requiring this could cause further delays. • Determining the relevance of medical records to deliver is complex; better organization and removal of duplicate records would be beneficial. • A central electronic repository could improve record delivery, but privacy and logistical concerns remain.
How has the quality of Med-Legal reports changed since 2012, and what is the best way to ensure the quality of QME reports?	• The Med-Legal system has not provided enough opportunities for feedback on QME reports, but this might be improved by recent changes. • QMEs need more practical experience as part of their education. • QMEs would appreciate more opportunities for mentorship.
Are the time frames built into the QME process appropriate and being met?	• Requesting multiple panels adds to overall timeline. • The time frames for QMEs to schedule appointments is too long. • Extra time for writing reports with many medical records would be helpful.
Are remote telehealth or remote health evaluations being used appropriately, and should any changes regulating their use be considered?	• Telehealth could be appropriate for psychiatry and other mental health evaluations. • Telehealth offers flexibility when parties agree to use it.

Research Question	Summary of Select Themes
How have litigation practices in the Med-Legal system changed since 2012?	• Litigation has gotten more contentious in recent years. • Use of multiple panels leads to additional litigation.
What role have MMCs played in the Med-Legal process?	• MMCs are helpful with administrative tasks. • Some MMCs provide mentorship and help recruit QMEs. • The quality of MMCs is variable.

SOURCE: Authors' qualitative analysis of 27 interviews and 6 focus groups.

We conducted several quantitative analyses to understand how the demand for QME panel evaluations and the supply of QMEs have changed over time and differ by geographic region and specialty. We found that the number of panel assignments has increased steadily over time with the exception of 2013, when evaluations commenting on medical treatment were moved to a separate process, and in 2020–2021 during the coronavirus disease 2019 (COVID-19) public health emergency (Figure S.1).

Figure S.1. Panel Assignments and Number of QMEs, by Year

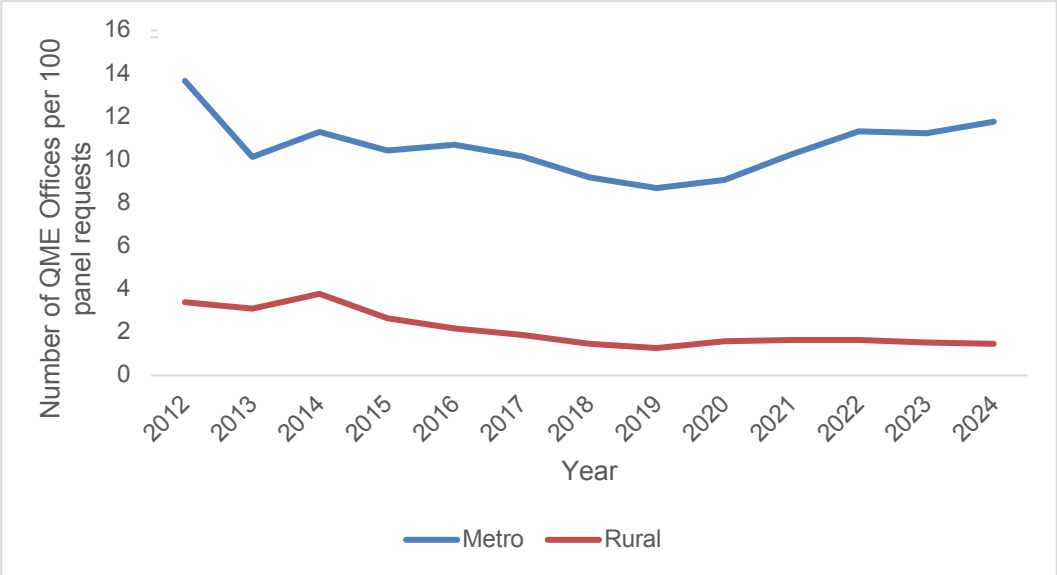


SOURCE: RAND analysis of QME data.
NOTE: N=1,752,557 assigned panels 2012–2024, N=36,922 total QME years active representing 5,034 QMEs. Year refers to the year that the panel was assigned or year during which a QME had an active office for at least part of the year.

To understand whether the supply of QMEs was keeping pace with the demand, we examined the number of QMEs and QME offices (currently, QMEs may have offices in up to ten locations in California) by specialty and geographic location. Overall, we found that the number of offices dropped sharply following the 2013 legislative change limiting QMEs to ten offices. The number of QMEs and offices began to increase gradually from 2013 to 2016, then gradually

decreased from 2016 to 2020. Concerns about the decreasing supply of QMEs and increasing demand for panels contributed to a 2021 fee schedule change, designed in part to raise QME reimbursement rates and attract more QMEs to the system. We observed marked increases in the number of QMEs and QME offices following the 2021 fee schedule change, although we noted that these increases were seen primarily in metropolitan counties (Figure S.2). We also noted that, even with the overall increase in QMEs, there were still not enough QMEs to field panels in certain subspecialties, such as oncology.

Figure S.2. QME Offices per 100 Panel Assignments, by Metro or Rural County Status and Year



SOURCE: RAND analysis of QME data.

We also conducted several analyses examining the timeliness of the Med-Legal process over time. In general, we noted modest improvements in the time to complete some types of processes, such as time from panel request to panel assignment and time from panel assignment to QME exam date, in recent years. For example, Table S.3 shows the time from panel assignment to QME exam date. While there is a decrease in average time to exam date from 2016 to 2023 (in part because the amount of time for which we can observe cases decreases in later years), the time to exam date remains high: 118 days in 2023. The percentage of exam dates occurring within 90 days remains fairly consistent over time, although there is a small decrease in 2020. However, we observe improvements in the percentage of exams occurring in less than 365 days (from 39.0 percent in 2016 to 53.7 percent in 2023). For context, up until 2020, appointments were supposed to be scheduled within 60 to 90 days of panel assignment; otherwise, the party requesting the panel could request a replacement panel or the parties could agree to a timeline extension. In 2020, this time frame was changed to 90 to 120 days under an emergency COVID-19 regulation, and this change was made permanent in 2023.

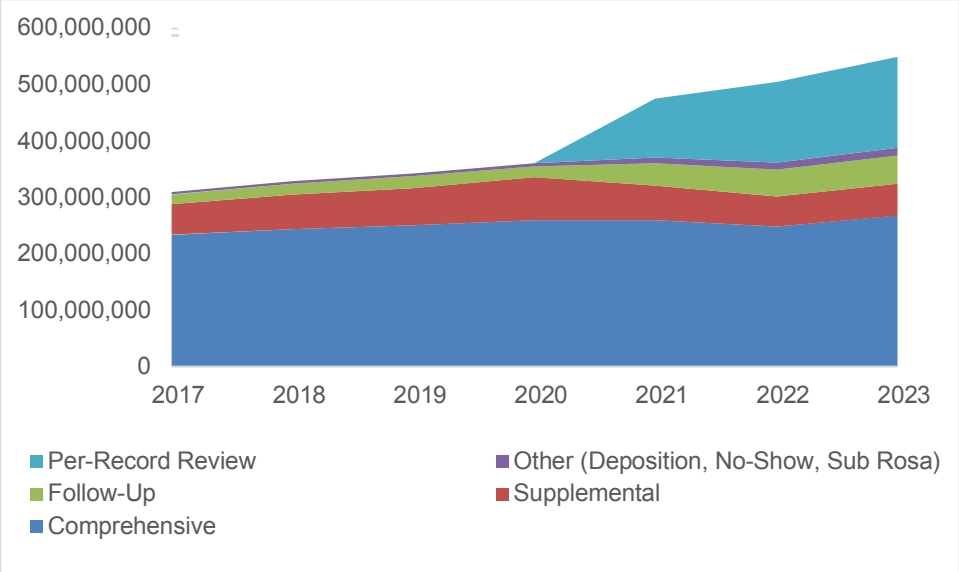
Table S.3. Duration from Panel Assignment Date to QME Exam Date, by Time Interval

Report Year	Average Duration	% Within 90 Days	% Between 91-365 Days	% Over 1 Year	% With No QME Exam from Panel	N
2016	150	22.9%	16.1%	3.3%	57.7%	51,231
2017	138	25.2%	17.7%	2.8%	54.3%	58,922
2018	126	26.0%	18.7%	2.2%	53.2%	66,201
2019	132	25.3%	19.1%	2.5%	53.1%	70,008
2020	139	20.7%	27.3%	2.3%	49.8%	67,569
2021	131	23.4%	28.3%	2.3%	46.0%	63,063
2022	125	23.9%	28.2%	2.0%	45.9%	64,411
2023	118	22.4%	31.3%	0.9%	45.4%	67,747

SOURCE: RAND analysis of linked QME-Workers' Compensation Information System (WCIS) data.
NOTE: Durations reflect time elapsed between panel assignment and completed QME exam for panels issued from 2016 to 2023. N refers to the number of panels in each year. "No QME Exam from Panel" includes records where no matching QME identifier was found or where a match existed, but the exam occurred outside the panel assignment window (i.e., before the exam or after a subsequent panel assignment).

Figure S.3 shows total Med-Legal payments by type of service from 2017 to 2023 to look at overall trends in payments, including following the 2021 fee schedule change that replaced time and complexity payments for QME evaluations with a flat fee, a two-time multiplier for psychiatric and psychologic evaluations, and a $3 per page fee for review of medical records over 200 pages. We found that the 2022–2023 Med-Legal payment average was 57 percent higher than the 2016–2020 average, more than double the 25-percent increase set as a target when the regulations were adopted.

Figure S.3. Med-Legal Payments, by Type of Service, 2017–2023



SOURCE: RAND analysis of WCIS data.

Recommendations and Considerations

Based on our quantitative and qualitative analyses, we provide several high-level recommendations to improve the QME system, which are described in greater detail in the report (Table S.4). Along with each high-level recommendation, we suggest specific actions that could be considered and note whether the action, if pursued, would require a legislative change, a regulatory change, or an administrative or other type of change. We also note some areas in which future data collection, analysis, or monitoring may be warranted.

Table S.4. Summary of Policy Recommendations and Considerations

High-Level Recommendation	Action for Consideration	Type of Change
Increase the number of QMEs with specific characteristics	Increase recruitment efforts from under-represented specialties and in rural areas	Administrative/Other
Increase the number of QMEs with specific characteristics	Include fee schedule modifiers for examinations in rural areas or for under-represented specialties	Regulatory
Increase the number of QMEs with specific characteristics	Allow some number of offices beyond the ten-office limit for offices in rural areas	Legislative
Increase flexibility in QME workload	Allow QMEs to set a maximum number of panels per month	Regulatory
Increase flexibility in QME workload	Add additional time for report writing for cases with large numbers of medical records	Legislative
Reduce time to payment for QME services	Increase enforcement of payment deadlines for QME services	Judicial
Improve record delivery	Require medical record delivery prior to QME evaluation	Regulatory
Improve record delivery	Investigate ways to improve record delivery, including use of a central electronic repository	Monitoring/Further Investigation
Allow reasonable use of telehealth	Maintain current telehealth flexibilities while monitoring report quality and disputes over use of telehealth	Monitoring/Further Investigation
Ensure adequate compensation to recruit and retain QMEs	Monitor average QME payments relative to the Medicare Economic Index and consider adding a cost-of-living adjustment to fee schedule	Monitoring/Further Investigation
Ensure adequate compensation to recruit and retain QMEs	Evaluate and reconsider modifiers for psychiatric and psychological evaluations	Monitoring/Further Investigation
Monitor changes in payment for Med-Legal reports	Monitor rates of supplemental and follow-up reports	Monitoring/Further Investigation
Provide more formal and informal mentorship opportunities	Pair new and experienced QMEs through a voluntary mentorship program	Administrative/Other
Emphasize practical experience in training courses	Evaluate and build upon recent regulatory changes, such as those that emphasize report writing or assessing example reports in training courses	Monitoring/Further Investigation

High-Level Recommendation	Action for Consideration	Type of Change
Provide earlier and more targeted feedback to QMEs	Evaluate the impacts of recent regulatory changes to increase review of Med-Legal reports for quality and consider expanding feedback on QMEs' first reports and to QMEs who are flagged as needing additional help using objective criteria	Administrative/Other
Reduce time-to-case resolution	Give unrepresented injured workers the option of requesting a panel online	Regulatory
Collect additional data to monitor and improve quality	Collect data on role of MMCs in the Med-Legal system	Administrative/Other or Legislative
Collect additional data to monitor and improve quality	Collect data on medical record delivery and completeness	Administrative/Other or Regulatory
Collect additional data to monitor and improve quality	Include additional information for linkage to WCIS/Electronic Adjudication Management System	Regulatory

Contents

Figures and Tables

Figures

Tables

Chapter 1. Introduction

Workers who are injured in the course of their employment are entitled to workers' compensation benefits, including medical care and disability payments. In most states, including California, the majority of workers' compensation benefits are not administered by a state government agency but rather through insurance companies or through employers who self-insure. However, some classes of benefits are administered by state agencies, such as those paid to state employees or state agencies acting as the insurer of last resort.

Sometimes, there are disputes between the defense (i.e., employer or insurer representatives) and applicants (i.e., injured workers [IWs] or their representatives) over issues, such as whether injuries are work-related and the degree of disability. Even when insurance companies or employers administer the benefits, state workers' compensation agencies often play an important role in resolving disputes, although the resolution processes and the agencies' roles in them differ widely by state. Most commonly, the defense and/or the applicant can request an independent medical examination (IME) or a similar type of Medical-Legal (Med-Legal) evaluation from a physician not involved in the ongoing treatment of the patient. The evidence from the evaluation can then be used to resolve disputes. State statutes and regulations determine who may request an evaluation and who may act as an evaluator.

In California, Qualified Medical Evaluators (QMEs)—physicians who have been certified by the California Division of Workers' Compensation (DWC) to assess and write reports on IWs—play a critical role in California's Med-Legal process and in dispute resolution. The California DWC in the Department of Industrial Relations (DIR) is responsible for the appointment, reappointment, and certification of QMEs and for administering the process through which QMEs are assigned to cases. The Med-Legal system also includes Agreed Medical Evaluators (AMEs)—physicians who are mutually selected by the parties to a litigated action to resolve a medical legal dispute. An AME may or may not be certified as a QME.

California DIR contracted with RAND to better understand whether the Med-Legal process is meeting its purpose, whether it is sustainable, and how it could be improved, with a focus on the role of QMEs in the Med-Legal process.

Purpose

This study has three overarching questions:

1. Does the current Med-Legal process satisfy the purpose of the systems as it was initially envisioned by the Legislature?
2. Is the Med-Legal process, as it currently stands, sustainable?

3. In what ways can the Med-Legal process be improved to satisfy the purpose that has been identified and as the system has been utilized?

To address these overarching questions, we explored a wide range of specific research questions across many aspects of the Med-Legal process. These specific research questions can be broadly grouped into ten high-level questions about the Med-Legal system in California:

1. Is there a mismatch between the supply and demand of QMEs across specialties and geographic areas?
2. What is the best way to recruit and retain QMEs?
3. How have recent changes to QME reimbursement structure impacted overall costs to the workers' compensation system and should additional changes be considered?
4. What have been the impacts of structural changes to QME selection, and should additional changes be considered?
5. How can medical record delivery to QMEs be improved?
6. How has the quality of Med-Legal reports (i.e., reports written by QME and other types of evaluators) changed since 2012, and what is the best way to ensure the quality of QME reports?
7. Are the time frames built into the QME process appropriate and being met?
8. Are remote telehealth/remote health evaluations being used appropriately, and should any changes regulating their use be considered?
9. How have litigation practices in the Med-Legal system changed since 2012?
10. What role have medical management companies (MMCs) played in the Med-Legal process?

Organization of Report

To answer the above research questions, we conducted interviews and focus groups with key participants in California's Med-Legal process and analyzed California DIR's data from 2012–2024. Additionally, we reviewed policies related to Med-Legal evaluations from 17 states' workers' compensation systems and spoke with representatives from two of those states to explore how these programs are structured and what lessons California could learn from other states' experiences. Chapter 2 provides detailed background on the Med-Legal process, the roles of QMEs and other stakeholders in the process, time frames involved in the Med-Legal process, a timeline of key policy changes, and an overview of relevant prior studies that evaluated aspects of the Med-Legal process. Chapter 3 describes our review of other states' Med-Legal evaluation policies in workers' compensation. Chapter 4 describes quantitative and qualitative analysis methods for the report. Chapters 5 through 7 provide detailed results from our qualitative and quantitative analyses, organized according to the ten questions above. Chapter 5 addresses

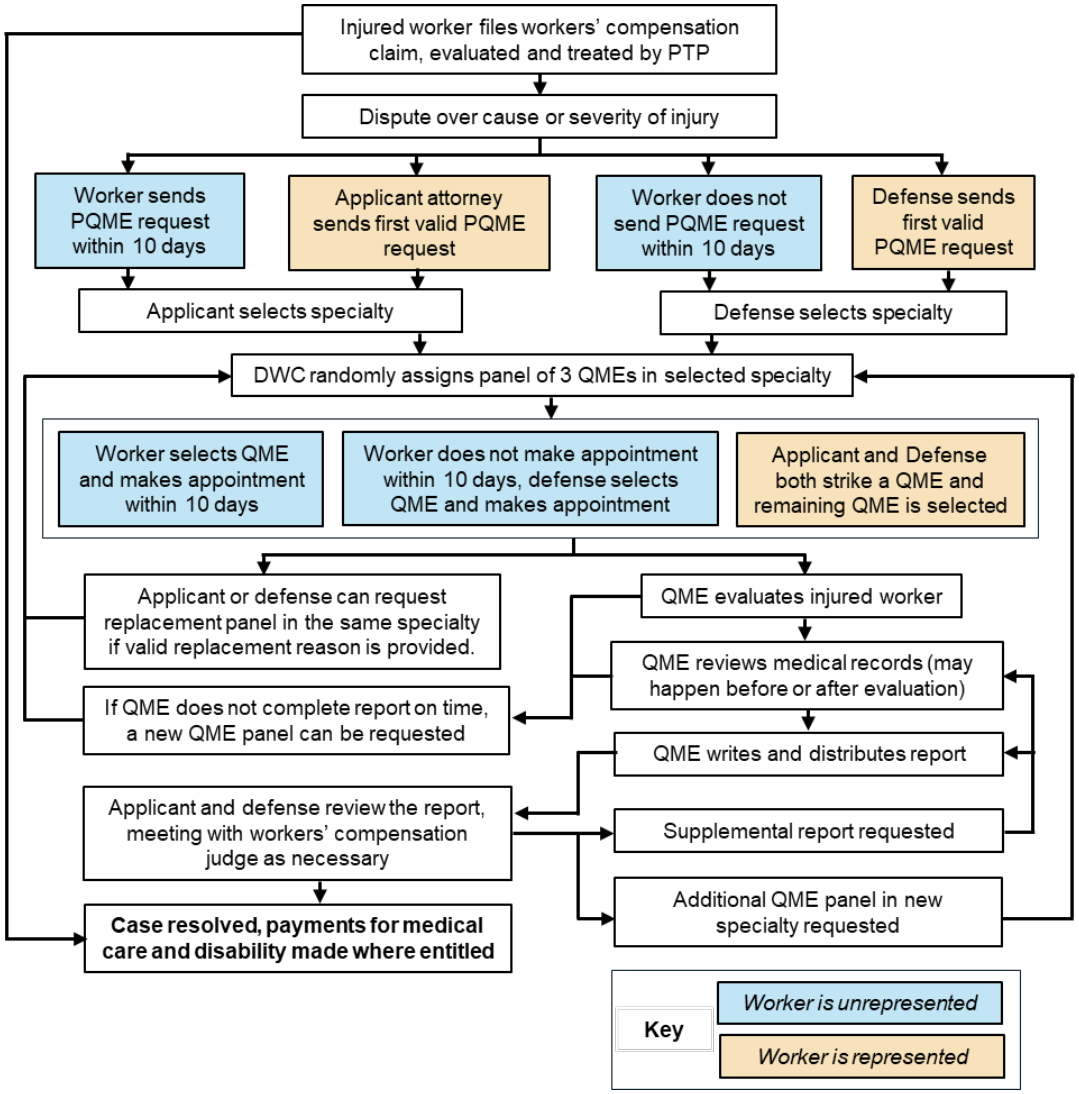
questions about the supply of QMEs and demand for QME services (Questions 1 and 2), Chapter 6 addresses reimbursement for QME evaluations and other Med-Legal services (Question 3), and Chapter 7 addresses structures and processes in the QME system (Questions 4–10). In Chapter 8, we synthesize our quantitative and qualitative findings and assess how statutory or regulatory changes could be adopted to improve the functionality and sustainability of the QME program. For each high-level research question, we also considered whether there was additional data that DIR could collect to facilitate future research or quality improvement activities.

Chapter 2. Background

Overview of the Current Medical-Legal Process in California

The Med-Legal process in California, described in detail below and summarized in Figure 2.1, involves multiple steps, which are detailed in later sections. The time frames associated with each step are summarized in Table 2.1; some steps may be repeated over the course of a single case. The structure of the process depends on several different factors, such as whether an IW is represented or unrepresented by an applicant's attorney (AA).

Figure 2.1. Overview of QMEs' Roles in the Med-Legal Process



SOURCE: RAND review of California policies and forms, cited in next section.
NOTE: IWs may also gain representation during their case. If a worker on the unrepresented track (blue) gains representation after a panel selection and the panel has not been used, the worker may select a new panel on the represented track (orange) shown above. This chart focuses on the role of QMEs in the Med-Legal process and does not include every action or process involved in resolving workers' compensation cases. For example, utilization review, independent medical review (IMR), AME evaluations, and independent medical examiner/Regular Physician evaluations are not included. PQME=Panel Qualified Medical Evaluator; PTP=Primary Treating Physician.

Table 2.1. Time Frame Requirements in the Med-Legal Process

Event	Responsible Party	Time Frame
Mail completed Form 105 to medical unit in unrepresented cases	IW	Within 10 days of receiving Form 105 from their employer (otherwise employer may request the panel)
Assign three QMEs for panel in unrepresented cases	DWC Medical Director	Within 5 working days of receiving request (if panel not assigned within 20 working days, IW can pick any QME)
Select QME from panel in unrepresented cases	IW	Within 10 days of panel issuance (otherwise employer may select the QME)
Send relevant documents intended for QME review to opposing party	Applicant, defense	At least 20 days prior to sending documents to QME for review
Object to any documents intended for QME review sent by opposing party	Applicant, defense	Within 10 days of receiving documents
Schedule the QME evaluation	Applicant, defense	Within 90 days of QME selection
If unable to schedule within 90 days, request replacement panel or waive right to replacement and reschedule	Initial requestor	Within 90–120 days of initial QME request (if unable to schedule within 120 days, may report QME unavailability and request replacement or waive right to replacement and reschedule)
Write the QME report	QME	Within 30 days of evaluation, can be extended another 30 if QME is waiting for test results; 15 days "with good cause"
If necessary, supplemental report	QME	Within 60 days of request
If necessary, appear for deposition	QME	Within 120 days of deposition request

SOURCE: RAND review of California policies and forms, cited above.

Filing a Claim and Initiating Treatment

When an injury or illness occurs at work, the IW must notify their supervisor, and the employer must then give the employee a claim form. When notified of an injury by an employer, the claims administrator files the First Report of Injury (FROI) with DWC. The IW can be treated immediately by a provider of emergency care. The IW can then select a PTP. The IW's provider choice may be limited to medical provider networks adopted by employers.

The first provider of medical care for the injury is required to file a doctor's first report with the claims administrator, who is then required to file it with DWC. PTPs provide ongoing medical care and make determinations about the nature and duration of temporary disability, determine work restrictions, release a patient to return to work, determine a permanent and stationary date, determine the need for future medical care, and conduct the initial permanent disability evaluation when necessary.

Med-Legal Evaluations

The IW or employer may disagree with the PTP about key issues, such as whether the injury is work-related, whether the worker has reached maximum medical improvement (MMI), and

what permanent impairment rating should be assigned to a worker who experiences residual impairment after the injury has become permanent and stationary. If agreement on these issues cannot be reached, a Med-Legal evaluation to resolve the dispute may be requested by the IW, by an AA representing an IW, or by an employer representative. The process for requesting and scheduling Med-Legal evaluations differs depending on whether the IW is represented or unrepresented. The DWC maintains a list of QMEs who have the qualifications required by CA LAB § 139.2 across a range of specialties and with office locations across California. In cases where the IW is unrepresented, the IW may select the desired specialty of their evaluator. The IW requests the QME panel using a mail-in QME panel request form 105 (California Division of Workers' Compensation, 2015). If the unrepresented IW does not request the panel within 10 days of receiving the form from their employer, the claims administrator may submit the form and select the QME panel specialty (California Labor Code, Division 4, Section 4062.1; California Department of Industrial Relations, 2015). If the IW has representation, both the applicant and the defense can request a specialty through an online form 106 at least 10 days after the objection was mailed, and the panel specialty is determined by the party that submits the first valid request (California Labor Code, Division 4, Section 4062.2). Only one specialty panel will be assigned unless mutually agreed upon by the parties.

After the panel and specialty have been requested in an unrepresented case, the DWC medical unit, within five working days of receiving the request, randomly assigns a panel of three QMEs in that specialty who have an office located near the IW's residence. If there are not enough QMEs within the requested specialty near the IW's residence, QMEs from elsewhere in the state may be selected, and the employer will pay necessary travel costs. If a panel is not assigned within 20 working days, the IW may pick any QME within a reasonable geographic area (California Labor Code, Title 8, Section 139.2, 2024).

In unrepresented cases, the IW has 10 days after panel assignment to select a QME from the panel and call the QME's office to schedule an appointment; otherwise, the employer may select the QME (California Department of Industrial Relations, 2015). In represented cases, the applicant and defense each may strike one of the three QMEs, and the remaining QME is selected to examine the IW.

In both represented and unrepresented cases, either the applicant or defense can request a replacement panel in the same specialty if a valid reason is provided (e.g., the QME is not available for an appointment within 90 days or the selected QME has a conflict of interest) (California Code of Regulations, Title 8, Section 31.5, 2023).

In cases where the IW is represented, the AA and defense attorney (DA) may opt to use an AME. The use of AMEs is also briefly discussed in this report, but the AME process is not administered by California DWC, and the full details of the AME process are outside the scope of the present report. If the parties do not use an AME, one party can request a QME panel. In represented cases, the panel of three QMEs is generated instantly through the online process (California Code of Regulations, Title 8, Section 30).

Once the QME is selected and an appointment is made, usually the defense sends medical records, other relevant documents, and a cover letter to the QME outlining key questions to be answered by the report. The applicant may also send an advocacy letter, medical records, and other relevant documents. Each party must receive the information from the opposing party at least 20 days before it is to be given to the QME. After receiving the records, each party then has 10 days to object to records from the opposing party. The opposed records will then be removed from the records provided to the QME unless otherwise ordered by a workers' compensation judge (California Code of Regulations, Title 8, Section 35, 2024). If there are disagreements between the parties over which records to send to the QME, the QME may conduct the evaluation without receiving all relevant records. If the QME does not receive the medical records within 10 days after the date of the evaluation, the evaluator must still complete and serve the report (California Code of Regulations, Title 8, Section 35, 2024) to comply with the 30-day filing requirements with some exceptions for extensions (California Code of Regulations, Title 8, Section 38, 2025). If the QME does not answer all the relevant questions in their report or is not able to address certain questions in the required time frame due to lack of medical records, a supplemental report may be required. Sometimes, the QME may not be able to comment on medical questions outside of their specialty or specialties. In these cases, either party may request an additional QME panel in a different specialty, in which case the process of QME selection, record delivery, evaluation, and report writing is repeated (California Code of Regulations, Title 8, Section 35.5d, 2025). In some cases, a party may request that the QME give a deposition on their report, in which case the QME must be available within 120 days of the request, unless the applicant, defense, and the QME can agree to another time or a different time is ordered by a workers' compensation judge (California Code of Regulations, Title 8, Section 35.5, 2024).

Case Resolution

The case is resolved when there is an agreement between the IW and the claims administrator or a judge issues an order to determine the settlement. The case can be settled with "stipulations with request for award," in which the IW and the claims administrator agree on the amount of temporary disability and permanent disability and that there is a need for ongoing or future medical care. Alternatively, the case can be settled with a "Compromise and Release," in which the IW and claims administrator agree on total compensation, typically paid as a lump sum, to settle all aspects of the case (California Department of Industrial Relations, 2023). Compromise and release agreements must also be approved by a judge who consults the IW's medical records and reviews the settlement for accuracy. Finally, a case may be resolved with "Findings and Award," in which a judge decides on all issues including permanent disability and whether the IW is entitled to future medical care.

Participants in California's Medical-Legal Process

The Med-Legal process in California involves many different stakeholders, each with a unique role in the system.

Injured Workers and Applicants' Attorneys

In California's Med-Legal system and broader workers' compensation system, IWs have several responsibilities. When a worker is first injured on the job, the worker must report their injuries to their employer and file a workers' compensation claim. IWs may seek care from a predesignated physician (i.e., one selected by the worker and authorized by the employer or insurer prior to injury), a doctor from their employer's medical provider network or health care organization, or a doctor selected by the workers' claims administrator (California Department of Industrial Relations, 2024a). Unrepresented IWs are responsible for tracking deadlines, including deadlines for requesting the QME panel and selecting a specialty and for making the QME appointment. An unrepresented IW must also, within ten days of receipt from the defense, review and document objections to the cover letter and records provided to the QME (California Code of Regulations, Title 8, Section 35, 2024). Some IWs seek representation by AAs. Depending on when in the process the IW gains representation, the AA can help IWs select an AME (if the defense agrees) or request QME panels and select a specialty and QME. Applicants' attorneys can also help the IW navigate evaluation appointments and timelines, write advocacy letters to evaluators on the IW's behalf, review records provided by the defense, and argue on the worker's behalf in front of workers' compensation judges.

Employers, Insurers, Claims Administrators, and Defense Attorneys

Employers in California are required to have workers' compensation insurance. Employers must either purchase workers' compensation insurance through a company licensed by the California Department of Insurance or, for larger employers or groups of employers, obtain a certificate of self-insurance through California DIR (California Labor Code, Division 4, Section 3700). Claims administrators are responsible for reviewing and administering workers' compensation claims. They review care requested or received by the IW's PTP to ensure that it is medically appropriate. Claims administrators may be employed by a workers' compensation insurer, or, for self-insured companies, claims administrators may be part of the company's in-house claims department. Both insurance companies and self-insured companies may use claims administrators through a third-party administrator.

DAs provide legal representation for employers or insurance companies. Some employers and insurers may have in-house counsel, or employers may work with an outside attorney or law firm that provides workers' compensation defense. These DAs act in the interest of the employer or insurer and advocate to control costs of workers' compensation claims.

Qualified Medical Evaluators

QMEs are physicians who are licensed to practice in California, are board-certified in a relevant specialty or specialties, and have gone through required training and passed the QME competency exam (California Labor Code, Division 1, Section 139.2). In the Med-Legal process, the term "physician" includes physicians holding a Doctor of Medicine or Doctor of Osteopathic Medicine degree, psychologists, optometrists, dentists, podiatrists, acupuncturists, and chiropractic practitioners (California Labor Code, Division 4, Section 3209.3). When there are disputes over the cause or severity of a workplace injury that cannot be resolved by the PTP, either the applicant or the defense may request a QME evaluation. The QME is then responsible for reviewing records provided by the applicant and the defense, evaluating and examining the IW, and writing a report. In the report, the QME must

- determine whether an illness or injury is work-related to a "reasonable medical probability"
- determine the existence and extent of temporary or/and permanent disability (i.e., whether the illness or injury impacts the worker's ability to work)
- make return-to-work decisions for resolving disputes over the duration of temporary disability, if necessary
- assign an impairment rating based on American Medical Association (AMA) guides for a permanent disability (which is used to determine the disability rating)
- determine whether any portion of impairment should be apportioned to nonindustrial cause(s) or a prior industrial injury and if so, the extent of apportionment
- determine a permanent and stationary date for permanent disability, if applicable
- determine the need, if any, for future medical treatment.

QMEs may not comment on current or ongoing treatment disputes (California Senate Bill 863, 2012). If there are any questions that cannot be answered due to incomplete records or because some disputed issues are outside the scope of the QME's licensure or clinical competence, the QME must note this in the report and a QME panel for a new specialty may be requested. QMEs must also make themselves available for depositions within 120 days of the notice of deposition to answer questions about Med-Legal reports that they write. QMEs are also responsible for scheduling appointments within 90 days of being selected and, if they are unable to schedule or perform medical evaluations during the year, must notify the medical director of their unavailability using Form 109 (California Code of Regulations, Title 8, Section 33, 2024).

Medical Management Companies

Many QMEs work with MMCs to help schedule appointments, find office space, manage records, and meet required deadlines. In return, MMCs receive a portion of the QME's evaluation fees. Some MMCs also recruit new QMEs or provide education and training. MMCs may not write reports for QMEs. DIR does not have jurisdiction over MMCs, and QMEs are ultimately responsible for meeting deadlines and for the contents of their reports.

California Division of Workers' Compensation

DWC is a division of the California DIR. DWC administers the QME system in the state. They are responsible for administering QME testing, certification, and recertification in addition to handling all matters relating to QME discipline. DWC is also responsible for processing requests for QME panels and assigning panels based on specialty and location. When complaints are made against a QME, DWC is responsible for disciplinary action as it pertains to the QME system (medical boards or other entities may take additional disciplinary action, depending on the nature of the complaint). DWC may investigate and take action against QMEs for infractions, such as writing late reports, improper billing, or discrimination (California Department of Industrial Relations, 2022). Disciplinary actions can result in the suspension or termination of QMEs. Increasingly, DWC is taking a role in monitoring and improving the quality of QME reports. While their role in this process is still limited, they have recently begun requiring that QMEs submit their two most recent Med-Legal reports meeting specific criteria when applying for reappointment (Cal. Code Regs. Tit. 8, §50). DWC also provides several resources, including information for prospective QMEs, fact sheets, frequently asked questions documents for different stakeholder groups (California Department of Industrial Relations, 2024b), a quality assurance checklist for QMEs and other evaluators (Feinberg, Richardson, and Rassp, 2025), continuing education classes for QMEs, and live assistance for IWs (California Department of Industrial Relations, 2025b).

DIR also takes an active role in recruiting QMEs. They advertise the QME program and upcoming exams on the DIR website and on board specialty websites and newsletters, including for less common specialties, such as oncology. They work with medical organizations, such as the California Society of Industrial Medicine & Surgery and the California Orthopaedic Association to advertise upcoming exams. DIR also conducts follow-up with QMEs who signed up to take the qualifying exam but did not pass or sit for the exam to encourage them to take it again. They also follow up with physicians that have recently left the QME program.

Timeline of Changes to the Medical-Legal Process

The Med-Legal process in California has undergone significant changes since QME panel assignment first began in 1991. Table 2.2 summarizes the key legal decisions, legislation, regulations, and administrative changes affecting QMEs' roles in California's Med-Legal process from 1991 to 2024. The changes are also described in additional detail in the text following the table.

Table 2.2. Timeline of Legislative, Regulatory, and Administrative Changes in QME Process

Event Type	Year	Description
Legislation	1991	CA LAB § 139.2: QME panel assignment begins in unrepresented cases
Legislation	2004	CA LAB §§ 4060, 4061, 4062, 4062.1 & 4062.2: Legislative reforms set up current system of QME panel requests
Regulation	2006	Cal. Code Regs. Tit. 8, § 9795: Change to Med-Legal fee schedule, increase in basic reimbursement multiplier
Case	2007	*Nelly Romero v. Costco*: Establishes that replacement QME panel may be requested if the prior panel was not used and representation of the IW changed
Regulation	2009	Cal. Code Regs. Tit. 8, § 13: Combined several QME medical specialties
Cases	2009–2010	*Almaraz v. Environmental Recovery Services* and *Guzman v. Milpitas Unified School District*: Commented on how the AMA guides should be used to determine impairment ratings
Case	2011	*Messele v. Pitco Foods*: Established the wait time to obtain a QME panel in both the unrepresented and represented tracks
Legislation	2013	CA S.B. 863: Restricted number of QMEs offices, prohibited QMEs from commenting on current and ongoing treatment or on permanent disability arising from certain conditions, removed requirement to first consider AME before applying for a QME panel in represented cases
Regulation	2013	Cal. Code Regs. Tit. 8, § 26: Required QMEs to remain at an office for at least 180 days from certification date
Case	2014	*Ismael Navarro v. City of Montebello*: Determined that an employee does not need to use the same panel QME for an evaluation of a subsequent injury claim
Regulation	2015	Cal. Code Regs. Tit. 8, §§ 30 & 30.5: Required use of new online panel request process for represented cases, removed the neuropsychology specialty, and enforced board certification for subspecialties at the time of appointment and reappointment
Regulation	2020	Cal. Code Regs. Tit. 8, §§ 36.7, 46.2 & 46.3: Emergency COVID-19 regulations allowed for electronic delivery of Med-Legal documents and reports and for telehealth exams; versions of these regulations later became permanent in 2022
Regulation	2021	Cal. Code Regs. Tit. 8, § 9795: Med-Legal fee schedule change, replaced time and complexity payments with flat fee plus additional payments for record review
Regulation	2023	Cal. Code Regs. Tit. 8, §§ 31.3(e): Extended the initial time frame for QMEs to schedule an appointment from 60-90 days to 90-120 days Cal. Code Regs. Tit. 8, §§ 34(b): Allowed initial QME evaluations to occur at any office listed with the DWC Medical Director, not just the one on the panel selection, with the agreement of both parties
Regulation	2024	Cal. Code Regs. Tit. 8, § 50: Requires QMEs to submit two recent reports through online portal for reappointment Cal. Code Regs. Tit. 8, § 33: Extends the number of unavailability days that a QME can use during a calendar year from 90 to 120 Regs. Tit. 8, §§ 11.5 and 55.1: Increased education course requirements for appointment of QMEs after passing the exam and increased the required Continuing Medical Education (CME) hours for QMEs recertifying

SOURCE: RAND review of California policies, with input from DIR.
NOTE: Year refers to year of relevant decision in case and effective date for regulations and legislation. COVID-19 = coronavirus disease 2019.

Legislative Changes

In 1991, CA LAB § 139.2 initiated QME panel assignments for unrepresented cases only. This was followed by CA S.B. 899 in 2004, which included significant reforms to the Med-Legal process (California Labor Code, Division 4, Sections 4060, 4061, 4062, 4062.1, 4062.2). These reforms established the current system of QME panel requests and expanded QME panel assignments to represented cases. Prior to the 2004 reforms, applicants and defense in represented cases each selected their own evaluators, sometimes referred to as "dueling QMEs" (California Department of Industrial Relations, 2019). The reforms also specified that the insurer could request the panel if the unrepresented IW failed to do so.

Significant legislation in 2012 (California Senate Bill 863, 2012) with provisions effective at different times in 2013 led to several changes to the QME process. The legislation limited the maximum number of offices QMEs could have to ten. It also prohibited QMEs from commenting on current and ongoing treatment, moving this to a separate IMR process, and from increasing impairment ratings due to permanent disability arising from sleep disorders, sexual dysfunction, and non-accepted psychological add-ons, except where directly caused by the work-related injury. Finally, it established that parties no longer needed to consider an AME before applying for a QME panel.

Regulatory Changes to the Med-Legal Fee Schedule

The Med-Legal fee schedule is set in regulations and determines how QMEs are reimbursed for evaluations, record review, report writing, and providing testimony. In 2006, Cal. Code Regs. Tit. 8, § 9795, which sets the Med-Legal evaluation fee schedule, was updated to increase the basic reimbursement multiplier for evaluators. The fee schedule was not updated again until 2021—the current version of the fee schedule. Prior to 2021, QMEs were compensated based on the time required to complete the evaluations and record review and the complexity of the injuries in the case. In 2021, the previously used time and complexity-based payments were replaced with flat fees for each initial evaluation, follow-up evaluation (i.e., a follow-up evaluation of the IW occurring within 18 months of the original evaluation, extended from within 9 months prior, in 2021), Med-Legal report, and supplemental report (i.e., an additional report that may involve review of new records but not a new evaluation). Under the 2021 fee schedule revision, record reviews were compensated at $3 a page for record reviews above 200 pages. There were two main goals of the fee schedule change: 1) to increase average QME reimbursement for a report and attract new QMEs and 2) to simplify the fee schedule and prevent excessive increases in hourly billing that had been observed (California Department of Industrial Relations, 2019). Testimony was still compensated on an hourly basis under the new fee schedule, but the hourly fees for Med-Legal testimony for depositions increased.

Other Regulatory Changes

Other notable changes to the California Code of Regulations included a 2009 update to Tit. 8, § 13, which combined several QME specialties; the 2013 addition of Tit. 8, § 26, which required QMEs to remain at an office for at least 180 days from the date that the DWC Medical Unit certified the office; and the 2015 updates to Tit. 8, § 30 & 30.5, which required use of a new online panel request process for represented cases and removed the neuropsychology QME panel specialty.

Several other changes to regulations included Cal. Code Regs. Tit. 8, § 36.7, 46.2 & 46.3, which were developed in response to the COVID-19 public health emergency. These temporary regulations allowed for electronic delivery of Med-Legal documents and reports and for telehealth exams. Versions of these temporary regulations later became permanent. In 2023, Cal. Code Regs. Tit. 8, §§ 31.3(e) and 34(b) extended the initial time frame for QMEs to schedule an appointment from 60–90 days to 90–120 days and provided more flexibility in selecting where the evaluations can occur, respectively.

Finally, in 2024, Cal. Code Regs. Tit. 8, § 50 was updated to require that QMEs submit their two most recent reports through an online portal as part of reappointment process, Cal. Code Regs. Tit. 8, § 33 extended the number of days that a QME indicates that they are unavailable for appointments during a calendar year from 90 to 120, and Regs. Tit. 8, §§ 11.5 and 55.1 increased education course requirements for appointment of QMEs after passing the exam and increased the required CME hours for QMEs recertifying.

Case Law

Important Workers' Compensation Appeals Board (WCAB) panel decisions, such as from *Nelly Romero vs. Costco* (2007), *Messele v. Pitco Foods* (2011), and *Ismael Navarro v. City of Montebello* (2014), clarified certain aspects of the QME panel process in represented and unrepresented tracks. Multiple decisions over 2009 and 2010 from *Almaraz v. Environmental Recovery Services* and *Guzman v. Milpitas Unified School District* (collectively referred to as "Almaraz/Guzman") commented on the use of AMA guides to determine impairment ratings. More specifically, it clarified that "when determining an injured employee's WPI [Whole Person Impairment], it is not permissible to go outside the four corners of the AMA Guides; however, a physician may utilize any chapter, table, or method in the AMA Guides that most accurately reflects the injured employee's impairment." While this decision is not related to the QME assignment process, it changed the way that QMEs could apply the AMA guides when writing Med-Legal reports.

Prior Research on QMEs and California's Med-Legal Process

Several prior studies have evaluated aspects of California's Med-Legal process and use of QMEs. A 2016 Workers' Compensation Insurance Rating Bureau (WCIRB) report evaluated the

impacts of California Senate Bill (SB) 863 (WCIRB California, 2016), which created the IMR process. The study found that the costs of Med-Legal services increased significantly following California SB 863, contrary to WCIRB's earlier projections that use of IMR instead of QMEs for treatment decisions would reduce overall costs (WCIRB California, 2012).

Another report by the Workers Compensation Research Institute compared Med-Legal costs across California and 17 other states and found that California had the highest Med-Legal costs per claim over the 2012–2016 study period and corroborated WCIRB's finding that Med-Legal costs had increased following CA SB 863 (Yang and Rothkin, 2016).

A 2017 report by Neuhauser also examined the impact of SB 863 as well as examined other trends in QME evaluations (Neuhauser, 2017). The report noted both a decline in the number of QMEs and an increase in the number of QME panel requests, which resulted in the number of requests per QME approximately doubling over the 2007–2017 study period. The report found that the increase in panel requests was entirely due to the increase in represented cases and that the increase was driven equally by requests from the applicant and the defense. The report also noted that more than half of panel assignments went to the busiest 10 percent of QMEs, nearly all of whom had exactly ten offices and were in orthopedic specialties. Despite the increases in panel requests and decrease in QMEs over this time period, the report found that the percentage of QME panel assignments for which a subsequent panel was requested because the selected QME was not available within 60 days was very low in 2016. However, this percentage had more than tripled since 2013, potentially signaling future sustainability concerns. The report also noted an increase in the use of QMEs relative to AMEs in represented cases after the passage of SB 863, signaling increased demand for QME services. A 2018 report by the California Workers' Compensation Institute (CWCI) also confirmed Neuhauser's findings that the number of QMEs decreased between 2012 and 2017 while the number of Med-Legal evaluations increased (Jones, 2018). The report also found that time-based payments for supplemental reports more than doubled from 2007 to 2017. The report noted increased use of MMCs with the percentage of Med-Legal services managed by ten management groups more than doubling 2012 to 2017.

A 2018 report by Wynn analyzed Workers' Compensation Information System (WCIS) medical claims data from 2007 to 2014 and qualitative data from stakeholders in the Med-Legal process to identify the characteristics of a high-quality Med-Legal report and to recommend potential changes to the Med-Legal fee schedule (Wynn, 2018). The quantitative analyses found that increases in Med-Legal payments were largely driven by an increase in the time billed for evaluations and for the number of follow-up evaluations. Interviews identified several characteristics of a high-quality Med-Legal report, including a comprehensive review of a worker's prior history and current issues, a thorough response to all of the relevant Med-Legal questions to be addressed, a focus on objective findings, and, where applicable, a well-reasoned permanent disability explanation with appropriate references.

A 2019 report by the California State Auditor echoed sustainability concerns in prior reports, noting that panel QME requests had increased while the number of QMEs had decreased (California State Auditor, 2019). The report also noted an increase in the number of replacement panels requested because of QME unavailability. Furthermore, the report expressed concerns about the quality of QME reports, although it noted that little data were available at the time to assess report quality. The report made several recommendations, including that the legislature update the fee schedule every two years to account for inflation and that DWC create and implement a plan for regular monitoring of QME report quality.

CWCI conducted an early evaluation to determine how payments for Med-Legal evaluations changed following the 2021 fee schedule update (California Workers' Compensation Institute, 2024). The CWCI report found that the average payment per comprehensive evaluation increased by 52 percent from the pre-fee schedule change period (January 2019–March 2021) to the post-fee schedule change period (April 2021–October 2023), exceeding the 25 percent increase DWC was targeting to attract new QMEs. They found that most of the increased payments were due to medical record reviews over 200 pages. There was also some evidence that the new fee schedule increased the overall number of QMEs. The number of QMEs increased by 6 percent from 2019 to 2023, which outpaced the 3-percent increase in QME panel requests over the same time period.

Chapter 3. Med-Legal Evaluation in Other States

Method for Review of Other States' Med-Legal Processes

In order to learn about potential alternatives to California's system of PQMEs, we conducted an environmental scan to understand the Med-Legal processes used in other states' workers' compensation systems. First, we conducted an internet search using Google, an academic literature search using Google Scholar, and a legal database search using WestLaw to identify states that used evaluators similar to QMEs or used panels of evaluators as part of the Med-Legal process in workers' compensation. For these searches, we required at least one Panel Evaluator term and one Workers' Compensation term (defined in Table 3.1). We did not identify any other states that used the term "Qualified Medical Evaluator" and only identified one state (Colorado) that used a panel process of selecting evaluators in a workers' compensation context, similar to California's.

We then conducted additional searches of select states to better understand how Med-Legal evaluations to resolve workers' compensation disputes function in those states. Because the goal was to focus on states with the most relevance to California's workers' compensation system, we prioritized states that had similarities to California either in their size and diversity or in the structure of their system of resolving workers' compensation disputes through Med-Legal evaluations. We prioritized states with large populations (i.e., the nine next most populous states after California using 2020 U.S. Census data), racially or ethnically diverse states (i.e., the top ten most diverse states, excluding California, as measured by the U.S. Census diversity index (Jensen et al., 2021)), and states suggested by DIR or the medical association representatives with whom we spoke (described in the next chapter) as having some similarities in their Med-Legal evaluation system. This left us with a list of 17 states (Arizona, Colorado, Florida, Georgia, Hawaii, Illinois, Maryland, Michigan, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Texas, and Washington) to review further. For each state, we conducted an internet search using Google, academic literature searches using Google Scholar, and a legal database search using WestLaw. Each search included the state name or postal abbreviation in combination with at least one term related to Med-Legal evaluations and at least one term related to workers' compensation (see Table 3.1). Finally, we reviewed the website of each state's workers' compensation agency or closest DWC counterpart (hereafter "workers' compensation agency"). We sometimes used the results of our internet searches to update the search terms for our policy reviews. For example, workers' compensation Med-Legal evaluators are referred to as "Designated Doctors" in Texas, so we used this term in subsequent searches of Texas policies.

For each state, we compiled the following information:

- evaluator selection process
- evaluator required qualifications and certification process
- evaluator compensation structure
- evaluator quality assurance and discipline
- other notable features of the Med-Legal process.

We identified states whose workers' compensation agency played a role in selecting Med-Legal evaluators to make determinations related to disability ratings and/or make determinations about cause of injury. We identified individuals with knowledge of the Med-Legal evaluator process from other state workers' compensation agencies through internet searches and referrals from California DWC and contacted those individuals with requests for interviews.

Table 3.1. Search Terms

Category	Search Terms
Panel Evaluator Terms	• "Qualified Medical Evaluator" • QME • Panel AND Evaluat* • Panel AND Med* Legal
Broader Evaluator Terms	• Evaluat* • IME • Med* Legal
Workers' Compensation Terms	• Worker* Comp* • "Industrial Relations" • DWC • DIR

NOTE: * represents a search wildcard (e.g., evaluat* may return "evaluation," "evaluate," or "evaluator").

Results of Review of Other States' Med-Legal Processes

The 17 states we reviewed had notable variations in their policies addressing Med-Legal evaluations to resolve workers' compensation disputes. Overall, we found that few states took as active a role in the Med-Legal evaluation process as California did. In most states, the state's DWC equivalent has no role or only a limited role in selecting evaluators. In eight states (FL, GA, HI, MD, NC, NV, NM, NY), either the defense or applicant (whichever requested the evaluation) selects the evaluator. In another five states (AZ, IL, MI, NJ, OH), only the defense can request and select the evaluator. In Colorado, the applicant and defense must agree on an evaluator; otherwise, the Workers' Compensation Division will issue a panel of three physicians known as Division Independent Medical Examiners (DIMEs), similar to California's system from 2004 to 2012 when, for represented cases, both sides were required to first reach an agreement on an AME before requesting a QME panel. Although done in a narrower set of

circumstances than in California, 11 states (CO, FL, GA, HI, NV, NM, NY, OH, PA, TX, WA) will assign evaluators in some circumstances. For example, in Nevada, the DIR Workers' Compensation Section maintains a panel of Rating Physicians and assigns them to workers' compensation cases to make permanent partial disability ratings, but these physicians do not perform other functions of a QME. Two states examined, Ohio and Washington, are monopolistic workers' compensation insurers, meaning that employers typically purchase insurance through the state, not through a private workers' compensation insurer. In those states, the state DWC equivalent can request an evaluation and select an evaluator in their capacity as the insurer. Of the states we reviewed, Texas takes the most prominent role in assigning evaluators through their Designated Doctor program, in which either the applicant or defense may request a Designated Doctor evaluation, and the Texas DWC will assign an evaluator.

Other states' workers' compensation agencies play different roles in setting and enforcing evaluator qualifications. In nine states (AZ, GA, HI, IL, MD, MI, NC, NJ, NM), the state workers' compensation agency has no requirements for evaluators conducting IMEs other than license and good standing to practice in their discipline. Nine states (CO, FL, NM, NV, NY, OH, PA, TX, WA) have state-specific accreditation requirements for at least some types of evaluators, and two of those states (CO, NV) use certification from a national board, such as certification by the American Board of Independent Medical Examiners or the American Academy of Disability Evaluation Physicians, as an alternative to or replacement for state-specific requirements in some situations. Ten state workers' compensation agencies (AZ, GA, HI, IL, MD, MI, NC, NJ, NM, PA) have no specific role in evaluator discipline or quality assurance outside of monitoring that the evaluator is still licensed and in good standing to practice in the state. Seven states have some additional role in discipline of evaluators (CO, FL, NV, NY, OH, TX, WA), and only four states (CO, NV, OH, TX) have an explicit role in reviewing and enforcing rating or report quality.

States also differ in which party pays for evaluations and how the level of compensation for evaluators is determined. In six states (CO, HI, IL, MD, NC, NY), whichever party requested the evaluation must typically pay for it (with some exceptions, as detailed in Appendix A). In 12 states (AZ, FL, GA, MI, NC, NV, NJ, NM, OH, PA, TX, WA), as in California, the employer or payer must typically pay for it (with some exceptions, as detailed in Appendix A).

States differ in how the rate of compensation is set for evaluations, as well. In eight states (AZ, FL, IL, MI, NC, NJ, NM, PA), the state is not involved in setting the evaluation rates; instead, it is negotiated between the payer and the provider. In nine states (CO, GA, HI, MD, NV, NY, OH, TX, WA), as in California, evaluation rates are set by a state fee schedule. The structure of the fee schedules varies markedly by state. For example, some states establish flat fees for examinations and reports while others pay hourly rates, some states establish higher rates for specific medical specialties or for multiple body areas or systems, some states include "no show" fees in their schedules, and some states establish fees for such activities as evaluator travel

or testimony. Full findings and references to relevant legislation, regulations, and other policy documents are provided in Appendix A.

Chapter 4. Qualitative and Quantitative Methods

In this chapter, we describe the methods used in our qualitative and quantitative analyses. Our qualitative analyses included interviews with AAs; interviews with defense attorneys, employer, or insurance representatives (hereafter "defense representatives"); interviews with MMC representatives; interviews with IWs; interviews with representatives from other states' workers' compensation agencies; and focus groups with active and former QMEs. Our quantitative analyses included a review of data sources maintained by California DIR, including data on QMEs and panel assignments, all-payer workers' compensation claims data, and case status data. For each of the ten study questions, we summarized our relevant qualitative findings. For several of the study questions, we also presented quantitative results to support or complement our qualitative findings. In subsequent chapters, the quantitative results are presented alongside the qualitative results and organized by research question, with some analyses cutting across research questions.

Qualitative Analyses

Background Discussions with Medical Associations

Prior to beginning other qualitative activities, we conducted background discussions with representatives of California medical associations representing the largest QME specialties (Orthopedic Surgery, Chiropractic, and Pain Medicine). These discussions helped us focus the policy review previously presented in Chapter 2, identify other states with Med-Legal processes that would provide useful points of comparison for California, and refine our interview and focus group guides.

Interviews and Focus Groups

We conducted 27 informational interviews and 6 focus groups with key stakeholders in the Med-Legal process between November 2024 and October 2025. First, we developed our recruiting strategy, drafted recruiting scripts and emails, developed information sheets to use during recruitment, developed the interview protocols, and submitted these for Human Subjects Protection Committee approvals with RAND's Human Subjects Protection Committee. Next, we recruited participants, conducted interviews and focus groups, developed a qualitative coding scheme, and coded interviews.

Recruitment for Interviews

We conducted approximately 60-minute, semi-structured interviews with the following groups:

- AAs (8 individuals)
- IWs (5 individuals)
- DAs and representatives of self-insured employers (hereafter, collectively referred to as "defense representatives," 7 individuals)
- MMC representatives (representatives of 5 MMCs)
- representatives from other states DWC counterparts (representatives of 2 states)

We recruited AAs, defense representatives, and MMC representatives through referrals by California DIR, referrals from medical associations, referrals from the California Applicants' Attorneys Association, and from other individuals we interviewed or initially contacted for interviews. Represented IWs interested in participating in the study were referred by the AAs with whom we spoke, and unrepresented IWs were referred by the California DWC Information and Assistance Unit. Interview participants received an incentive of a $50 gift card, if allowed by their employer.

Interviews with Representatives from Other States

We interviewed representatives from two states' workers' compensation agencies—Colorado and Texas—to learn more about how the workers' compensation Med-Legal process functions in their states and what challenges and successes the states have encountered. In these two states, like in California, the state DWC plays a relatively larger role in the Med-Legal process. Qualitative findings from these interviews are described in the qualitative results section for each research question.

Characteristics of California Interview Participants

We conducted interviews with eight AAs, seven defense representatives (i.e., DAs or employer or insurance representatives), five MMC representatives, and five IWs (two represented and three unrepresented). Several of the interviewees were also able to provide additional perspectives. For example, some AAs had previously worked as DAs and vice versa, and some MMC or defense representatives were active or former QMEs. All stakeholder groups included representatives from both Northern and Southern California.

Recruitment for Focus Groups

We conducted six focus groups: three with active QMEs and three with former QMEs who were active at some point between 2020 and 2024. We recruited QMEs using California DIR's QME database. We used a combination of a stratified random and purposeful sampling strategy, with the goal of including representation from QMEs with

- different lengths of time as a QME: one or two 2-year appointment cycles, corresponding to approximately four or fewer years as a QME; or three or more 2-year appointment cycles, corresponding to more than four years as a QME
- geographic practice area: at least half of offices were located in Northern counties. Northern counties were defined as those in California census regions 1–4 (California Census Office, undated) or majority of office locations in Southern counties (i.e., counties in all other census regions)
- urbanicity of practice area: at least one office location in a rural county (U.S. Department of Agriculture Economic Research Service, 2025) or all office locations in metro counties
- number of offices: less than ten or exactly ten
- number of specialties: single specialty or multiple specialties

We also sampled with the goal of getting representation from the following specialties: Orthopedic Surgery, Chiropractic, Pain Medicine, Psychiatry (other than pain medicine), an underrepresented specialty mentioned during three or more interviews (i.e., Medical Oncology, Neurology, or Cardiovascular Disease), and other internal medicine. The QME database does not note whether the QMEs also serve as AMEs, so we also invited two active and two former QMEs, referred through prior interviews, to include representatives who could speak to this perspective.

For our initial list of email invitations to active QMEs, we randomly selected without replacement QMEs from each characteristic category such that each category was represented at least four times in the sampling list of active QMEs. One week after the initial email invitations, we sent additional rounds of emails randomly selecting additional QMEs from categories for which we had not yet received confirmed responses until we had at least one QME representing each category and we had scheduled a total of 13 active QMEs to participate in one of three focus groups, with 11 ultimately attending.

To recruit former QMEs, we began with a list of QMEs who had served on a panel 2020–2024 and were no longer active, excluding those that had been removed due to disciplinary action, who were deceased, or who did not have valid contact information. This list was much smaller and did not allow us to use the same sampling strategy as we did for active QMEs given insufficient number of QMEs in certain categories. Therefore, we contacted every QME in those categories and selected the rest of the former QMEs for the initial email using the above strategy until we had scheduled 14 former QMEs to participate in one of three focus groups with ten ultimately attending. Active and former QMEs received a participation incentive of a $150 gift card.

Characteristics of Focus Group Participants

At least one active or former QME represented each of our categories of interest. Participant characteristics are presented in Table 4.1. By chance, one QME from our focus group also served as a Designated Doctor in Texas in addition to serving as a QME in California and could provide insights comparing experiences in the two systems.

Table 4.1. Focus Group Characteristics

Characteristic	Active QME Focus Group, N (%)	Former QME Focus Group, N (%)
1–2 appointment cycles	3 (27%)	2 (20%)
>2 appointment cycles	8 (73%)	8 (80%)
≥ 50% Offices in Northern California	1 (9%)	2 (20%)
> 50% Offices in Southern California	10 (91%)	8 (80%)
Office in Rural County	1 (9%)	1 (10%)
No offices in Rural Counties	10 (91%)	9 (90%)
<10 Offices	6 (55%)	5 (50%)
10 Offices	5 (45%)	5 (50%)
1 Specialty	7 (64%)	10 (100%)
>1 Specialties	4 (36%)	0 (0%)
Specialty*		
Orthopedic Surgery	0 (0%)	1 (10%)
Pain Medicine	2 (18%)	1 (10%)
Chiropractic	2 (18%)	2 (20%)
Psychiatry (other than Pain Medicine)	3 (27%)	0 (0%)
Underrepresented specialty	2 (18%)	1 (10%)
Other internal medicine	1 (9%)	0 (0%)
Other	3 (27%)	5 (50%)

SOURCE: RAND analysis of QME data.
NOTE: Some QMEs have multiple specialties, so sum of percentages can exceed 100.

Qualitative Coding and Analysis

We developed semi-structured interview guides with input from subject-matter experts and California DWC, addressing key study research questions. Interview topics are provided in Appendix B. Interviews were recorded, transcribed, and deidentified, then uploaded to Dedoose (Dedoose, 2025), an application for analyzing qualitative data. We first used deductive content analysis, meaning that we used prior constructs directly related to the research questions, to develop a coding scheme. We then updated our coding scheme using inductive content analysis, meaning we added additional themes that emerged repeatedly in the data. Two researchers began by each coding a separate interview transcript, meaning that they reviewed the transcripts and assigned statements to specific themes. A third researcher, the project lead, independently coded each of those two interview transcripts. The three researchers then met and assessed agreement and discussed discrepancies in coding. Where there were discrepancies in coding, the researchers revised the coding guides to provide additional detail and specificity. The first two researchers then each coded two additional interviews, which were reviewed by the study lead, and met again to discuss clarifications to the coding guide. The first two researchers then coded the

remaining interviews and focus groups. After the coding was complete, the study lead reviewed each statement tagged under a specific theme and tabulated and synthesized the results, summarizing key themes and selecting illustrative quotes for themes.

Limitations of Recruitment

While we sought to gain perspectives from a large and diverse set of stakeholders within the Med-Legal process, we note some limitations. First, while we took steps to ensure that the group of QMEs we spoke with represented a diversity of characteristics with regard to geographic location, specialty, and length of time serving as a QME and randomly selected who we reached out to within strata of these characteristics, not all QMEs we contacted chose to participate, and these QMEs may be different than those who did choose to participate. Despite oversampling invitations to QMEs with primarily Northern California office locations, QMEs in rural areas, and orthopedic surgeons, only a small number of QMEs with those characteristics participated in the focus groups. We also note that the other interview participants and focus group participants we spoke to were not randomly selected. Rather, these participants were referred to us by DIR, professional organizations, and other interviewees and may differ in important ways from those with whom we did not speak.

Organization of Results

In our interviews with AAs, employer or insurance representatives, MMC representatives, and IWs, we discussed several topics related to the role of QMEs in the Med-Legal process. We also discussed many of these topics in our focus groups with active and former QMEs. When presenting qualitative results, we describe common themes in the interviews and focus groups, along with information about how many of each stakeholder type expressed certain viewpoints, supported by illustrative quotes. The themes are organized by research question, although in some cases, themes may cut across questions. We included themes that were endorsed by at least two participants. We also discuss several instances where participants expressed variations on or contrasts to the main theme or acknowledged complexity to their viewpoints. Where relevant, we also discussed how the other states we spoke with, Colorado and Texas, approached similar issues in their states. Not all the themes are relevant to or were discussed with each stakeholder type. The qualitative results summarize views expressed by a wide range of participants in the QME process but do not comment on feasibility of any specific change or policy proposed by participants, except where explicitly noted by those participants. Specific recommendations that draw from both quantitative and qualitative findings, along with an assessment of feasibility (i.e., if the change would require changes to legislation, regulation, or neither) are presented later in Chapter 8.

Quantitative Analyses

To complement our qualitative analyses, we conducted several quantitative analyses using California DIR data.

Data Sources

We conducted analyses using several data sources. First, we used data from the WCIS, an all-payer database maintained by DWC. The WCIS is the most comprehensive available source of data on California workers' compensation claims and medical bills submitted to workers' compensation payers. The WCIS is a transaction-based Electronic Data Interchange system through which insurers and other workers' compensation payers are required to submit information about claim filings, benefit payments, medical bills, and changes in the status of a case.

DWC programmers extracted databases for the RAND team containing two types of records from the WCIS: medical billing data, which capture detailed information on medical services, procedures, and payments associated with workers' compensation claims; and FROIs, which document the initial report of workplace injuries and the characteristics of affected workers, employers, and incidents. The medical billing data were particularly important because medical bills reflect Med-Legal reports and allow us to observe the dates of and payments for these reports. As we describe in Appendix C, Med-Legal reports and information about the type of provider who examined the worker can be identified from a set of procedure codes and modifier codes. We also use information about physicians in the medical billing data to address research questions about the utilization of QME panels (i.e., for each panel, whether there was a subsequent QME evaluation by one of the QMEs on the panel). WCIS FROIs, meanwhile, provide information about the population of IWs and facilitate linkage between data on QME panels and providers with the WCIS.

Second, we used a QME database maintained by DWC. These datasets include longitudinal information about QMEs, such as specialties, certification dates, status (e.g., active, unavailable), and office locations. The datasets also include information about requests for QME panels, including the requestor, date of request, date of panel assignment, requested specialty, and which QMEs were assigned to the panels. As this is an administrative database and not used frequently for research, we conducted several data quality checks on the data for accuracy and internal consistency. For example, we tested whether panel assignment dates ever preceded panel request dates and tested for invalid specialty codes in panel requests. Data quality issues were typically minimal and, where noted, were discussed with and investigated by DWC. Where appropriate, a small number of observations with invalid data (less than 1 percent) were dropped from analyses and noted in the results section. We used these data to examine questions involving the frequency of panel requests, requested specialties, and the timing of panel requests and assignments over time.

Finally, we used Electronic Adjudication Management System (EAMS) data. EAMS is the case management system used by DWC to support the adjudication of workers' compensation claims. It records case-level information entered by workers' compensation judges and parties in the workers' compensation courts and is used to determine changes to status of the case, particularly case closure. We used these data to identify when and how claims progress through the adjudication process and link panel and claims information to case events.

Limitations of WCIS Medical Billing Data

The WCIS medical billing data have some limitations that must be noted, especially for Med-Legal reports and medical care provided prior to April 2016. Data prior to that date were submitted in the X12 4010 format, which had some issues that prevented linkage between the medical billing data and FROIs. As a result, a sizable fraction of medical bills in the system during this time period lack information on the IW and cannot be linked to other data on QME panels. These problems were resolved by improvements in data quality following implementation of the X12 5010 format in April 2016. The implication for our study is that we were only able to analyze data prior to April 2016 in aggregate; thus, research questions requiring analysis of individual-level WCIS data cannot be addressed for the time period prior to April 2016. Data from before April 2016 were used only for analyses focused on the total volume of Med-Legal services or payments for Med-Legal services.

Because the preferred methods used to de-duplicate and process the WCIS medical billing data require a patient identifier to group together bills for a given patient, aggregate data presented here on trends in Med-Legal report volumes or other measures may be affected by a series break in 2016 that undermines the comparability of the data. Due to these limitations, comparison of pre-2016 to post-2016 results involving the WCIS medical billing data should be interpreted with caution. In some cases, results including pre-2016 data are shown only in the Appendix because we were concerned that the series break in 2016 would make it uninformative to present the results here.

Data Linkage

Several research questions require that we combine information on individual cases from two of the datasets described above. Because there was no unique identifier common to any pair of datasets, we used several variables in combination to identify candidate linkages between each pair of datasets and then applied some simple rules to select the most likely match when multiple candidate matches were identified for a given case. The variables used to link cases across datasets were the IW's name, the date of injury, the IW's zip code of residence, and the claim administrator claim number. Further details on our linkage approach, including linkage rates, are given in Appendix C.

To address questions about utilization of panel QMEs, we also had to link the QME data to data on providers who submitted Med-Legal reports in the WCIS medical billing data. This

linkage built on the QME to FROI linkage described above (which linked IWs in the WCIS to QME panels) and then linked the physicians assigned in each panel to those observed in the WCIS medical billing data using the physicians' license number (in the QME data) and the National Provider Identifier (NPI), reported in the WCIS medical billing data. We used the National Plan and Provider Enumeration System (NPPES) to identify medical license numbers associated with each NPI.

Analyses

Using these three data sources, we constructed several measures quantifying different aspects of the QME process, such as time from panel request to panel assignment, time from panel assignment to QME evaluation, number of initial and replacement panel requests, and distribution of assigned panel based on office specialty. Each measure was assessed by year.

Methods for WCIS Data Analysis

Medical billing data from the WCIS was processed to remove duplicate bills and reconcile disagreements between bill-level and line-level paid amounts. Several analytic files were created from the WCIS data to address different sets of research questions.

Questions focused on trends in the number of Med-Legal services and the amounts paid for those services were addressed using the processed bill lines. These questions could be addressed without reliable information about which IW or workers' compensation claim a medical bill was associated with, and so it was possible to calculate these aggregate statistics throughout the entire study period (2012–2024), even though data quality issues with the pre-2016 WCIS data prevented us from reliably grouping together medical bills by the IW who received the care. We believe that procedure codes and charges (the amount billed by the provider, which may be higher than the amount ultimately paid) can be accurately totaled in the pre-2016 WCIS data, but that payment information may be unreliable.

Procedure codes were used to identify bill lines for Med-Legal services and classify the following specific types of services:

- Med-Legal Reports (including reports from QMEs and other Med-Legal evaluators)
  - Comprehensive Med-Legal Reports: ML102, ML103, ML104, ML201
  - Follow-Up Med-Legal Reports: ML101, ML202
  - Supplemental Med-Legal Reports: ML106, ML203
- Depositions: ML105, ML204
- Per-Record Review: ML205
- Other Med-Legal Services (Sub Rosa Record Review and No-Show Fees): ML100, ML200, ML205

Another set of questions required information about the workers' compensation claims for which Med-Legal services were required (for example, questions about the number of Med-

Legal services per injury claim). For these questions, we limited attention to claims in the 2016 and later WCIS data because it was critical that we be able to link the medical bills to FROI data on the IW. Because this linkage was also necessary to connect the WCIS medical billing data to QME panel requests and EAMS, analyses requiring linkage across those datasets was also limited to Med-Legal services occurring in 2016 or later. In some cases, we plotted measures as a percent change relative to a baseline year (either 2017 or 2018) to compare trends in variables with different levels.

For analyses involving WCIS claims data, we did not present data from later years due to claims runout or censoring issues. For analyses of WCIS claims data, we noted a marked decrease in the volume of Med-Legal procedure codes in the last six months of 2024, which we attribute to the lag between the service date and the claim being finalized and submitted to the WCIS. For other analyses that examined the time between events (e.g., time from panel assignment to QME evaluation), we excluded 2024 and, in some cases, 2023 panel data so that each panel request had adequate post-request follow-up data. These exclusions are explained in greater detail in the table notes for each figure.

Methods for Linked Data Analysis

While Appendix C contains the full description of the methods for the linked data analyses, we summarize the high-level points here. For the WCIS-QME analyses, we excluded records with implausible timing, such as panel requests occurring before the claim was reported to the claim administrator. Our unit of analysis was either the QME panel or the IW, depending on the research question, and our time span covered 2016–2023 for most research questions. For analyses that attributed claim activity to panels, we ordered panels by assignment date to ensure that this activity was attributed to the correct panel. For analyses that measured time intervals, such as the time from claim reporting to panel request, we addressed censoring by excluding claims whose filing dates occurred too close to the end of the data to observe a complete request window, using early claim cohorts to define consistent cutoffs across years.

For the WCIS-EAMS analyses, we summarized outcomes at the case level and report findings for 2016–2023 to avoid WCIS claims runout or censoring issues. We focused on cases with observable Med-Legal reports and excluded records that could not be reliably followed through closure. To address censoring within individual case time spans, we excluded cases with report dates occurring too close to the end of the data to observe closure, using early report cohorts to define consistent follow-up windows across years. Censoring thresholds by research question are detailed in Appendix C.

For analyses combining QME panel records and EAMS case information, we treated the panel as the unit of analysis and summarized EAMS activity at the panel level. We collapsed detailed EAMS case events into indicators capturing whether key types of litigation activity occurred, such as panel replacement orders or medical report rejections, and grouped closely related replacement reasons to reduce administrative variation. For analyses measuring time from

panel issuance to case closure, we addressed censoring by excluding panels issued near the end of the data for which closure could not yet be observed, again using earlier panel cohorts to define comparable follow-up periods across years.

Chapter 5. Results: Supply of and Demand for QMEs

Is There a Mismatch Between the Supply and Demand of QMEs Across Specialties and Geographic Areas?

Qualitative Results: Perceptions of QME Supply

We spoke with participants about several issues related to their experiences either as QMEs or interacting with QMEs in the Med-Legal system. We asked about their perceptions of the supply of QMEs in California both overall and across specialties and geographic areas. We also discussed their perceptions and experiences regarding the sustainability of the QME system—that is, whether they thought there would be enough QMEs to meet demand in the future.

Theme: There Are Enough QMEs Overall, but not in Certain Specialties and Geographic Areas.

Participants did not express concerns about the current, absolute number of QMEs, noting that the recent fee schedule change had helped bring a new influx of QMEs into the system. As one defense representative noted, "Sustainable would be having enough QMEs to do the evaluations that are necessary to provide the benefits. And I think recent evaluation or studies of that indicate that, you know, we're doing okay in that area."

However, many participants still had some concerns about the supply of QMEs in specific specialties. Three AAs and three defense representatives noted that there were still not enough QMEs to field a panel for several specialties and that obtaining a panel for other rarer specialties could be difficult. As one AA noted,

> Getting an actual oncologist as a Med-Legal evaluator can be virtually impossible. Because right now the medical unit won't issue a panel in a specialty unless there's at least five doctors in that specialty. And we have three oncologists in the entire state. . . . And there are a couple other specialties where there are not a lot of doctors. . . . So, you know, I think we need to find a way to encourage more doctors to get involved in the system. I don't know what that is. But I'm not sure that, at the current numbers, it's sustainable long term.

Several other participants, including four MMC representatives, one former QME, two additional defense representatives, and one additional AA also noted a general perception that there was not a sufficient supply of QMEs in some specialties with Cardiology, Neurology, Obstetrics and Gynecology, Ophthalmology, Nephrology, and Gastroenterology all mentioned as difficult to obtain specialties.

A representative from Colorado's workers' compensation agency also noted that recruiting rarer specialties to become DIMEs (i.e., evaluators for Colorado's workers' compensation agency, similar to QMEs) was a challenge in their state and also noted how their system of

matching by doctor's self-assessment of area of expertise along with their ability to obtain non-DIME specialist referrals could fill this gap,

> We have this, like OB [obstetrics], Cardiology. They have to see the value in taking the accreditation courses. You don't have to be accredited to treat the patient if you have been referred by the primary designated physician. As [role at organization], I hunt down those specialties and bring them into the system. I focus more on psychiatry, more recently pulmonology. For DIMEs, we often don't have that specialty, so we fall back on the IME physician's knowledge of general medicine and ability to glean important information from the medical record, fill themselves in as needed in order to make an appropriate determination but then to be the expert in finding the impairment rating.

Theme: The Ten-Office Limit Made QME Selection Fairer but May Have Decreased Access.

Three AAs suggested that the ten-office limit made the system fairer with one saying,

> My understanding is they wanted to increase the accessibility to the QMEs on the list. If you sign up as a QME and you have two offices and someone has 40 offices, they're going to pop up more than you are. That's probably the only way they can manage to ensure that everyone gets a bite of the apple under the current system.

One former QME agreed, even suggesting that the limit of ten offices should be reduced even further to prevent QMEs associated with specific MMCs to, as they put it, "saturate the community of possibilities."

However, another AA who worked in a more rural area noted that the restriction hit their county hard because more doctors would list offices in their area and travel to them prior to the ten-office restriction.

Two MMC representatives suggested that the ten-office limit may have made it more difficult to obtain panels in certain specialties or resulted in increased travel time for workers to these specialties. These representatives suggested raising or removing the office limit for rarer specialties.

Quantitative Results

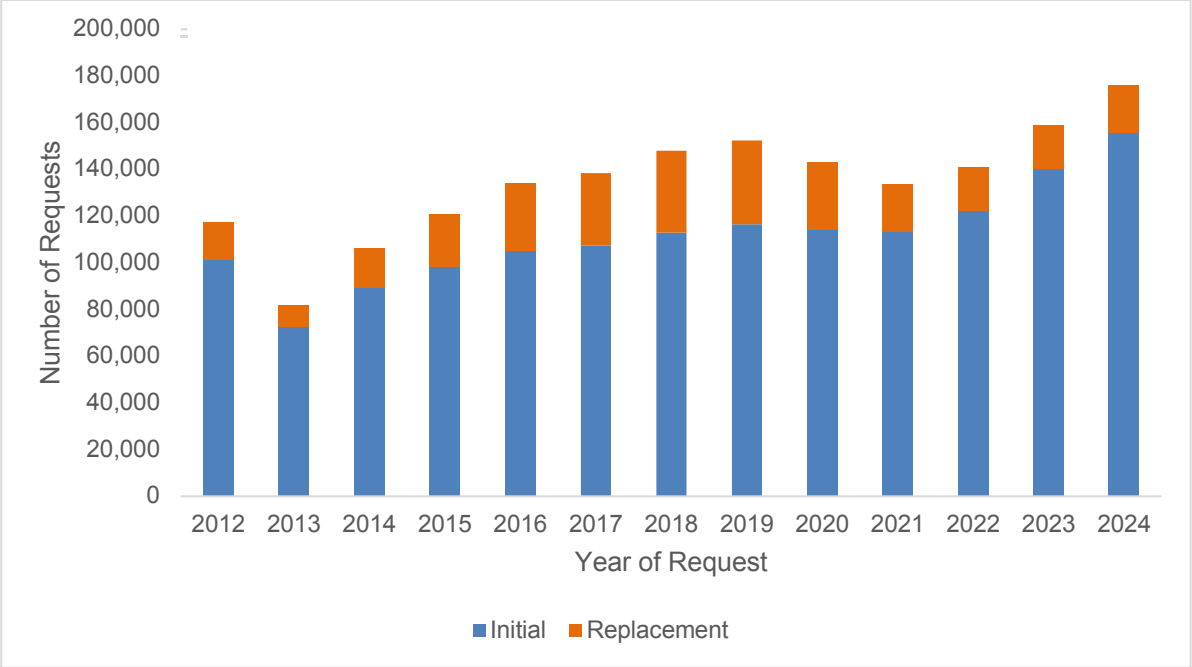
Supply and Demand for QME Panels

Figure 5.1 shows the number of initial panel assignments, meaning the first assignment for a workers' compensation case in a given specialty, and replacement panel assignments, meaning any subsequent panel request within the same specialty, in each year from 2012 to 2024. The number of total QME panel assignments has generally increased over time, with the exception of a decrease in 2013 following an increase in panel request rejections as stakeholders met new compliance requirements stemming from SB 863 and during the COVID-19 public health emergency in 2020 and 2021. Between 2012 and 2024, the total number of panel assignments increased by 50 percent.

Replacement panels, both in number and as a share of total assignments, increased every year from 2013 through 2019. Beginning in 2020, there was a drop in the number of replacement panels, and this number has remained steady from 2021 through 2024, while their share of total assignments has decreased. It could be that the increased number of QMEs following the fee schedule change or the increased time frames to schedule from 90 to 120 days may have helped reduce the number of replacements needed due to untimely scheduling and unavailability. The sequence of replacement requests is stratified further (i.e., into the second, third, fourth, etc. request for the same case and specialty) in Table D.1 in Appendix D.

At DWC's request, we compared the number of QME panel assignments to the number of new workers' compensation claims in California. Over our study period, the number of QME panel assignments has grown faster than the number of workers' compensation claims. In 2012, there were 626,600 new injuries reported (California Department of Industrial Relations, 2025a). This number increased each year to 726,439 in 2019; decreased to 683,590 in 2020; and then increased again to a high of 780,890 in 2022 before decreasing to 679,537 in 2024 (California Department of Industrial Relations, 2025a). The decline in new workers' compensation claims since 2022 was driven by the declining number of COVID-19 claims in the system: 107,324 COVID-19 claims with 2022 injury dates, compared to 24,777 claims with 2023 injury dates and 7,669 claims within 2024 injury dates (California Department of Industrial Relations, 2025a). Demand for QME evaluations should not be expected to mirror the volume of new workers' compensation claims since it takes some time for claims to mature to the point where QME evaluations are requested. That said, the size of the overall workers' compensation system in terms of the number of claims provides context for the growth in QME requests.

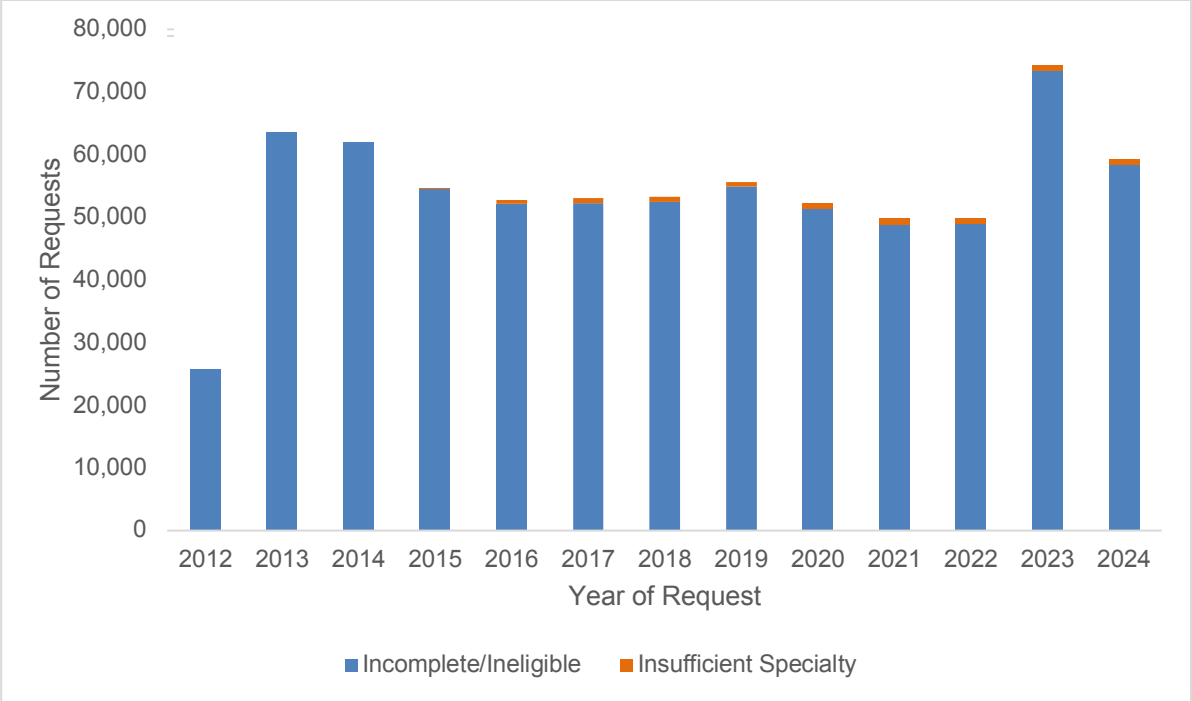
Figure 5.1. Initial and Replacement Panel Assignments, by Year



SOURCE: RAND analysis of QME data.
NOTES: N=1,752,557 total panel assignments. Year refers to the year that the panel request was received.

Figure 5.2 presents the number of panels in each year that could not be assigned due to either incomplete or ineligible requests or due to an insufficient number of QMEs within a specialty. The number of unassigned panels more than doubled from 2012 to 2013, coinciding with changes to the QME panel request process introduced by SB 863. In subsequent years, the number of unassigned panels decreased and then remained steady until 2022, even as the overall number of panel requests increased. There was a large increase in the number of unassigned panel requests in 2023 due to a high number of repeated online requests from a small number of requestors—an issue that was fixed later in 2023. In 2015, regulations enforced board certification for subspecialties at the time of appointment and reappointment. This resulted in some subspecialties, such as oncology, having fewer than five available QMEs—the minimum number required to fill a panel. Beginning October 1, 2015, the online system began to track when panels were unassigned due to fewer than five QMEs available within the subspecialty at the time of request. The number of panels rejected each year due to insufficient specialty were substantially lower than those rejected due to incomplete or ineligible requests. While a request for an unassigned panel does not necessarily mean that a panel was not later successfully assigned in a case, the number of unassigned panels over time track one source of administrative burden in the Med-Legal process and, in some instances, may indicate places where completing valid requests is challenging for requestors.

Figure 5.2 Unassigned Panel Requests, by Year



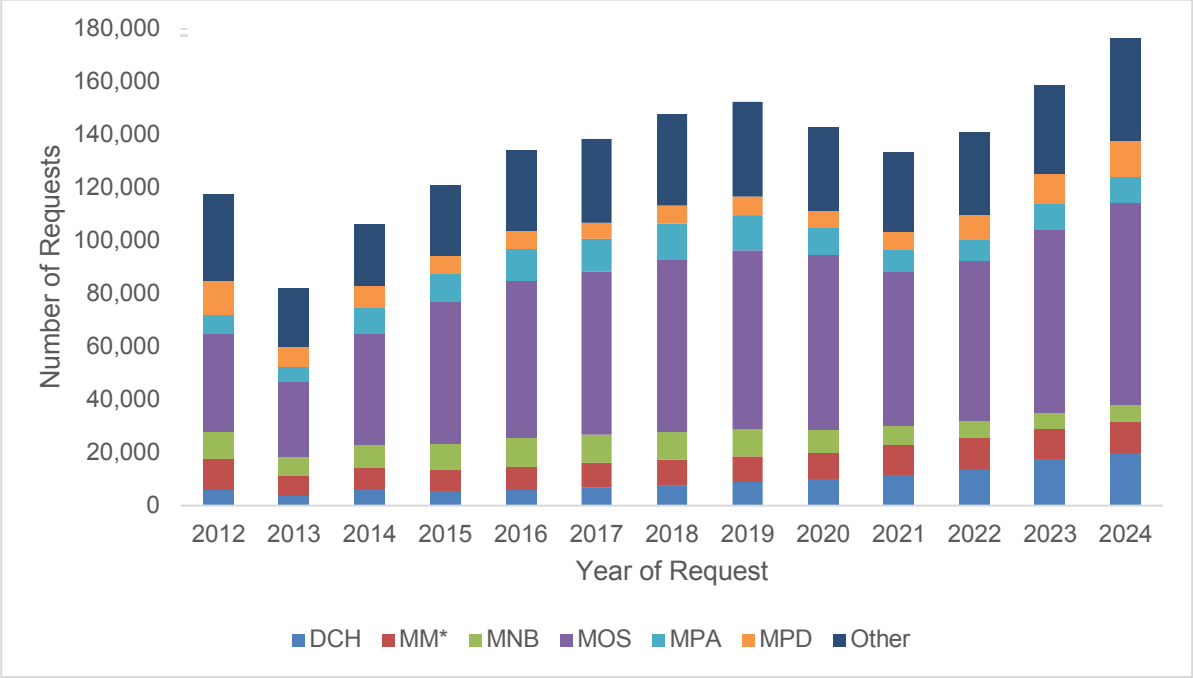
SOURCE: RAND analysis of QME data.
NOTE: N=703,138 unassigned panel requests.

Figure 5.3 presents the yearly number of total panel assignments for some of the most–commonly requested QME specialties. Counts of assignments for each specialty are presented in Table D.2 in Appendix D, and a breakdown of requested specialty by injured body part listed on the initial workers' compensation claim form is presented in Table D.3 in Appendix D. Table D.4 shows panel assignments by requested specialty and requestor (i.e., AA, DA, claims administrator, or unrepresented IW). QME panel assignments increased across most specialties, with some notable exceptions. Growth in panel assignments for chiropractors was especially rapid: The share of panel assignments for chiropractic specialties more than doubled from 5 percent of panel assignments in 2012 to 10 percent of panel assignments in 2024. Concurrently, the share of panel assignments for the spine specialty decreased from 9 percent in 2012 to 4 percent in 2024, and the share of panel assignments for other specialties decreased from 28 percent in 2012 to 22 percent in 2024. Of note, the neuropsychology subspecialty had no panel assignments after 2015, when it was removed from the approved specialty list. Several internal medicine subspecialties (Endocrinology, Hematology, Infectious Disease, Nephrology, and Oncology) also had no panel assignments following 2015, despite still being an option on the QME request forms, due to the aforementioned requirement that there be at least five QMEs available within the subspecialty at the time of request. Specialty requested differed notably by body part injured and by requestor. Of note, AAs were much more likely than other requestors to

request chiropractor and pain medicine specialties, and DAs were much more likely than other requestors to request orthopedic surgery specialties.

For context, we also provided a table comparing the number of panel assignments, active QME providers, and physicians in California by specialty in 2023 for some of the most-commonly requested QME specialties and the most-common specialties for all physicians (Table 5.1). This table shows that some QME specialties (e.g., orthopedic surgeons) are assigned to a disproportionate share of QME panels but that a high proportion of orthopedic surgeons in the state (approximately one-quarter) are already QMEs. By contrast, family medicine doctors receive very few panel assignments and a very small percentage (<1 percent) of these doctors are QMEs, illustrating the challenges of aligning the supply of physicians with panel assignments for in-demand specialties.

Figure 5.3. QME Panel Assignments, by Specialty



SOURCE: RAND analysis of QME data.
NOTE: DCH=Chiropractic, MM*=Any internal medicine specialty, MNB=Spine, MOS=Orthopedic Surgery, MPA=Pain Medicine, MPD=Psychiatry. Only filled requests are included. N=1,752,557 total panel assignments.

Table 5.1. Counts of QME Panel Assignments, QMEs, and Physicians, by Specialty, 2023

QME Specialty Code (Specialty Name in External Data Source)	QME Panel Assignments	QMEs	Physicians in California
MOS (Orthopedic Surgery)	69,043	598	2,289
MPA (Pain Medicine)	9,658	154	841
MPD (Psychiatry)	11,694	193	5,902
MMM (Internal Medicine)	5,729	189	16,736
MPN (Neurology)	5,683	86	1,749
MPR (Physical Medicine and Rehabilitation)	5,157	145	1,113
MTO (Otolaryngology)	1,877	23	1,278
MFP (Family Practice)	102	22	14,641
DCH (Chiropractor)	17,619	593	3,410

SOURCES: The number of physicians in California for all specialties except Chiropractor comes from the Association of American Medical Colleges (AAMC) 2023 data (the most recent available) (AAMC, undated). The number of Chiropractors in California comes from the Bureau of Labor Statistics (US Bureau of Labor Statistics, 2023). QME Panel Assignments and QMEs come from RAND's analysis of DIR QME data.

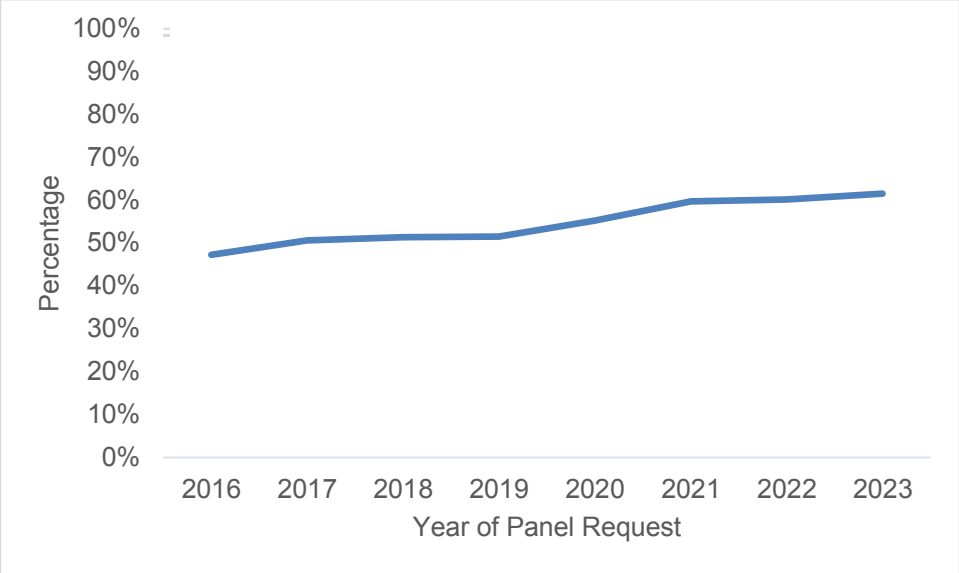
Panel Utilization and Completion of Evaluations

In addition to examining the number of QME panel assignments over time, we also linked panel assignments between 2016 and 2023 to WCIS medical claims data from 2016 through 2024 to estimate the percentage of panel assignments each year that were utilized (i.e., linked to a Med-Legal claim for the same IW and a QME on the assigned panel with a service date after the panel assignment date and before any subsequent panel assignment dates, if applicable). We did not include panel assignments from 2024 to allow for at least 90 days to schedule the Med-Legal evaluation and at least nine months of claims runout.

Figure 5.4 shows the percentage of panels with assignment dates between 2016 and 2023 that were utilized each year. As noted above, WCIS data from before 2016 could not be reliably linked to the QME data. The percentage of panel assignments that were utilized increased from 47 percent in 2016 to 62 percent in 2023. The increase in percentage of panels utilized could signal an improvement in the sufficiency of the supply of QMEs, potentially reflecting more panels for which appointments were successfully scheduled within required time frames. However, panels may not be utilized for reasons other than inability to schedule within the given time frame. As a note, we may understate panel utilization in the medical billing data because panel utilization is measured using linked medical billing records. These estimates depend on our ability to link QME physicians to billing data using NPIs from NPPES; incomplete or outdated NPI information may cause some services to go unobserved. The total numbers of panel assignments, panels linked to a WCIS claim, and panels assignments identified as utilized are presented in Table D.5, while the counts of utilized panels are shown in Figure D.1. Figure D.3 shows the utilization rate broken out by who requested the panel: The patterns suggest that

requests initiated by applicant or DAs are less likely to result in utilization, potentially because IWs have more flexibility to select any of the three QMEs from the panel, reducing the need for replacement panels.

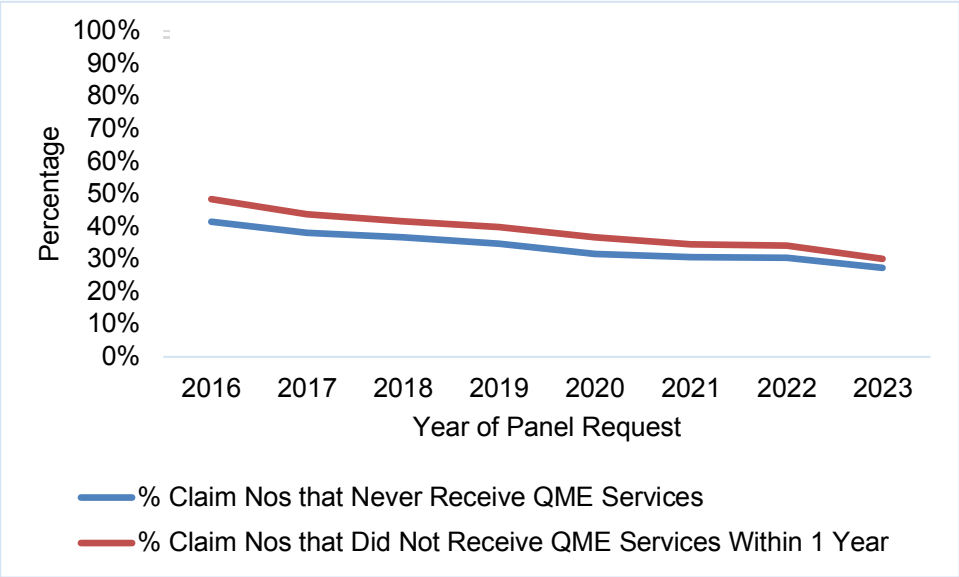
Figure 5.4. Percentage of Panels Utilized



SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: This figure shows the share of QME panels issued between 2016 and 2023 that generated at least one observed Med-Legal service.

We also used the linked QME-WCIS data to examine the number and percentage of IWs (defined as a unique claim number-injury date combination) who requested QME panels but did not secure the services of a panel QME at all for their claim (Figure 5.5). The figure shows that most IWs who are assigned a QME panel obtain Med-Legal services at some point, a pattern that is also evident in the declining raw counts shown in Figure D.2. The relatively small gap between the lines in Figure 5.5 further indicates that most IWs who secure services from a panel QME do so within one year of the panel request. Although the proportion of panel assignments requested by IWs that did not lead to Med-Legal services has declined over time, Figure 5.5 still shows that roughly 3 in 10 worker-initiated requests in 2023 did not result in observed services.

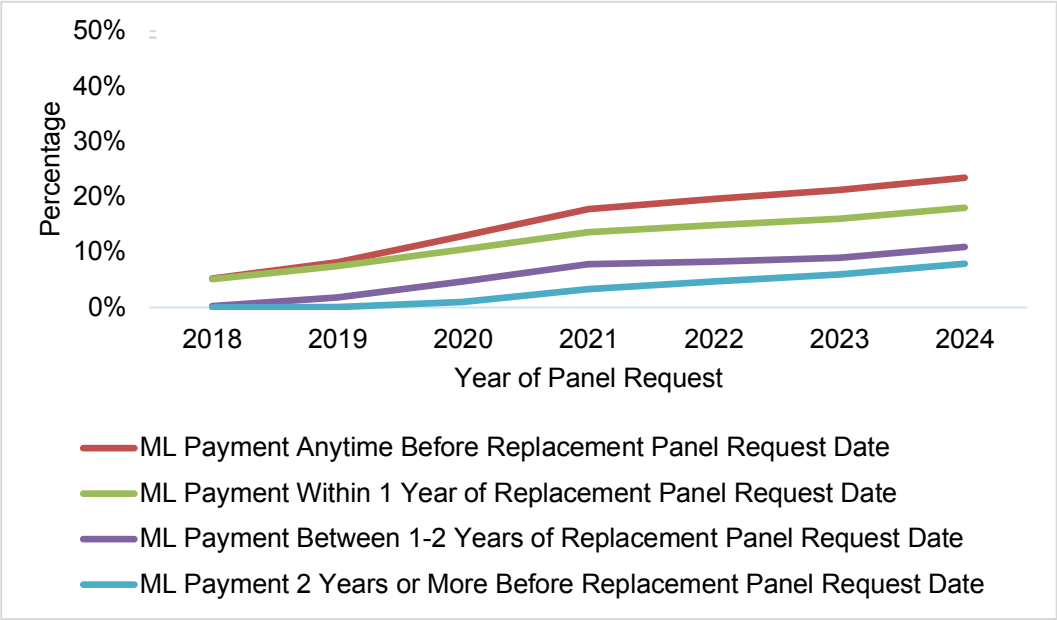
Figure 5.5. Percentage of Unrepresented Injured Workers Who Requested Panels and Did Not Secure Services of a Panel QME



SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: This figure shows the share of unrepresented IWs who requested QME panels between 2016 and 2023 and either did not secure services within 1 year of panel assignment or did not secure services from a panel QME at all. Records subject to truncation near the end of the medical billing data were excluded, but the blue line may still slightly understate the decline in non-utilization due to right-censoring near the end of the observation period due to truncation.

Building on these utilization patterns, Figure 5.6 shifts attention to the timing of replacement requests relative to observed Med-Legal activity on the claim. We observed a steady increase in the share of replacement panel cases with Med-Legal expenses paid any time prior to the replacement request over the 2018–2024 period, rising to over 20 percent by 2024. The additional lines broken out by category show that this increase is driven primarily by payments occurring within one year of the replacement request, but growth is also evident for payments made one to two years earlier and, increasingly, two or more years earlier. By 2024, nearly one-third of prior Med-Legal activity occurred more than one year before the replacement request. Taken together, these patterns indicate that replacement panels are increasingly requested after substantive Med-Legal work has already occurred, indicating a shift toward replacements that occur later in the claim life cycle rather than at the early, pre-exam stage. These patterns may have implications for delays, duplication of effort, and overall claim resolution timelines.

Figure 5.6. Percentage of Replacement Panel Cases with Med-Legal Expenses Paid at Time of Panel Replacement



SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: We exclude panels linked to claims where the injury date was before 2018 due to concerns about left-censoring, meaning we are likely to have observed only a subset of Med-Legal payments for those panels since the WCIS medical billing data we were able to link starts in 2016.

Geographic Distribution of QME Offices and Access

To understand whether the supply of QMEs is meeting demand by geographic area, we examined the number of QME offices by geographic region and year (Table 5.2). Panel requests are based on the zip code of the IW's residence. Because the same QME cannot appear on the same panel more than once, even if they have multiple offices in the same selection area, we also present the number of unique QMEs per region (Table D.6). Both number of QME offices and unique QMEs are important measures of accessibility for IWs. Figure D.4 shows a map of the geographic regions used in our analyses, which follow regions used in public reports from DIR (California Department of Industrial Relations, 2025c). For additional context, these reports from DIR also provide the number of injuries by year and geographic region of injury location. The reports note that Los Angeles has the highest number of injuries, accounting for between 25 and 27 percent of all injuries in California between 2012 and 2024, depending on the year. Eastern Sierra Foothills, North Sacramento Valley, and North State-Shasta have the smallest number of injuries, each accounting for less than 2 percent of total injuries in California across all years 2012–2024. The largest decreases in injury volume were seen in the Bay Area (from 21 percent of injuries in 2012 to 18 percent of injuries in 2024), and the largest increases in injury volume were seen in the Inland Empire (from 18 percent in 2012 to 21 percent in 2024).

Table 5.2. Number of QME Offices, by California Geographic Region and Year

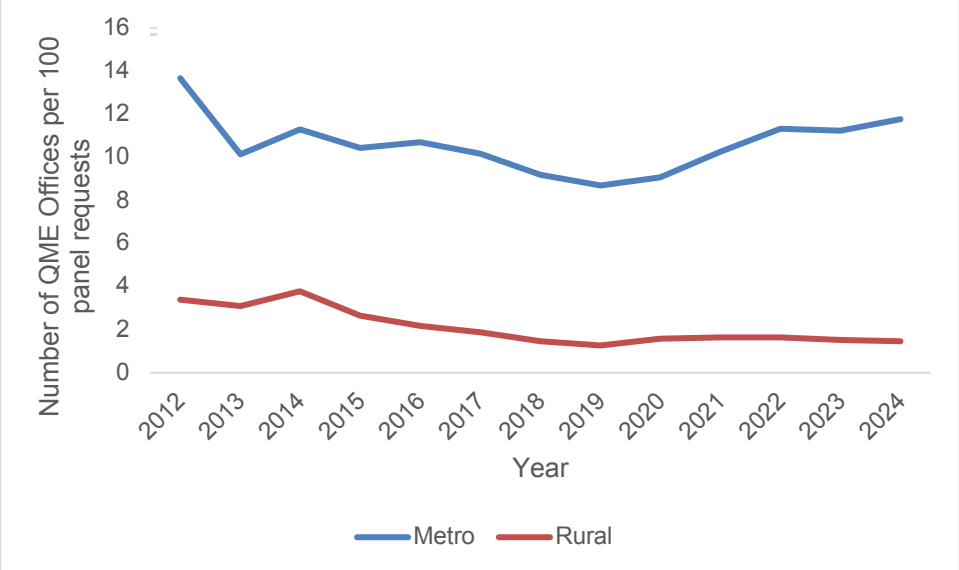
Region	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Bay Area	2,800	2,209	2,327	2,347	2,528	2,369	2,164	2,107	2,010	2,106	2,367	2,647	2,995
Central Coast	788	647	725	794	824	788	775	763	801	882	1,033	1,053	1,086
Central Valley	1,089	827	949	1,084	1,139	1,048	965	897	867	906	1,121	1,302	1,695
E. Sierra Foothills	154	112	120	128	130	134	129	120	103	95	126	166	261
Inland Empire	2,365	2,023	2,280	2,691	2,890	2,908	2,757	2,682	2,633	2,745	3,301	3,697	4,676
Los Angeles	3,497	3,022	3,407	4,267	4,831	4,908	4,908	4,767	4,775	5,130	5,964	6,407	7,390
N. Sacramento Valley	103	77	80	82	75	74	70	65	66	58	71	74	97
N. State-Shasta	127	110	107	113	103	89	87	84	87	74	70	74	76
Sacramento Valley	497	427	522	527	500	492	444	413	401	393	463	535	681
San Diego	718	684	804	822	857	916	930	931	921	956	1,027	1,154	1,395
Total	12,138	10,138	11,321	12,855	13,877	13,726	13,229	12,829	12,664	13,345	15,543	17,109	20,352

SOURCE: RAND analysis of QME data.
NOTE: Offices with an active status for at least one day during the calendar year are included in the total. A small number of QME offices (<1%) were excluded due to missing or invalid zip code data.

To illustrate the supply of QMEs relative to the demand in a different way, Figures D.5 and D.6 show the number of QME offices and unique QMEs, respectively, by geographic region and year and adjusted by number of QME panel assignments. Figure 5.7 shows the number of QME offices by location in rural or metro counties. These three figures show that, even after adjusting for panel assignment volume, there is considerable variation in the number of QMEs and QME offices by region and over time. Some regions, such as Los Angeles, San Diego, and the Bay Area, had high numbers of QME offices relative to the number of QME panel assignments. Other regions, such as Northern Sacramento Valley and North State-Shasta, had comparatively lower numbers of QME offices. For example, in 2024, San Diego had more than three times the number of offices per 100 panel assignments than North State-Shasta did. However, the variation in the number of unique QMEs by region was much smaller.

There were also notable changes in the number of QME offices and QMEs over time. The number of QME offices and, to a lesser extent, the number of QMEs across regions decreased sharply from 2012 to 2013, coinciding with the ten-office limit for QMEs. There was also an increase in both the number of QMEs and QME offices following the 2021 fee schedule increase. However, these increases were seen exclusively in metro counties.

Figure 5.7. QME Offices per 100 Panel Assignments, by Metro or Rural County Status and Year



SOURCE: RAND analysis of QME data.

As noted previously, a goal of the ten-office limit was to more evenly distribute the number of panel assignments among QMEs. To better understand whether this goal was met, we examined the number of annual panel assignments for 2012, before the ten-office limit was imposed, and for 2013–2024, once the ten-office limit was in place (Table 5.3). Overall, the mean and median number of panel assignments per QME increased, as the number of panel

assignments outpaced the number of QMEs. The variation in the number of panel assignments was similar for both time frames, indicating that some QMEs were still much more likely than others to get panel assignments, even after the ten-office limit. In 2012, the standard deviation of panel assignments per QME was more than double the mean (193 versus 85), and the third quartile number of assignments was approximately eight times the first quartile number of assignments (72 versus 9). By contrast, the standard deviation was just under double the mean between 2013 and 2024 (239 versus 148), and the third quartile number of assignments was approximately nine times the first quartile of assignments (159 versus 18).

Table 5.3. Annual Panel Assignments per QME Before and After Ten-Office Limit

Year	N QME-Years	Mean (SD)	Q1	Median	Q3
2012	3,243	84.97 (193.13)	9	27	72
2013–2024	33,679	147.63 (239.06)	18	56	159

SOURCE: RAND analysis of QME data.
NOTE: N=36,922 QME-Years, for which a QME had an active office for at least part of the year and was assigned to at least one panel representing 5,034 QMEs.

Even after imposing a ten-office limit, the variation in the number of QME panel assignments per QME was still quite large. Other factors, such as specialty and office locations, also contribute to the number of panel assignments a QME receives. Table 5.4 explores the relationship between specialty and number of panel assignments. Unsurprisingly, QMEs that list multiple specialties receive many more annual panel assignments, as do QMEs that list a single specialty (median of 230 versus 38 requests). There is also substantial variation in the number of panel assignments received among QMEs that list a single specialty. QMEs with an orthopedic surgery specialty receive a median of 110.5 panel assignments each year as compared to 19 for chiropractors and 35 for other single specialties.

Table 5.4. Annual Panel Assignments per QME, by Specialty

Specialty	N QME-Years	Mean (SD)	Q1	Median	Q3
Single Specialty	28,462	77.67 (114.81)	12	38	95
Chiropractor	8,557	43.97 (55.93)	8	19	57
Orthopedic Surgery	2,322	200.12 (214.90)	58	110.5	269
Pain Medicine	307	109.50 (124.54)	32	62	144
Psychiatry	2,687	119.64 (109.93)	31	93	178
Any internal medicine	1,300	114.46 (105.43)	38	86	159
Other specialty	13,289	65.15 (101.21)	12	35	72
Multiple Specialties	8,460	360.41 (370.23)	79	230	531
Including Internal Medicine	1,077	263.03 (235.58)	80	202	376

Specialty	N QME-Years	Mean (SD)	Q1	Median	Q3
Including Orthopedic Surgery	5,492	414.06 (388.53)	96	289	637
Other Multiple Specialties	1,891	260.03 (345.63)	51	128	350

SOURCE: RAND analysis of QME data.
NOTE: N=36,922 QME-Years, for which a QME had an active office for at least part of the year representing 5,034 QMEs.

We also examined the relationship between office location and the annual number of panel assignments (Table 5.5). The relationship between office location and number of panel assignments was not as strong as between specialty and number of panel assignments. However, there were some differences. Offices in Central Valley had the highest median number of panel assignments per office per year (16) while offices in the Bay Area, East Sierra Foothills, and North Sacramento Valley had the lowest median number of panel assignments per office (11).

Table 5.5. Annual Panel Assignments per Office, by Geographic Region

Region	N Office-Years	Mean (SD)	Q1	Median	Q3
Bay Area	30,976	29.46 (53.55)	4	11	30
Central Coast	10,959	26.48 (38.17)	4	12	33
Central Valley	13,889	42.40 (60.33)	6	16	55
E. Sierra Foothills	1,778	33.81 (51.05)	4	11	42
Inland Empire	37,648	28.35 (36.40)	4	13	38
Los Angeles	63,273	26.97 (36.83)	4	12	33
N. Sacramento Valley	992	33.44 (44.83)	5	11	47
N. State-Shasta	1,201	32.00 (45.91)	3	12	41
Sacramento Valley	6,295	41.57 (69.42)	5	15	50
San Diego	12,115	24.78 (30.48)	5	13	33

SOURCE: RAND analysis of QME data.
NOTE: N=179,126 Office-Years, for which an office was assigned to at least one panel in 2012–2024 and which had a valid California zip code.

What Is the Best Way to Recruit and Retain QMEs?

Qualitative Results: Reasons for Joining and Leaving the QME System

In focus groups with active and former QMEs, we discussed what factors initially attracted them to become QMEs, their views of the benefits and challenges of being a QME, and how California could better recruit and retain QMEs. For former QMEs, we also asked why they were no longer QMEs. We also discussed these factors with AAs, defense representatives, and MMC representatives.

Participants cited barriers to initially becoming a QME among themselves and their colleagues. One limitation is that we only spoke with active and former QMEs and not doctors who were never QMEs, so we did not get enough responses to define common themes to barriers to becoming QMEs. However, one active QME mentioned that they knew of some newer doctors whose employers had prohibitions on outside employment that prevented them from becoming a QME. A review of publicly available policies from five of the largest health care providers in California do not specifically mention prohibitions on becoming a QME but do note that approval is generally required for outside employment (Kaiser Permanente; UCLA, undated; CommonSpirit, 2023). An AA also suggested that some doctors they had spoken with did not want to become a QME because they perceived the regulations as being too onerous to navigate.

To get a perspective from outside California's QME system, we discussed with representatives from Colorado and Texas what strategies for recruiting and retaining DIMEs and Designated Doctors, respectively, were most successful in their states.

Theme: Recommendations from Friends and Colleagues Were a Common Pathway to Becoming a QME.

Four former QMEs and one active QME cited recommendations from friends and colleagues as the reason they first became a QME. Two QMEs (one former, one active) who lived in Texas specifically noted that word of mouth among chiropractors in Texas was the reason they first got involved. One active QME said, "I got recruited from within Texas . . . Somebody within QME was saying how great being a QME is over in California and that was just, that's word of mouth."

Theme: QMEs Found Work Intellectually Stimulating.

Two former QMEs and three active QMEs cited intellectually stimulating, multidisciplinary work as an important factor in joining. As one active QME noted, "I wanted to broaden skills, how I spend my time. I also love to write and wanted to use different parts of my brain."

Another former QME explained, "I like the confluence of psychology and the law. It's always been kind of interesting to me."

Theme: Extra Income Was a Motivating Factor to Become a QME.

Two active QMEs, a former QME, an AA, a DA, and two MMC representatives cited extra income as a primary motivator for new QMEs, particularly following the 2021 fee schedule change. The active QME who was also a Designated Doctor in Texas noted that California paid more than Texas did for similar work, even with the extra expense of traveling to California for evaluations.

Theme: Flexibility of Scheduling and the Ability to Do Some Aspects Remotely Were Appealing.

Two active QMEs and an MMC cited the flexibility of scheduling appointments according to their own availability and the ability to write reports and, in some cases, conduct evaluations

remotely as attractive aspects of becoming a QME. One active QME noted, "It is extremely flexible. That is appealing to me as a mom." These QMEs appreciated the ability to schedule appointments at times convenient for them, provided they fell within the required 90-day window, and to write reports on their own schedule. QMEs in specialties, such as psychiatry and psychology, also appreciated that they sometimes had the option to conduct evaluations remotely.

Theme: Uncertainty in the System Reduced Flexibility.

However, offering contrasting views, QMEs noted that some factors detracted from the potential flexibility. One active QME noted that the uncertainty of timing of when they would receive medical records removed this flexibility: "I will receive 2,000 pages of records ten days after the evaluation and after my report is 90 percent done. The law allows them to submit records 10 days after, so I really only have 20 days to finish the report."

Another former QME who initially liked the flexibility associated with being a QME noted that getting deposed was hard to plan for and reduced flexibility. They stated,

> In terms of my schedule, it was really hard coordinating the examinations but then also the depositions themselves, because that would mean like taking an entire day off work that I wasn't necessarily planning for. . . . Potentially, you could be there for an hour, you could be there for eight.

Theme: The Prohibition on QMEs Recommending Treatment Can Be Frustrating.

Two former QMEs, two AAs, a defense representative, and an MMC representative endorsed the view that the prohibition on QMEs recommending treatment was a frustrating change to the system. As one defense representative noted,

> The panel doctors not having input on medical treatment has added a bizarre layer. . . . When analyzing medical, you are looking at all the doctors. Yet the QME, whether they say no, I don't believe this person needs surgery, or yes, they do, it doesn't [mean] anything at court, unless another doctor looks at it, uses expert testimony, and incorporates it. . . . They stripped away what a QME is supposed to do and help move the case forward.

Two former QMEs cited this change as contributing to their departure from the system. As one former QME who had practiced before and after this change said,

> I'm not even sure why they have QMEs anymore, to be frank . . . they have the independent review . . . I say the patient needs surgery, and it's completely ignored. So I don't even exactly understand why they send a patient for a QME, because they're not going to listen to what we say anyway.

Relatedly, two participants—an AA and an MMC representative—noted that, while QMEs can still request diagnostic testing, they felt that the prohibition on treatment may have had the unintended consequence of decreasing requests for testing needed to complete evaluations. An AA noted,

> My biggest issue right now is if the QME requests testing, it is impossible to get done. It's not because of the defense. It is the system. [A requested test] took from 2023 to 2025, and both sides agreed. The QME could do the testing but believed she would get in trouble. Why would it take years?

Theme: Getting Deposed Makes Becoming a QME Less Attractive.

One defense representative and one former QME cited depositions as a potential deterrent for QMEs. A former QME who also worked as a Designated Doctor in Texas said,

> One thing that I do like about the workers' compensation in Texas versus the workers' compensation in California is you are rarely summoned to do depositions and things like that in the state of Texas. Your report carries presumptive authority, so they'll have court depositions, court hearings, things like that, and you don't necessarily have to testify.

A representative from the Texas workers' compensation agency noted that not having these requirements may help them attract and retain doctors. Commenting on California's system, they noted,

> I think that is something that may deter some QMEs. . . . For our DDs [Designated Doctors], once they have turned in their report, they're done. They're not called upon to be witnesses. There are no other time commitments for them . . . what we've tried to do is make it as easy for the, the DDs to practice in the system and not have a lot of unknown requirements or time commitments.

Theme: QMEs Left Because of Time Pressures and Inadequate Time to Write Quality Reports.

Two former QMEs cited lack of time to write quality reports as a major factor in leaving. For one QME who practiced less than four years before leaving, they felt that, as a new QME, it took longer to write quality reports. Another former QME who had served as a QME for longer noted that the number of requests they received were overwhelming. They also noted that California did not make it easy to reduce their time commitment; they stated,

> My main issue with resigning was that . . . some months I would get overloaded with panel QMEs. Scheduling them within the required time frame was impossible. . . . There was no way to throttle the number of QMEs sent to me. . . . There was no way to say I only want five panels a month.

This was an issue that Colorado considered in its DIME process. While acknowledging they were a smaller state, they allowed for a very personalized process where physicians could set their desired number of evaluations. A representative noted, "If the doctor says they have too many or too few cases, we can take them on or off the panel for a time frame. . . . If they only want two to four a month, we can work with that. It is customized. They can call me up."

Theme: QMEs Felt They Could Help Patients Better by Focusing on Treatment.

Two former QMEs said that they felt they could help patients better by focusing on their treatment practice and that they did not have time to do both well. One former QME expressed frustration with the QME system and felt that they could better serve patients through direct care.

As another former QME noted, "I'm still practicing [specialty] and it's very hard to do both . . . . And you kind of have to do a little bit of one or the other . . . because as the other practitioner said, it does take a lot of your time."

Theme: Delays in the QME System, Particularly in Getting Paid by Insurance Companies for Evaluations, Were a Factor in Leaving.

The most–commonly expressed reason, cited by five former QMEs, for becoming inactive was due to delays in the QME process, most notably delays in getting paid for evaluations. As one former QME stated,

> Dealing with insurance is demoralizing. They ask us, including the defense, to do a report. Then they deny it almost every time. I might get more [denials] because I am not in a large company. The first thing they say is that we didn't get the bill. This pushes things out three or four weeks. Then they say your proof of service, which came off the workers' comp website, it says, "Herein is enclosed the report," not the report and the bill, so it is my word against his. Now it is more than 60 days, and they are supposed to self-impose a penalty. They never do that. I have to send every case to my collections attorney.

Another former QME noted that working with an MMC added to this frustration because the MMC would want to be paid before the QME received payment for their evaluation. They stated,

> They charged quite a bit of money and that became a problem when the insurance companies would not pay you, yet you owed this chunk of money, thousands of dollars to these agencies, and they were not willing to wait until the compensation came through, and it just became a big hassle.

Theme: MMCs Play a Role in Recruiting New QMEs.

An AA, a defense representative, a former QME, and an MMC representative all noted that MMCs played an important role in recruiting new QMEs. As one MMC representative asserted,

> I have been told . . . the reason for the influx of doctors has been the fee schedule change. That is not the reason. It is because MMCs are recruiting heavily. . . . There's no shame in recruiting. They have done a great service. We have had a ton of orthopedists come in in the last two years thanks to the MMCs.

However, one defense representative noted that, while MMCs recruited new QMEs, they felt that sometimes the quality of reports from the MMCs' new recruits was not as good.

Theme: States Play an Active Role in Recruiting Evaluators.

Texas and Colorado shared some of the ways that they have marketed their Designated Doctor and DIME programs, respectively, to prospective evaluators.

Texas cited several methods that they used to recruit Designated Doctors, including running webinars for workers' compensation doctors, attending medical conferences, and developing relationships with medical associations. As one representative noted,

> We also have very close relationships with those various medical associations . . . if there's a need, we talk to the association so that they can then get the message out through their newsletters or emails or however they communicate with their members.

Representatives from Texas also explained that, within the past few years, they had partnered with medical schools to encourage participation both in the Designated Doctor program but also in the workers' compensation system more broadly.

Colorado developed a new unit within their workers' compensation system to recruit and support DIMEs. They credited the new unit with recruiting 20 new DIMEs. Speaking of recruitment, one representative noted,

> I targeted certain groups; we have an occupational medicine residency, so we try to get them into the pipeline automatically. But that pipeline is not enough. I am looking to family medicine and internal medicine to try to fill the gap. We are looking to approaching the CO [Colorado] chapter of the American Academy of Family Medicine and Internal Medicine board.

Chapter 6. Results: Reimbursement for QME Evaluations and Other Med-Legal Services

How Have Recent Changes to the QME Reimbursement Structure Impacted Overall Costs to the Workers' Compensation System and Should Additional Changes Be Considered?

Qualitative Results: Participants' Views on QME Reimbursement

We discussed the way that QMEs are compensated in interviews and focus groups. Discussion topics included the structure of payments, overall level of payments, and changes to the fee schedule. We also explored how Colorado and Texas addressed some of the same issues that arose when determining their fee schedule.

Theme: The Simplification of the Fee Schedule Was Easier to Navigate and Reduced Gaming.

As noted in Chapter 2, California moved from a fee schedule based on time and complexity of the evaluation to a flat fee to conduct the evaluation and write the report, with the fee doubled for psychiatric evaluations and an additional $3 per page for review of medical records beyond 200 pages. Two former QMEs, an active QME, and two MMC representatives explicitly noted their appreciation for the flat fee aspect of the fee schedule, arguing that it reduced gaming on both sides. As one MMC representative noted, "One goal was to minimize fraud and inconsistencies. The new structure accomplished that."

Coming at it from another angle, a former QME noted that the flat fee reduced friction and points of argument with insurers, saying,

> The good is that before the change, the QME would estimate the number of hours to prepare the report. And that's something that could be argued. Like, you spent ten hours doing this report? So, they did become more objective, like okay, you can't argue with this because these are the pages that you sent.

Theme: The Flat Fee Encouraged Poor Quality Work.

Three former QMEs and one active QME provided a counterargument, emphasizing that the flat fee incentivized speed over report quality. As one former QME put it,

> It encourages poor quality work and people who are constantly doing shortcuts around it. . . . I have a friend who has continued doing this and so what he told me is that while the patient is doing their assessment, he's actually writing the body of his report while sitting with them. That's the only way he can make it work.

In a similar variation of the theme, one active QME and one former QME noted that the fee schedule change was especially difficult for new QMEs who typically took longer to write reports. As one active QME noted,

> I think part of the challenge is the new fee schedule makes it harder to be new. It's a fixed fee regardless of how much time you spend. Inherently, that incentivizes speed and efficiency. Your first ten will take so much longer. Under the old fee schedule, you got paid by the hour, so you were paid for your time to be trained, just like if you worked at McDonald's. It incentivizes comprehensiveness and thoroughness.

Some participants acknowledged the complexity of developing a fair schedule. Two defense representatives spoke of the difficulty in striking a balance between developing simple, easy-to-enforce criteria while also recognizing that some cases were going to inherently take more time.

Similarly, an active QME acknowledged this complexity in response to another QME in the focus group who cited the downsides of using a flat fee, saying, "To be fair, we saw lots of doctors billing unbelievable amounts of money. There was a lot of cheating going on in the old system. The few destroyed it for the many."

Theme: The Number of Pages of Records Reviewed Does Not Always Correspond to the Work Involved.

While QMEs noted that record review took time and could relate to the complexity of the case, they also described exceptions in both directions in which they felt that the number of records they reviewed was not reflective of the work they did on a case. Two former QMEs, an active QME, a defense representative, and an AA endorsed similar statements. As one former QME noted, "You can have a report, they have no medical records, but there's like 20 body parts, and the report is very complicated, and yet you're not getting any credit for that." An AA noted,

> It's doing it more for review of documents, which is not why we're going to these doctors for, right? We're not going to them to review these documents. We want their expertise in the AMA guides and in the QME process, so I think it did compensate the doctors, but not for the right thing.

Theme: Payment per Page of Record Review Encourages Additional Litigation.

Two AAs, a former QME, and four active QMEs expressed frustration that they felt the charges for pages of records led to additional litigation and overall costs, such as supplemental reports. Specifically, participants noted that records appeared to be culled to remain within the 200-page limit over which additional record review charges began. As one former QME noted:

> The problem is that the insurance companies . . . would send hardly any medical records over, and then they have all these questions for you, like, well, you got to send me the medical records for me to find out what's going on with this patient. . . . For a very complicated case . . . 50 pages of medical records with nothing prior to the date of injury. So, I can't figure out apportionment or anything else.

> . . . That's just a waste of time.

Two active QMEs also expressed this same frustration, but felt the problem was recently improving, with one noting,

> The new fee schedule with $3 per page, there was a lot of record culling. The attorneys were making medical decisions about what records to give to me. They were taking away hundreds of pages of records that were referenced by other doctors, so I knew they existed. It seems to have improved because they were just buying themselves more supplemental reports. To me, that is a medical determination they should not be making.

Theme: Psychiatry and Psychology Specialists Felt That the Fee Schedule Change Worked Against Them.

Three former QMEs and two active QMEs expressed frustration with the fairness of the new fee schedule for Psychiatry and Psychology specialties. The QMEs in these specialties noted that they received less compensation under the new fee schedule than they did under the old. They perceived that a flat fee, even with the available modifiers for Psychiatry and Psychology (typically multiplying the payment rate by two), was not sufficient for QMEs in these specialties. They felt that they were typically required to do longer and more complex evaluations. One former QME explicitly cited this change as a reason for leaving the system, saying,

> The reason I am getting out of it is because it is not worth it financially or emotionally. . . . The 2X multiplier is absurd and ridiculous. The [DWC]says explicitly that psychiatrists or psychologists need to spend a minimum of one hour, but we typically spend three hours. Orthopedists are required to spend 20 minutes. If you spend nine times as much time with the patient, you are going to spend nine times as much time working up the report. And they have a 1 percent standard for causation, and we have a 50 percent+ standard, so we have to do a much more complicated analysis.

Another active QME said that, "[With] the new fee schedule, I took an 18 percent pay cut. . . . I am giving away money by being a QME. I value it, but it will be hard to keep doctors."

Theme: Participants Prioritized Adding a Cost-of-Living Adjustment, Noting That It Was a Key to Sustainability of the QME Program.

Although we did not specifically ask about a cost-of-living adjustment (COLA) in our discussion of the fee schedule, it was the most commonly mentioned aspect of the fee schedule in discussions with participants. Four MMC representatives, four active QMEs, and one QME noted this as one of their most important requests for a fee schedule change. Participants argued that without a COLA, the gains in QME recruitment that they felt had been driven in large part by the fee schedule change could not be sustained. One MMC representative cited inflationary pressures that they felt would undo the progress made in recruiting new physicians saying, "We don't want to go back to that and lose these new young doctors that are coming in." An active QME expressed a similar sentiment, saying, "The 2021 solution kicked the can down the road."

This was also an issue Texas faced, leading them to recently build an adjustment into their Designated Doctor reimbursement process. A representative from the Texas workers' compensation agency cited this change as one of the most important features of reimbursement, saying,

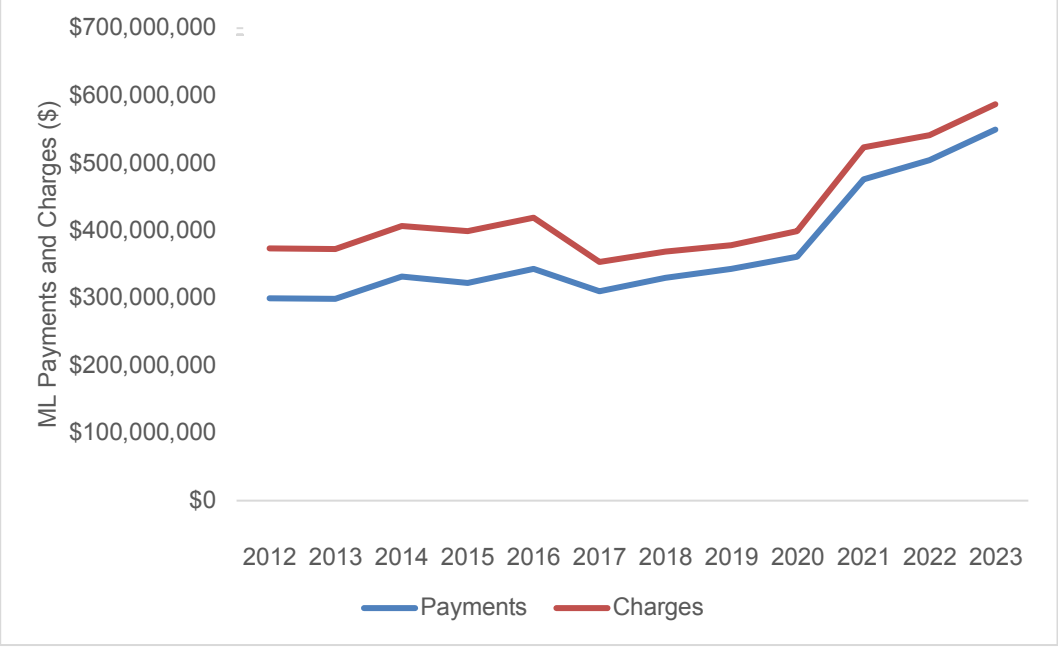
> And then the last thing, which I think it's the best thing that we did on this rule, is to add an inflation rate that automatically adds without us opening the rule on an annual basis using the Medicare Economic Index [MEI] factor. . . . And so at the beginning of the year, those doctors know exactly what they will be reimbursed for.

A second representative from Texas agreed, saying, "The big deal is that we're not going to be 20 years behind in addressing fees going forward. Anything that we can do to make that process simpler is going to help."

Quantitative Results: Analysis of WCIS Cost Data

We examined WCIS medical billing data from 2012 through 2023 to describe trends in the volume of Med-Legal reports and Meg-Legal costs. Figure 6.1 shows the total amount of Med-Legal charges and payments by year from 2012 to 2023; data from 2024 were incomplete at the time that data were extracted for the study. We caution that paid amount estimates for 2015 and earlier years are not directly comparable to those for 2016 and later years due to changes in the submission format of WCIS data.

Figure 6.1. Med-Legal Charges and Payments, by Service Year, 2012–2023

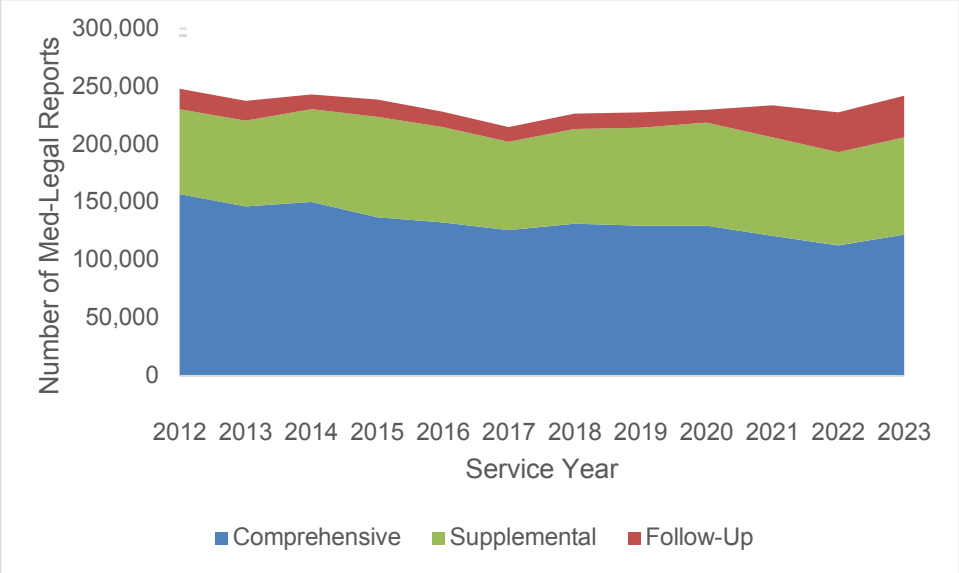


SOURCE: RAND analysis of WCIS data.
NOTE: Pre-2016 payment data may not be comparable to payment data in 2016 and later years due to limitations of the 4010 format data used for 2012–2015 estimates. See Chapter 4 for further discussion of limitations.

As expected, Med-Legal payments increased sharply after adoption of the new fee schedule in 2021. Between 2016 and 2020, Med-Legal payments were $334 million per year on average (with yearly totals ranging between $309 million and $358 million). The new fee schedule, which took effect in April 2021, contributed to an increase in Med-Legal payments to $474 million in 2021. Med-Legal payments continued to increase in 2022 ($502 million) and 2023 ($503 million). If we compare the 2022–2023 average ($524 million) to the 2016–2020 average ($334 million), the increase in annual payments was 57 percent—more than double the 25 percent increase set as a target when the regulations were adopted. Charges (the total amount billed for Med-Legal services) follow a similar trajectory to paid amounts. Payments averaged 90 percent of charges between 2016 and 2023.

One objective of the fee schedule change was to increase the supply of QMEs. If IWs found it easier to access Med-Legal services after the fee schedule change, we might expect that some of the increase in payments would reflect increases in the volume of evaluations performed and reports issued. We also used the claims data to tabulate the number of Med-Legal reports issued by year (Figure 6.2) and the number of Physician Depositions by year (Figure 6.3).

Figure 6.2. Number of Med-Legal Reports Issued, by Type of Report and Service Year, 2012–2023



SOURCE: RAND analysis of WCIS data.
NOTE: Counts in figure include paid Med-Legal reports only.

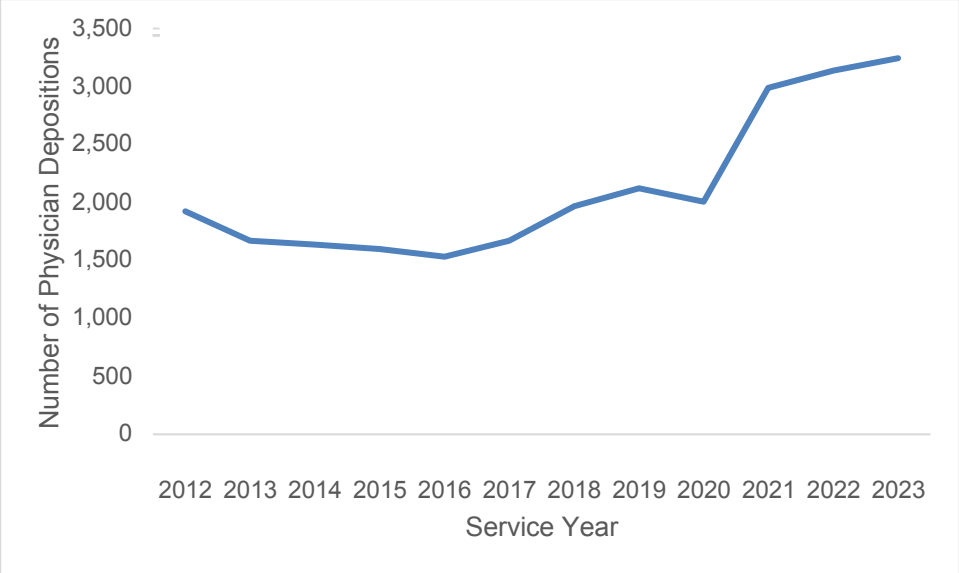
In comparison to the amount of Med-Legal payments, the volume of Med-Legal reports issued has been much more stable. The total volume of reports declined slightly between the earliest years shown and the years leading up to the COVID-19 pandemic and the fee schedule change, with the total volume across all report types averaging 242,000 between 2012 and 2015, compared to 226,000 between 2016 and 2020. The number of reports issued increased slightly

after 2021, reaching 242,000 in 2023. While the series break associated with the switch from 4010 to 5010 format data in 2016 is not as pronounced as it was for payments, we caution that the comparability of data between pre- and post-2016 years is also limited by changes in data quality.

Figure 6.3 reports the number of physician depositions by year between 2012 and 2023. The adoption of the new fee schedule in 2021 coincides with a sharp increase in deposition volume, from between 1,500 to 2,000 before 2021 to 3,000 or more per year between 2021 and 2023.

We were not able to determine why the volume of depositions increased so sharply, but findings from our interviews with workers' compensation attorneys suggest (as discussed further in a Chapter 7) that depositions are needed in cases where a QME report does not address all of the Med-Legal questions in a case. It is possible that the increase in new QMEs in 2021 led to more reports that required a deposition, as inexperienced QMEs learned about the system. Other explanations are possible, however, and we caution that we did not directly examine the quality of QME reports in this study.

Figure 6.3. Number of Depositions, by Service Year, 2012–2023

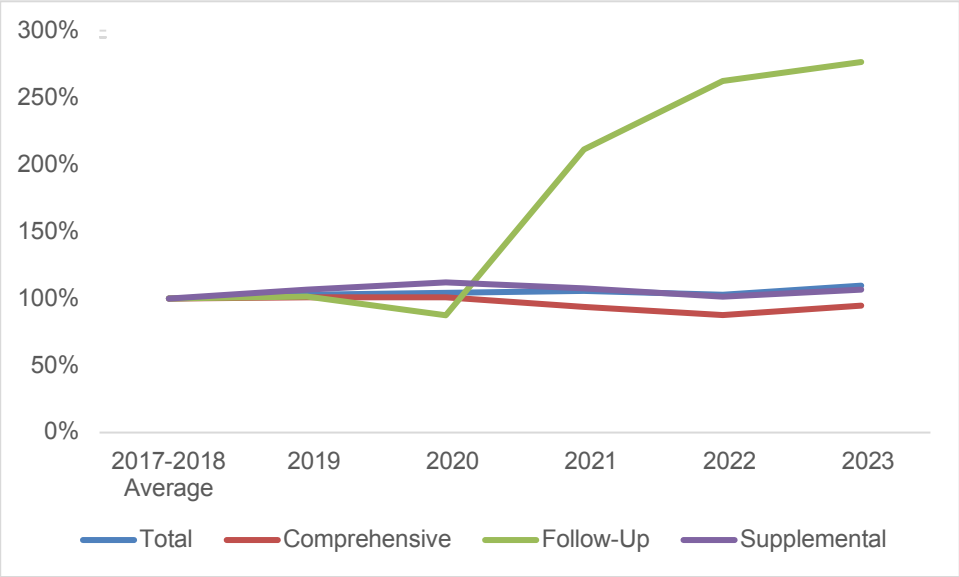


SOURCE: RAND analysis of WCIS data.
NOTE: Counts in figure include paid Med-Legal depositions only.

Figure 6.4 shows that the recent growth in the volume of Med-Legal reports has been driven by a sharp increase in follow-up reports after the new fee schedule was adopted. Follow-up reports were only about 6 percent of Med-Legal reports between 2017 and 2018, however, so the growth in follow-up reports has been modest compared to the total number of reports issued. Volumes of comprehensive and supplemental reports have changed relatively little, with comprehensive reports declining slightly since 2021. Of note, in 2021, the time period within

which a report can be considered a follow-up was extended from 9 months to 18 months, which may explain the increase.

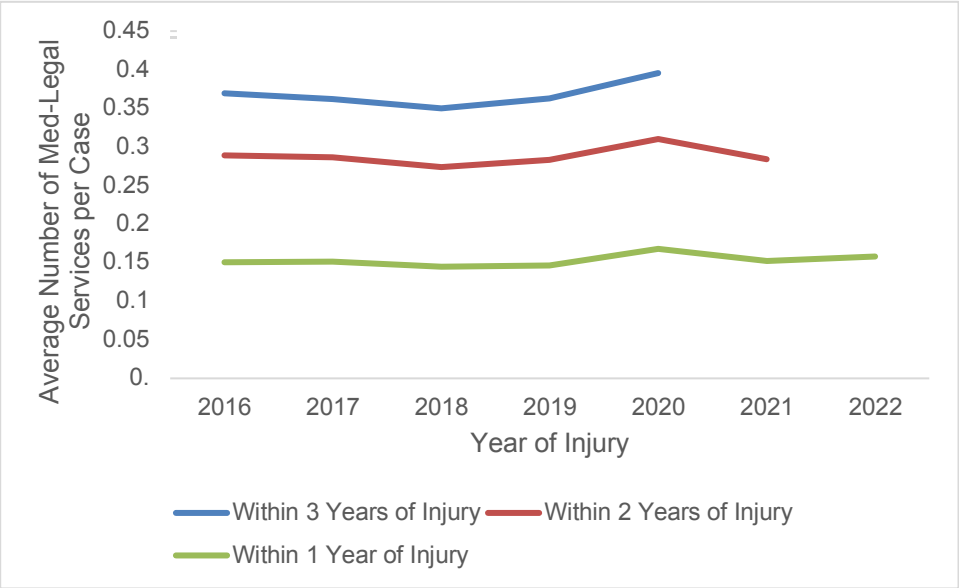
Figure 6.4. Number of Med-Legal Reports, by Type Relative to 2017–2018 Average



SOURCE: RAND analysis of WCIS data.
NOTE: Counts in figure include paid Med-Legal reports only. 100% = average yearly count of each type of reports in 2017–2018. (Total is the sum of Comprehensive, Follow-Up, and Supplemental reports).

Figure 6.5 takes a different perspective, reporting the average number of Med-Legal services per injury case by year of injury. Because cases can take some time to receive Med-Legal services, a comparison of very recent injury dates to earlier injury dates would be biased by right-censoring (i.e., different length of follow-up period after the injury). To avoid this issue, we report the number of Med-Legal services received within different windows of time after the injury date. Figure 6.5 suggests a slight uptick in the number of Med-Legal services per case in recent years when we consider reports over three years post-injury, but trends in the number of reports within 1 or 2 years post-injury appear flatter.

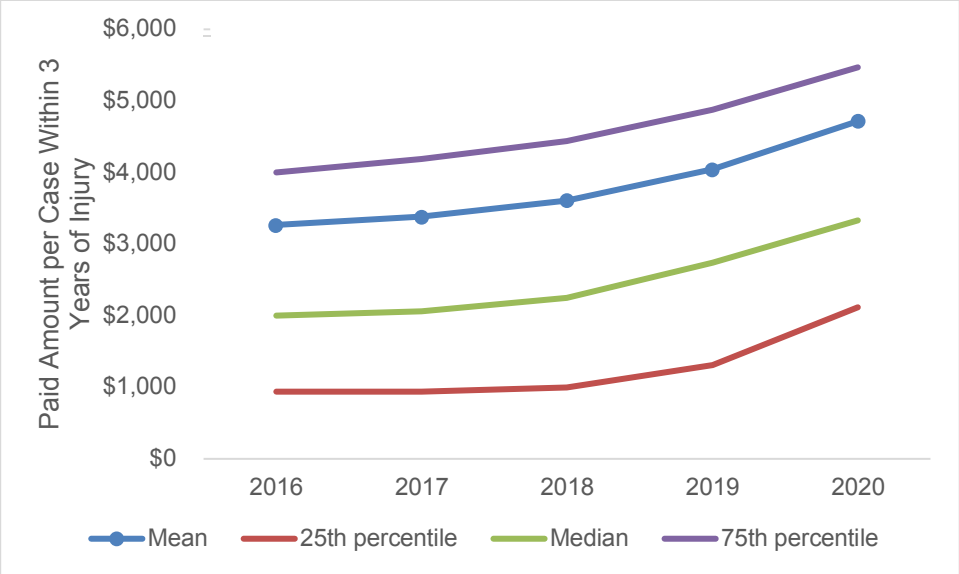
Figure 6.5. Average Number of Med-Legal Services per Case, by Year and Duration from Date of Injury, 2016–2022



SOURCE: RAND analysis of WCIS data.
NOTE: Med-Legal Services = number of bill lines with a Med-Legal procedure code. N = 3,512,211 cases for 1-year follow-up ("Within 1 Year of Injury"); N = 2,995,678 cases for 2-year follow-up ("Within 2 Years of Injury"); N = 2,494,089 cases for 3-year follow-up ("Within 3 Years of Injury").

Figure 6.6 shows trends in payments per case within three years of injury, by the year of the injury, for cases with at least one paid Med-Legal service. The increase in payments starting in 2018 reflects increasing exposure to the new Med-Legal fee schedule. The figure shows that payments per case among cases receiving Med-Legal services have increased across the distribution, in line with the new fee schedule.

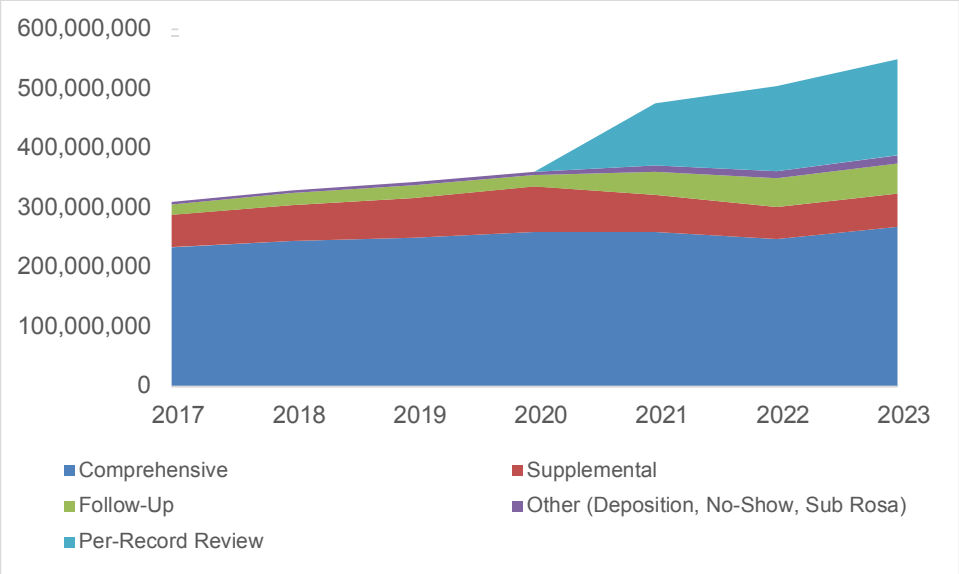
Figure 6.6. Payments for Med-Legal Services per Case, by Year of Injury, 2016–2020



SOURCE: RAND analysis of WCIS data.
NOTE: Statistics in figure are for the total amount of Med-Legal payments per case within three years of injury among cases with 1 or more Med-Legal services paid. N = 369,819 cases.

To illustrate the contribution of different Med-Legal services to the increase in payments, Figure 6.7 reports total payments for each of the three types of reports, for per-record review, and for other services (depositions, sub rosa recording review, and no-show fees). Growth in payments under the new fee schedule has been driven principally by fees for per-record review, with some additional growth due to increasing payments for follow-up reports. There was also a large growth in payments for other services, including depositions, although they remained a small percentage of overall Med-Legal payments.

Figure 6.7. Med-Legal Payments, by Type of Service, 2017–2023



SOURCE: RAND analysis of WCIS data.
NOTE: Figure shows total amount paid, by type and service year.

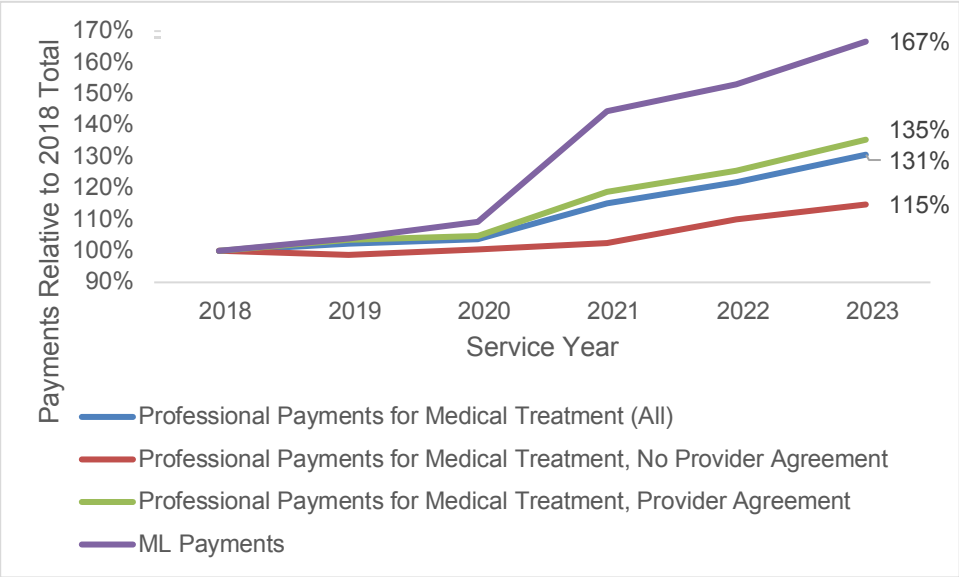
In Figure D.7, we show the distribution of case-level per-record review payments among injury dates in 2016 or later with 1 or more paid bill line for per-record review. The median per-record review payment on these cases was $939, but a small number of cases with very high per-record review payments lead to a much higher average payment of $2,533: Payments were about $10,000 at the 95th percentile and about $23,000 at the 99th percentile.

To provide context for the growth in Med-Legal payments, Figure 6.8 reports the aggregate amount of medical treatment (i.e., all services other than Med-Legal) payments for professional services in each year from 2018 to 2023. Amounts in each category of payment are shown relative to total payments in 2018. Overall, professional payments for medical treatment rose by 31 percent between 2018 and 2023, while Med-Legal payments rose by 67 percent over the same time period.

We also compared growth in Med-Legal payments to growth in payments made under the Official Medical Fee Schedule (OMFS). The OMFS defines a ceiling on payment rates for services provided to IWs; payers can also negotiate payments below those specified in the OMFS under provider agreements. To address this request, we also analyzed growth in payments separately for care covered by provider agreements and care not covered by provider agreements.

Payments made without provider agreements grew more slowly (15 percent growth between 2018 and 2023) than payments made with provider agreements (35 percent growth between 2018 and 2023). Because a majority of professional services were paid under provider agreements, however, overall trends in payments are driven by care with provider agreements.

Figure 6.8. Med-Legal Versus Medical Treatment Payments for Professional Services, by Provider Agreement Status and Service Year, Relative to 2018 Total



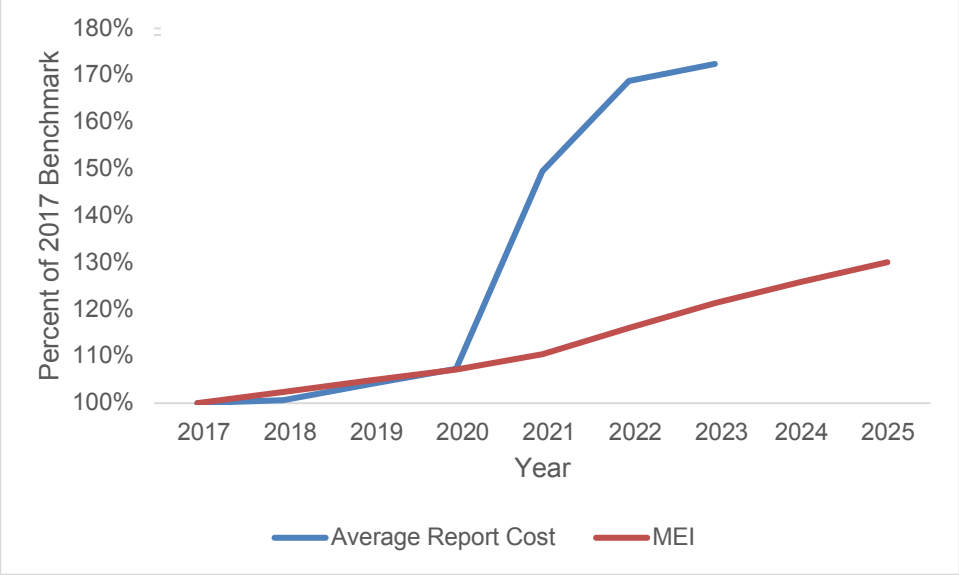
SOURCE: RAND analysis of WCIS data.
NOTE: Figure compares total payments in WCIS to amount observed in 2018 (2018 total payments by type of payment = 100%). Trends in professional payments are reported for all professional payments and separately based on whether the bill was covered by any type of provider agreement (including Health Maintenance Organization agreement [provider agreement code = H], Preferred Provider Organization agreement [provider agreement code = Y], or a participation agreement [provider agreement code = P]). The participation agreement code (P), which should reflect participation in a Medical Provider Network, was counted as a Provider Agreement. Bill lines with no provider agreement were defined as those with provider agreement code = N.

Some caveats to this analysis must be noted. 2018 was chosen as a base year because this was the first year when the prevalence of provider agreements was relatively stable. Comparison of amounts with versus without provider agreements to earlier years in our study period would be driven in large part by the growth of care with provider agreements between 2012 and 2018, from 48 percent of all professional services in 2012 to 78 percent in 2018. Between 2018 and 2023, the proportion of professional services covered by provider agreements remained stable at 77 percent to 78 percent of all professional services. Even though the total share of services provided under provider agreements was stable, we cannot rule out the possibility of changes in the mix of services from year to year or in which services were provided with versus without a provider agreement in place.

Another way to look at growth in Med-Legal payments relative to an outside benchmark is by comparing the average cost of a Med-Legal report to the MEI—an index that measures changes in the market price of the inputs contributing to physician services that is maintained by the Centers for Medicare and Medicaid Services (Centers for Medicare and Medicaid Services, 2025). As noted previously, Texas also uses the MEI to determine fee schedule increases for Designated Doctor services in the workers' compensation system. In Figure 6.9, we plot the average Med-Legal costs per Med-Legal report. As a caveat to the analysis, we include all Med-

Legal costs, even those for things like depositions that, while not costs directly for a Med-Legal report, are still associated costs. We compare these average costs to the MEI relative to 2017 (i.e., the MEI = 1 in 2017). The graph shows a sharp increase in the average cost per Med-Legal report following the 2021 fee schedule change. As noted previously, this 2020 to 2021 percentage increase exceeded the targeted increase set by DIR, and Figure 6.9 indicates that it also far exceeded the percentage increase in the MEI. However, the increases in average Med-Legal report costs begin to level out from 2022 to 2023 and increase at a smaller rate than the MEI.

Figure 6.9. Average Annual Med-Legal Costs per Med-Legal Report Relative to Medicare Economic Index



SOURCE: RAND analysis of WCIS data and Centers for Medicare and Medicaid Services MEI.
NOTE: The average report cost is determined by dividing total Med-Legal costs across all types of Med-Legal services in a year divided by the total number of Med-Legal reports, irrespective of type. MEI is the average across the four quarters of the unadjusted index for that year. Both average report costs and MEI are presented relative to 2017 (2017=100).

Chapter 7. Results: Structures and Processes in the QME System

What Have Been the Impacts of Structural Changes to QME Selection and Should Additional Changes Be Considered?

Qualitative Results: Views on and Changes Proposed to QME Selection Process

We discussed several structural aspects of the QME specialty selection, panel selection, and striking processes with participants, including what worked well, what was challenging, and where improvements could be made.

Theme: It Is Difficult to Create a Fair Process for Selecting Specialty.

As noted in the Introduction, once a party has decided to request a QME, one of the first decisions the party must make is which specialty to select. Three defense representatives noted that the process could be litigious, but they were not sure how to improve it. As one defense representative noted, "You know there's advantages and disadvantages of [the current system]. I mean, I think someone's [going to] have to decide which is the appropriate specialty, and no one's [going to] be happy with it."

Theme: The Removal of the Neuropsychology Specialty Has Led to Difficulties.

Four AAs, two defense representatives, three MCCs, two active QMEs, and two former QMEs noted the difficulties caused by the 2015 removal of the Neuropsychology specialty, which examines the physiological processes of the nervous system as they relate to behavior and cognition (American Psychological Association, undated).

The removal of this specialty, combined with the perceived difficulties of getting AME evaluations (discussed further as part of the discussion of changing litigation practices), could make finding an appropriate evaluator for traumatic brain injuries difficult. As one AME noted,

> It either requires the parties to agree to use an [AME] for neuropsychology or go to the workers' comp board and get an order from a judge. And I deal with the fair number of cases that are either traumatic brain injuries or have other cognitive issues . . . with a lot of defendants not willing to use AMEs, it could be quite time consuming to get that.

A defense representative noted that another option was to use two panels, which created additional costs and delays for the defense, saying,

> Often times we might, you know, you go to a psychiatrist, and they'll say, "Well this person needs to go see a neuropsych." But there's no neuropsych panel . . . so then we have to go see a neuro separately and then the psych separately. There's two different panels.

Participants noted that this specialty was previously an option they could request for QME panels evaluating traumatic brain injuries, but, given that the Board of Psychology does not recognize neuropsychology as a subspecialty, it could no longer be requested. One active QME noted that a legislative attempt to reinstate it had failed, so simply adding the specialty back may not be an option.

Theme: Alternatives to Having the Applicant or Defense Select the Specialty Should Be Considered.

Four defense representatives and one active QME noted that it may make sense for a doctor with more generalized knowledge across specialties, such as occupational medicine, emergency medicine, or family practice, to do evaluations or choose an appropriate specialty for the evaluator rather than having the parties select a specific specialty. As an active QME noted,

> I think the question is more . . . should it be chosen like that where it's like, okay, you need the specialty, this is what the complaint is. And so based on what those complaints are, or the injuries related to, then on a blind way on the back end, then that panel appears. And it might be an orthopod, it might be a chiropractor, it might be an [emergency room] doctor, whatever is relevant in that case.

Theme: Injured Workers Weren't Sure Which Specialty to Choose or, If Represented, How Their Lawyer Chose Their Specialty.

Of the five IWs we spoke with, all expressed that the specialty selection process was confusing. One unrepresented IW noted that they saw a QME of the specialist that their insurance company selected, even though they felt it was not the correct one for their specific injury.

Another represented IW said,

> It would be nice to know more about how the QME selection process works and everything else. As an injured employee, I don't feel like there is much up front given to you about how the whole process works. You have to find people to ask questions to if you don't have an attorney.

However, one unrepresented IW said that they did extensive research, watching YouTube videos and speaking with lawyers (who did not take their case) about which was the most advantageous specialty to choose. The IW noted that they selected the specialty that they were advised would provide the most favorable rating.

Texas and Colorado take different approaches than California does; in these states, QMEs are not selected to conduct evaluations based on specialty. Rather, in Texas, Designated Doctors are selected based on scope of practice. For example, in Texas, chiropractors can evaluate musculoskeletal injuries, but physicians are required for evaluating other types of injuries, such as traumatic brain injuries, spinal cord injuries, or burns. As a representative from the Texas workers' compensation agency noted,

> We have a program that's developed [based on] the 32, which is the form that injured employees or carriers fill out when they're requesting the exam. There's a table . . . that table pretty much mirrors the rule. And so they get to check those boxes of, "What is the injury?" . . . the database selects the next available and qualified Designated Doctor and so it's never going to the same kind of doctor because it's a rotation. And as long as you are the next in line and you have the qualifications that match that injury.

The Colorado workers' compensation agency uses another strategy, allowing the DIME to define the type of cases they can evaluate. As a representative explained, "The physician fills out an inventory sheet what they feel comfortable providing a rating for. We match the claimant's issue that needs an impairment with that inventory. That has worked out pretty well."

Theme: The Current Panel System Has Advantages over the "Dueling QME System."

As noted previously, the panel system was implemented in California in 2004, replacing a system where each side selected its own QME. Two active QMEs, one former QME, and an MMC representative noted that they preferred the panel QME system. As one former QME noted, "I liked the system because there was less pressure to provide an opinion favorable to the party referring. The striking process . . . I liked that more."

However, one defense representative disagreed saying, "Sometimes I just kind of want to get rid of [the current QME selection process]. And I say, 'Let's go back to do the defense QME route.'"

Another former QME and MMC representative noted pros and cons of the new system as compared to the old system. The former QME noted that the new system prevented "doctor shopping" but felt that QMEs who registered the maximum number of offices allowable were distorting the new system. The MMC representative felt that the new system brought down overall costs but that the quality of reports may have decreased because QMEs did not have to try as hard to attract business.

Theme: The Use of Replacement Panels Could Be Opaque.

Three active QMEs noted that they did not have good visibility into the process of requesting a replacement panel for such reasons as unavailability but felt that the process could be used for attorneys to remove QMEs that they did not like from the panel. As one active QME noted, "We have no visibility into that. We never get notice that we're supposedly doing something wrong and getting booted off. It would be nice to have a way to rebut it."

Quantitative Results: Analysis of Replacement Panels

To further ground these views, the quantitative analyses examine how these structural features manifest in administrative data, focusing on the distribution of replacement reasons and their correspondence with EAMS case activity. By linking coded panel replacement outcomes with observable case events, this analysis provides an empirical lens on whether the procedural

issues described by stakeholders—such as delayed appointments, specialty mismatches, and judge-directed interventions—appear systematically in recorded case behavior, offering a complementary view of how structural changes have functioned in practice.

A panel can be replaced for several reasons. For example, if two QMEs were struck by attorneys on a panel and the selected QME was unavailable, the entire panel would be replaced with three new QMEs, even if the struck QMEs had availability. A panel can also be replaced for reasons not specific to the selected QME. For example, under the previously described Romero case exception, a panel can be replaced if a previously unrepresented IW gains representation and has not yet utilized the panel that was assigned when they were unrepresented. Table 7.1 shows the distribution of replacement reasons from 2012–2024 at the panel level, excluding attorney strikes. These reasons remained remarkably stable suggesting that structural changes to QME selection and related administrative processes have not substantially shifted the underlying drivers of panel replacement. Among the reasons not related to attorney strikes, "Untimely appointment" (i.e., the QME was not able to schedule an appointment within the required time frame) has consistently been the dominant reason for replacement panels, accounting for the main reason for about half of panels in each year, with little variation over time. The next most common reasons—QME unavailability and panels with multiple reported reasons—each account for roughly 10–14 percent of replacement panels and have also remained largely unchanged over time. All other categories individually represent relatively small shares of replacement reasons. While the distribution of reasons for replacement panels has not changed substantially over time, we note in a prior chapter that the overall percentage of panel assignments that are for replacement panels have decreased in recent years.

Table D.8 shows replacement reasons by year at the QME level. That is, it provides the reasons each QME on the panel was replaced, including QMEs who were replaced because they were struck from the panel. The table shows that replacement patterns have remained highly stable from 2012 through 2024: Attorney strikes account for roughly 45 percent of reported reasons annually, untimely appointments consistently represent about one-fifth, and all other reasons individually comprise relatively small and largely unchanged shares over time.

Table 7.1. Most-Frequent Reasons for Panel Replacement, by Year

Replacement Reason	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Untimely appointment	47%	47%	48%	49%	50%	49%	50%	51%	50%	49%	49%	49%	48%
QME unavailable	13%	14%	13%	13%	13%	13%	13%	13%	14%	13%	13%	13%	13%
Multiple Reasons	11%	11%	10%	9%	10%	11%	9%	10%	9%	10%	10%	10%	10%
WCAB judge ordered change	4%	4%	4%	4%	4%	5%	4%	4%	4%	4%	4%	4%	5%
Romero case exception	4%	4%	3%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
QME is PTP	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	2%
Other	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Report time frame infraction	2%	2%	2%	3%	3%	3%	2%	2%	2%	2%	2%	2%	2%
Wrong or changed specialty	2%	2%	2%	1%	1%	1%	1%	1%	1%	2%	2%	1%	2%

SOURCE: RAND analysis of EAMS data.
NOTE: This table shows the distribution of reported reasons for QME panel replacement by panel assignment year for replacement requests observed between 2012 and 2024, for the top 10 most-frequent reasons. Romero case exception refers to replacements permitted under *Romero v. Workers' Compensation Appeals Board*, which allows departure from standard QME selection procedures under specific legal circumstances. Multiple Reasons indicates cases in which more than one replacement reason was reported for the same panel request.

Table D.9 further indicates that reported replacement reasons generally align with observable activity in EAMS adjudication records. In particular, replacements attributed to WCAB judge-ordered changes show a high incidence of associated EAMS case events, consistent with the fact that judicial orders are formal actions that generate documented case activity. In contrast, replacements driven by administrative or logistical factors—such as QME retirement, reticence, or address changes—are less likely to coincide with EAMS events, which is expected given that these routine adjustments typically occur without judicial involvement.

How Can Medical Record Delivery to QMEs Be Improved?

Qualitative Results: Views on Medical Record Delivery

The processes and timelines surrounding medical record delivery and review were discussed by many participants. Participants gave their thoughts on how medical records should be delivered and how to best determine the relevance of records which they received.

Theme: Medical Records Need to Be Available Prior to the Evaluation.

As noted in the Introduction, the applicant and defense must each have an opportunity to review medical records, a cover letter, and other relevant documents and to object to the inclusion of documents that are sent to the QME. The QME is not required to receive these records until ten days after the evaluation. If the QME has not received the records within ten days following the evaluation, they are still required to proceed with writing the report with the available information. However, a supplemental report may be required later after receiving the records. Two MMC representatives, two active QMEs, and three former QMEs argued that medical records must be available prior to the evaluation. As one MMC representative noted,

> The records can come as late as nine days post eval. That makes zero sense. It is a large drag on efficiency. . . . You could have 10,000–15,000 records. If the doctor goes into a QME without records, they don't know what they are looking for. That's the number one issue that needs to be addressed.

An active QME noted the importance of receiving both the medical records and cover letter ahead of time, stating, "I have examined the applicant, went through the body parts, and then find out from the cover letter ten days later it is a different injury, different body part. I examined the neck, and it is the left foot in question." Another active QME with multiple specialties noted that at times, they were not sure which specialty they were supposed to be using on the day of the exam.

> A represented IW also noted their frustration at their QME not having medical records at the examination saying, "Most of the doctors I have seen don't have my medical records. I was so angry with them. Why don't you have my medical records? You should have them in front of you."

Two other unrepresented IWs noted that their QME had their records at the time of the appointment, with one of the IWs noting that they called ahead of time to confirm that the QME received the records.

Another unrepresented IW expressed frustration that their insurance company had not yet sent their records shortly before the appointment but that they were able to contact their provider and obtain the records themselves to bring to the appointment. The remaining represented IW we spoke with was not aware whether the QME received their medical records before they were evaluated.

Theme: Requirements for Record Delivery Have the Potential to Cause Further Delays.

One defense representative and one active QME pushed back against the idea that records should be available to the QME prior to the evaluation. The defense representative noted,

> You know, and I've heard some people suggest . . . require that the examiner have the records and the cover letter there at least two weeks before the evaluation. That sounds great, except if they're in a situation where their caseloads are so high and active that that's an impossibility for them to meet consistently.

Similarly, the active QME said that while they would ideally receive records before the evaluation, they were concerned that requiring it would delay appointment scheduling even further.

Theme: Determining the Relevance of Medical Records to Deliver Is Complex.

Five defense representatives, two AAs, and two active QMEs agreed that deciding which records to send to QMEs was complex. One AA acknowledged that many records delivered to QMEs were not relevant to the case but also noted experiences where a QME needed to write a supplemental report because they were not originally provided with complete records. A defense representative also acknowledged that sometimes records that may not seem obviously relevant to the case could be important to include. However, the defense representative noted that the IW may have sensitive medical records, such as those involving sexual assault, that were not relevant to the case and should not be included. As they put it, "That's a case-by-case analysis. . . . Everybody's case is different."

Theme: Only QMEs Should Determine the Relevance of Records.

Other participants felt more strongly that all medical records should be included, and it should be solely up to the QME to determine which were relevant to the case. One AA, one defense representative, four current QMEs, a former QME, and an MMC representative argued this perspective. As one active QME noted,

> You really do need all the records. Patients, even very educated ones, don't remember things . . . sometimes buried in one page number, 4,000, whatever, very critical piece of information is there. A sleep study, a pulmonary function test, whatever it is. And so it's not really up to the attorneys or the system to determine what records need to be sent. What's available needs to be sent because the more information that is available, the more likely that there's going to be more substantial evidence in those reports.

Another QME agreed, "Leave it with the evaluating physician. You don't know where the gold is going to be. There might be a discussion of a traumatic accident that affected the patient's psyche."

Theme: Removing Duplicates from Records Was an Area of Common Agreement.

While participants differed on the extent to which they thought irrelevant records could be removed, no one objected to the removal of duplicate records. Three defense representatives or employer representatives, an active QME, and a former QME all endorsed the idea that duplicate records should be removed prior to sending them to the QME. One former QME noted, "I know the division is working on $3 a page. The easiest way to cut that is to look at the broader system and see where the waste is. They can have a secretary remove duplicate records. I spend a lot of time removing duplicates."

Multiple participants thought that artificial intelligence (AI) could have a role in removing duplicates. A defense representative noted,

> There's lots of tools out there that can sort through these pages without a human even doing it to consolidate them into a clean copy of all the records. Now, what that won't address is whether the records in that file are relevant to the injured. That is another whole step. But at least if you could eliminate some of the costs to the system that we see based on duplicate records being contained in the medical file. I just think in the age of technology we have now, we're really missing the boat if we don't try to leverage it in some way.

Theme: A Central, Electronic Repository Could Improve Record Delivery—Provided Privacy Concerns Were Addressed.

Several participants endorsed the idea of creating a central, electronic repository for parties to access medical records for a case. Four AAs, two defense representatives, and three active QMEs expressed enthusiasm for the idea. One AA noted that it would help patients who have seen multiple providers: "That'd be amazing. Right? Like everything has to be transparent. How many times the patient went and not having to rely on their own memory but at the time they actually go from one practitioner to another."

Participants noted the potential benefit of all parties being able to access information simultaneously and being able to verify what information parties have received and at what time. Participants also noted that the repository would need to be secure but had a lot of potential. One AA stated,

> Let's just say that I have two QMEs and the records are already there. And I don't have to send a new set of records to the QME to the second QME? That'd be amazing. . . . To manage that and have it be secure and have so many people access medical, that would be my concern. . . . But if there was one central repository of records where QMEs, PTPs could deposit their report, QMEs could access, and Utilization Review could also access, I mean that would be amazing.

Theme: Participants Expressed Concern About a Central Electronic Repository.

One AA, one defense representative, one MMC, and six active QMEs expressed concern about using a central repository. Primary concerns included security and concerns about adding an extra layer to an already complex process. A defense representative noted,

> You know, I think it's a great idea to have, like, an information superhighway . . . . It depends who runs it. So maybe if you guys contract it out to someone, but most of the people that respond to the RFPs [Requests for Proposals] don't know what the heck they're doing anyway in the first place. . . . Even though I believe it's a great idea. I just see a lot of problems with execution.

An active QME agreed, noting, "I would be a little afraid of it being an extra step. I like it in theory." Three active QMEs disagreed more strongly with the idea of a central repository with one saying, "I would be dead set against it. In a couple years, they are going to be hacked."

The Colorado workers' compensation agency recently took a central role in organizing and delivering medical records to DIMEs. The idea previously brought up about using AI to remove duplicate records is something that Colorado is in the early stages of testing. A representative from the Colorado workers' compensation agency explained,

> Another major change also took effect on April 1 with respect to medical records. The records packets were not consistently complete. For DIMEs only, the division receives the medical records and then culls them of duplicates, organizes them, gets any additional records from the opposing party, and gives them to the DIME physician. We are using an AI system to remove duplicates and organize, followed by human eyes to be sure the AI did it correctly.

Another Colorado representative continued,

> The parties appreciate this. We took a staged approach. We were extremely modest in communicating our expectations. Having the parties give up control of putting together a record packet is pretty significant. We intentionally addressed this in stages. First, we addressed administrative issues, as simple as putting things in chronological order, deduplicating, Bates numbering, providing an index. We knew that easy-to-say thing would be very difficult to do. The early returns are positive. We have met the modest expectations. It will get more interesting when we try to tackle the idea of relevance. That is an entirely different level of complication we are not yet ready to handle until our AI platform is up to snuff. So that will be on the back burner for now.

They cautioned that it was not as straightforward a process as it seemed, however. Colorado noted that the AI platform they used could remove identical records but not things like office notes that were copied and pasted on each record. They also noted that it was difficult to remove duplicate faxed or photocopied records as the platform had trouble recognizing those as duplicates.

Of note, Colorado is a much smaller state than California. Our discussion with Texas, which is more comparable in size to California, highlighted how another idea brought up in discussions—a central electronic repository—could be a more challenging prospect to implement in a larger state. One participant stated,

> That would be a lot to put on the on the agency . . . that's not our role, that's the carrier's role. So for us to have that information, it would just be a repository to have a lot of information that is not useful to the division . . . we have about 100,000 claims . . . on an annual basis, OK. And then our retention schedule is 50 years to keep data because once you're injured on the job, you basically have lifetime access to medical benefits as long as it's medically necessary to treat the compensable injury.

Theme: Some Participants Wanted Only Electronic Delivery.

Separate from an electronic central repository, we also discussed whether California should move to electronic-only delivery of medical records. Participants endorsed increased electronic delivery of medical records, with one AA, one defense representative, one active QME, and one former QME noting that it should be required. One defense representative noted,

> Everybody's going to a paperless system. Everybody's going to encryption. Sending paper out is not time efficient. It's not cost efficient. And we all have limited staff to transmit things by paper like we used to. Should it be mandated? On balance, probably.

Theme: Others Thought That While Electronic Delivery Was Usually Preferable, It Shouldn't Be Mandated.

Three active QMEs, one former QME, two defense representatives, and an AA noted that mandating the use of electronic records was not necessary. One active QME noted that on some occasions, physical delivery of things like imaging reports could be preferable, noting experiences where poor-quality images or large file size made electronic delivery difficult.

Others noted that the timing of record delivery was of far greater concern than the method of delivery. As an active QME noted, "The deadline is more important to me personally than the methodology . . . I like a hard copy, mail it to me or fax it to me. I can work off the electronic. That is not so important as when you get them."

While not specifically related to medical record delivery, one unrepresented IW expressed the desire to have more parts of the Med-Legal process available electronically for IWs. While they acknowledged that many IWs would prefer to have paper records, they felt that electronic transmission and receipt of documents should be an option. For example, they noted that unrepresented IWs need to submit a QME panel request form via mail, and they would have preferred to submit it online, similar to the process used in represented cases.

How Has the Quality of Med-Legal Reports Changed Since 2012 and What Is the Best Way to Ensure the Quality of QME Reports?

Qualitative Results: Perspectives on Report Quality

In interviews and focus group discussions, participants shared their perceptions of the quality of QME reports, how that quality has changed over time, and how the quality of reports could be improved.

Theme: The Med-Legal System Does Not Provide Enough Opportunities for Feedback.

A common theme, particularly in the active QME focus groups, was the desire for more feedback. Eight active QMEs and one former QME expressed that they did not get enough feedback on their reports. QMEs noted that there was generally no follow-up after submitting a report, and they did not know how the case turned out or whether the information they provided was useful to the parties. One QME noted,

> I think feedback would be useful as to whether our report is helpful or not. What impact does my report have? I will assign a psychiatric GAF [Global Assessment of Functioning] score. I don't know how that plays out in the long run for the injured worker.

One AA also expressed the desire to provide more feedback to QMEs, saying,

> They would get far more educated with real-life cases. . . . I've had so many . . . QMEs where I've had to make inquiries of, and I asked them, do you know the law of X? I don't. Do you know the law of Y? I don't. They don't know it, not because they purposely don't want to understand it. They only get educated when someone like me pushes them on an issue, and yet all the issues that I'm questioning them of are mandatory questions for them to address under the law.

Several QMEs noted that the only times they did receive feedback was when they were getting deposed, asked to write a supplemental report, or, indirectly, by not being selected for panels. They saw some value to this feedback but noted that it would be preferable to receive feedback at a much earlier stage and in a lower-stakes environment. They viewed this feedback as often coming too late to be helpful.

One QME was aware of California's new 2024 policy requiring QMEs to submit two recent reports through their online portal for reappointment and was hopeful that this would be a positive change to the system.

Colorado commented on its approach to providing feedback to DIMEs, which was targeted specifically towards new evaluators in the system. Colorado's process involves a technical review of the impairment rating. DIMEs who do not meet standards are sent a point-by-point letter explaining where the report diverges from standards. Once the ratings for the new DIMEs are deemed sufficient, they do not need to be reviewed again.

Texas also began a formal review process for all Designated Doctors in 2018. Under this review process, there are eight performance factor metrics that are automatically calculated for all Designated Doctors and can trigger a performance review towards the end of a two-year performance period. These performance factors are based on measures, such as the percentage of exams that receive complaints, the percentage of exams that require letters of clarification, and the percentage of reports that are not adopted at contested case hearings. If one of these performance factors is triggered, five random reports are selected for review by the DWC. The representatives from Texas emphasized that being flagged does not necessarily mean that the Designated Doctor should not be recertified, just that their reports need to be reviewed more carefully and that they may require some additional training. One representative discussed the feedback they initially received from doctors on this change, stating,

> So the feedback that we had from doctors was not necessarily that positive, especially because you know you're talking to them about things that are affecting them, especially if they're not going to be recertified again, right? But the more that they started seeing where we were coming from and how we were trying to do this objectively and it wasn't so much to pick on someone . . . and also not automatically to deny you . . . but first give you an opportunity to fix those errors. . . . If those issues went away, then you know the next time that you applied, everything was OK. We actually have designated doctors that wanted more of that being done because they wanted that education aspect to happen more on the front end. . . . We, our faculty, has come up with a lot of resources to

> really assist them . . . either on their own or also participate in educational, optional webinars that we have that will help them.

Theme: QMEs Need More Practical Experience as Part of Their Education.

Two former QMEs, an active QME, and an AA noted much of the initial training and continuing education taught concepts passively without much direct practice doing the work of a QME. As one former QME noted,

> Basically, there was a course that was offered. I think it was a one-day course. . . . My experience was that they provided enough training to pass the test but not necessarily to do an adequate job. And I did not feel prepared to do the job on my own.

An active QME similarly said, "We watch a video for education. It is very passive. We do that for our licensure, too."

However, one active QME did note that there were some practical components of the certification process, saying, "Currently . . . to get your final certification as a new QME, you have to submit a report writing sample and take a writing class. This is separate from the ongoing requirement to submit reports that will start in 2026."

Two QMEs also noted that templates and checklists for conducting evaluations were available through DIR and other sources and thought that their use should be encouraged. One active QME who served as a mentor for other QMEs noted that they gave their mentees a template specific to their specialty.

Colorado noted that they provided a template for DIMEs to use and that it helped them provide more structured feedback on reviews of new DIMEs reports, noting, "We have a DIME template, so everyone can find the information they are looking for."

Theme: There Was a Desire for New QMEs to Have a Mentor.

Three former QMEs, one active QME, and one MMC representative explicitly noted the importance of mentorship in the QME system and wanted to see more formal opportunities for new QMEs to learn from experienced QMEs.

Relatedly, a former QME noted the desire for more ability to formally connect with peers doing QME evaluations, saying, "It would be nice if there were a society where I could compare notes. Like, my billing agent charged $120 for this. Is this what your billing agent does?"

Theme: QMEs Need Additional Education and Monitoring, Particularly on the Legal Aspects.

At a high level, several participants noted that there should be additional education and monitoring of QMEs. In particular, a defense representative, two former QMEs, and an active QME emphasized wanting the need for more QME education in the "legal" part of "Med-Legal." One former QME noted, "I think the type of evaluations have enough legal bent that you really have to have a more thorough training to do it." Another active QME commented, "Anyone who does this work will need to go to workshops to stay on top of caselaw."

Are the Time Frames Built into the QME Process Appropriate and Being Met?

Qualitative Results: Views on QME Process Time Frames

As described in the Introduction, there are several time frames associated with different aspects of the Med-Legal process. We discussed each of these time frames with participants to learn which time frames were appropriate and which should be shorter or longer. We also discussed whether time frames were adhered to and other factors in the system that contributed to delays.

Theme: Requesting Multiple Panels Adds to Overall Timeline.

While participants thought that the timeline for requesting a panel was generally appropriate, four AAs noted that time frames for requesting panels became a problem when multiple panels were needed. As one AA noted,

> If we have an initial QME [panel] and we need to get additional QMEs [panels], there has to be an agreement by the parties for a joint request. And if one party, for whatever reason, isn't agreeing, I typically have to go to court and get a judge involved. And I'm usually successful in those efforts, but that can add anywhere from, you know, one, two, three months to a delay in the case.

Another AA suggested that IWs should be able to start with multiple panels, if indicated by the medical record saying,

> It doesn't make sense that we would have to start with one and then litigate our way through additional QME panels. . . . When you know the medical record may be clear that there you need additional specialties and then, that again, it's another delay in the process.

Theme: The Time Frames for QMEs to Schedule Appointments Is too Long.

As noted in the Introduction, the time frame to schedule an initial QME appointment was recently extended from within 60 days to within 90 days of the panel assignment. An AA and two active QMEs noted that they were disappointed that the time frame for scheduling had been extended. As one active QME said,

> The availability aspect is actually now elongated to 90 days . . . I do think that putting myself in the shoes of a client, this is already such a stressful event for them to have to go through trauma and then to have to wait things out even longer.

Theme: Extra Time for Writing Reports with Many Medical Records Would Be Helpful.

In general, participants did not object to the time frame designated to write reports. However, three former QMEs noted that, while the time allotted to write reports was appropriate in most cases, they would like to see extensions given for cases with a lot of records to review. One

former QME noted, “I’ve been able to do some for . . . 200 pages of records or even 400. But when it starts getting a lot higher, and they give you the stuff late, then it’s very frustrating.”

As another former QME noted,

> I find that the amount of time it takes me to complete a QME report depends on my schedule, the complexity of the case. Occasionally I get it out in a week. 30 days is not onerous, but if you get a box of records, that is a very different report. The deadline is a problem when it applies to every single case.

Theme: Enforcement of Time Frames Is a Larger Issue Than the Time Frames Themselves.

One defense representative and one active QME noted that the time frames as stated in laws and regulations were reasonable but that enforcement of timelines was a bigger issue. One defense representative noted, “I think when you read the rules, they make sense. And I think if people just followed it, it would be OK.”

Theme: Delays Add Up.

One AA and two defense representatives noted that, while time frames were generally appropriate for each step of the process, delays in the case were generally more related to the number of steps or the need to repeat steps.

Theme: Injured Workers Noted Some Delays, but These Were Not Specific to the Med-Legal Process.

We discussed timelines associated with the Med-Legal process with IWs. Experiences varied, but IWs noted that time frames associated with QME evaluations and reports were generally reasonable compared to other steps of the workers’ compensation process. As one represented IW noted,

> This whole thing has been frustrating . . . trying to find an orthopedist who will take [workers’ compensation] cases and go from there. Just to find one for my shoulder took me almost a year to get in and see a doctor. That’s frustrating. You’re making phone calls, they submit a claim, the whole process gets strewn out longer than it should.

One unrepresented IW provided a contrasting perspective and noted that they were able to get their surgery scheduled very quickly and that California DWC’s Information and Assistance unit was very responsive to questions. They thought that the time to schedule their QME evaluation appointment was reasonable.

Two other unrepresented IWs noted that the biggest delays came from getting required information from the insurance company to move forward with their case but that they did not have large delays in scheduling their QME appointments or in the QME writing the report.

One represented IW noted that there were delays throughout the process, including getting treatment, getting needed information from their insurance company, and scheduling a QME appointment. Of getting a Med-Legal evaluation for a rare specialty, the IW noted, “They

couldn't find any facility. When they find one, I had to wait for an appointment. So I had to wait for two years for one appointment to submit to my lawyer so he could close my case."

Quantitative Results: Time Frames Observed in Workers' Compensation Data

We examined the actual time frames associated with different events in the Med-Legal system and how these observed time frames changed by year.

Table 7.2 shows the time from the date the claim was reported to the claim administrator to the first panel request date. Across the time interval categories, the share of panel requests submitted within shorter time frames—particularly within 30 and 90 days of claim reporting—increased steadily from 2016 to 2023, indicating that QME panels are being requested earlier in the course of workers' compensation cases. Although the average duration from claim reporting to first panel request dropped substantially across the period, this decline is partly influenced by data truncation in the later years, which limits visibility into longer pending cases still open at the time of observation. However, Tables D.10 and D.11 show that, when removing cases with longer durations (one and two years, respectively) to allow for comparisons with equal follow-up time, the share of panel requests occurring within 30 and 90 days of claim reporting still increased steadily from 2016 to 2023 while later requests declined.

Table 7.2. Duration from Date Reported to Claim Administrator to First Panel Assignment Date, by Time Interval

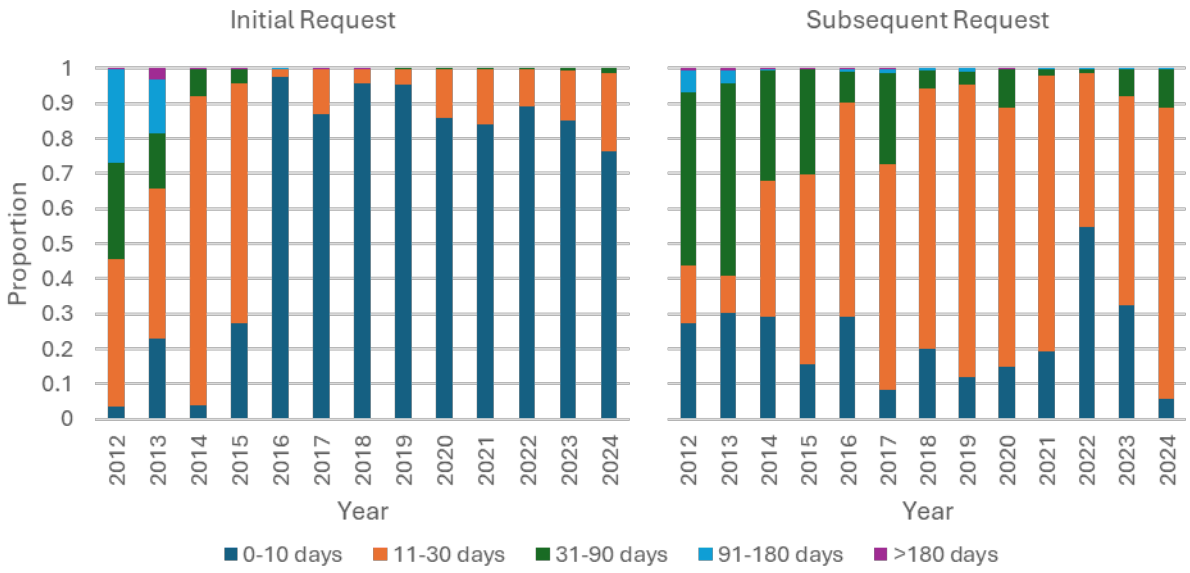
Report Year	Average Duration	% Within 30 Days	% Between 31–90 Days	% Between 91–365 Days	% Over 1 Year	N
2016	325	4.9%	19.7%	44.5%	30.8%	66,860
2017	305	5.7%	20.0%	45.8%	28.6%	70,894
2018	295	6.1%	20.4%	45.8%	27.7%	73,743
2019	291	6.3%	21.2%	45.0%	27.5%	77,478
2020	276	7.6%	21.8%	44.6%	26.1%	68,514
2021	268	7.9%	22.5%	42.7%	27.0%	73,876
2022	229	9.2%	24.9%	43.2%	22.6%	77,693
2023	160	13.4%	30.4%	45.1%	11.2%	76,724

SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: Durations reflect the time between claim reporting and panel request among merged QME-FROI records from 2016–2023. N refers to the number of initial panel assignments in each year. Later years may be affected by right-censoring, as longer-pending cases remain open and are underrepresented in the data.

Figure 7.1 shows the time from receipt of panel request to panel assignment by year of request, stratified by whether it was an initial or replacement request. Overall, the time from panel request to panel assignment has decreased substantially from 2012 to 2024. Most notably, the days from panel request to assignment for initial requests decreased markedly from 2015 to 2016, following the requirement to use the online request portal for initial requests for

represented cases. Initial panel requests in unrepresented cases were still required to be submitted by mail. In 2014, only 4 percent of initial panel requests were filled within 10 days, and 92 percent were filled within 30 days. This increased to 98 percent of requests filled within 10 days and more than 99 percent of requests filled within 30 days in 2016. There was a moderate increase in time to panel assignment for an initial request from 2016 to 2024, although the percentage of requests with panel assignments within 30 days remained at 99 percent. Although replacement requests still must be made by mail regardless of requestor, there was, to a lesser extent, also a reduction in the number of days to panel assignment for replacement requests. Replacement panels also may require additional steps before assignment, such as verifying that the reason for replacement is valid. Of note, the percentage of replacement panel requests taking more than 30 days decreased from 56 percent in 2012 to 11 percent in 2024.

Figure 7.1. Days Until Panel Assignment, by Initial or Replacement Requests



SOURCE: RAND analysis of QME data.
NOTE: N = 1,449,046 initial requests and N = 303,363 replacement requests. 128 requests with assignment dates prior to request date were dropped from the analyses.

Table 7.3 shows that the time from panel assignment to QME exam has remained fairly stable across most duration categories from 2016 to 2023. The shares of panels with exams completed within 90 days and those taking over one year changed little over the period, while the proportion with exams occurring between 91 and 365 days increased steadily. The percentage of panels with no QME exam from the assigned panel declined slightly—from roughly 58 percent in 2016 to about 45 percent in 2023—indicating some improvement in panel utilization once panels are issued. Table D.12 shows that the Spine/Neurosurgery and Psychiatric/Behavioral specialties have the highest shares of exams completed within 90 days, while Pain Medicine and

Chiropractic/Acupuncture/Occupational Specialties have the lowest. These differences may partly reflect limitations in the multi-stage NPI matching process but may also reflect differences in scheduling timelines and compliance across specialties.

Table 7.3. Duration from Panel Assignment Date to QME Exam Date, by Time Interval

Report Year	Average Duration	% Within 90 Days	% Between 91–365 Days	% Over 1 Year	% With No QME Exam from Panel	N
2016	150	22.9%	16.1%	3.3%	57.7%	51,231
2017	138	25.2%	17.7%	2.8%	54.3%	58,922
2018	126	26.0%	18.7%	2.2%	53.2%	66,201
2019	132	25.3%	19.1%	2.5%	53.1%	70,008
2020	139	20.7%	27.3%	2.3%	49.8%	67,569
2021	131	23.4%	28.3%	2.3%	46.0%	63,063
2022	125	23.9%	28.2%	2.0%	45.9%	64,411
2023	118	22.4%	31.3%	0.9%	45.4%	67,747

SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: Durations reflect time elapsed between panel assignment and completed QME exam for panels issued from 2016 to 2023. N refers to the number of panel assignments in each year. “No QME Exam from Panel” includes records where no matching QME identifier was found or where a match existed, but the exam occurred outside the panel assignment window (i.e., before the exam or after a subsequent panel assignment).

Table 7.4 shows that the time from initial panel assignment to EAMS case closure has gradually shortened from 2012 to 2023, reflecting steady improvements in case processing efficiency. Earlier years were dominated by long-duration closures—over 40 percent of cases closed more than two years after panel assignment in 2012—whereas by 2022, that share had fallen to about 13 percent. The proportion closing within one year grew modestly but remained consistent at just under one-third across most of the period, while the share closing between one and two years also stayed relatively stable. The percentage of cases with no recorded closure date increased in recent years, reaching about 46 percent in 2023, which reflects right-censoring and outstanding cases still open at the time of extraction. Average durations dropped from 924 days in 2012 to 329 days in 2023, although this trend should be interpreted with caution as truncation in the most recent years limits visibility into longer-duration case closures that have not yet occurred.

Table 7.4. Duration from Initial Panel Assignment Date to EAMS Case Closure, by Time Interval

Report Year	Average Duration	% Within 1 Year	% Between 1–2 Years	% Over 2 Years	No EAMS Close Date	N
2012	924	22.5%	26.0%	44.7%	6.7%	44,582
2013	853	25.6%	24.9%	39.9%	9.7%	54,639
2014	786	28.3%	27.0%	37.4%	7.3%	51,850
2015	743	30.1%	27.0%	35.3%	7.5%	62,937
2016	721	30.7%	27.7%	34.1%	7.5%	63,560
2017	700	31.3%	27.9%	32.5%	8.3%	64,534
2018	675	32.0%	26.2%	32.0%	9.8%	68,373
2019	666	29.4%	26.6%	32.4%	11.6%	71,147
2020	624	28.3%	27.8%	29.8%	14.1%	68,889
2021	554	28.7%	27.6%	23.5%	20.2%	66,738
2022	457	29.6%	28.2%	12.9%	29.3%	70,189
2023	329	31.9%	21.9%	N/A	45.5%	72,417

SOURCE: RAND analysis of linked QME-EAMS data.
NOTE: Durations reflect the time between panel assignment and EAMS case closure for initial panels issued from 2012 to 2023. N refers to the number of panels in each year. “N/A” indicates that for 2023 cohorts, closures occurring more than two years after the panel assignment cannot yet be observed because the dataset extends only through 2024. Percentages 1–2 years in 2023 and over percentages over 2 years for all years should be interpreted with caution as the follow-up time observed varies.

Table 7.5 shows that the shares of cases closing within one year or between one and two years have remained relatively stable. The average duration from first report to case closure declined from roughly 690 days to 320 days over the period; however, this measure should be interpreted with caution, as right-truncation in the most recent years limits visibility into these cases.

Table 7.5. Duration from First Med-Legal Report to EAMS Case Closure, by Time Interval

Report Year	Average Duration	% Within 1 Year	% Between 1–2 Years	% Over 2 Years	No EAMS Close Date	N
2016	689	34.5%	22.6%	30.6%	12.4%	68,686
2017	655	35.8%	23.4%	28.6%	12.2%	45,289
2018	619	37.8%	22.4%	28.1%	11.7%	43,937
2019	600	35.9%	24.0%	27.5%	12.5%	42,226
2020	570	34.7%	24.8%	25.6%	14.9%	43,938
2021	517	33.9%	25.5%	21.1%	19.5%	42,081
2022	435	33.6%	27.0%	11.8%	27.6%	38,790
2023	321	35.7%	21.3%	N/A	42.2%	37,685

SOURCE: RAND analysis of linked EAMS-WCIS data.
NOTE: Durations reflect the time between the first observed Med-Legal report and EAMS case closure for claims reported from 2016 to 2023. N refers to the number of unique claim numbers in each year. "N/A" indicates that for 2023 cohorts, closures occurring more than two years after the report date cannot yet be observed because the dataset extends only through 2024.

Table 7.6 shows that the percentage of cases from which the last Med-Legal report to EAMS case closure is within one year has decreased slightly between 2016 and 2023, with more than half of cases closing within one year across nearly all years. The proportions closing within one to two years have remained relatively stable, while the share closing after more than two years declined substantially—from nearly 13 percent in 2016 to less than 5 percent in 2022. The percentage of cases with no recorded closure date increased for recent cohorts, reflecting open or ongoing matters still within follow-up.

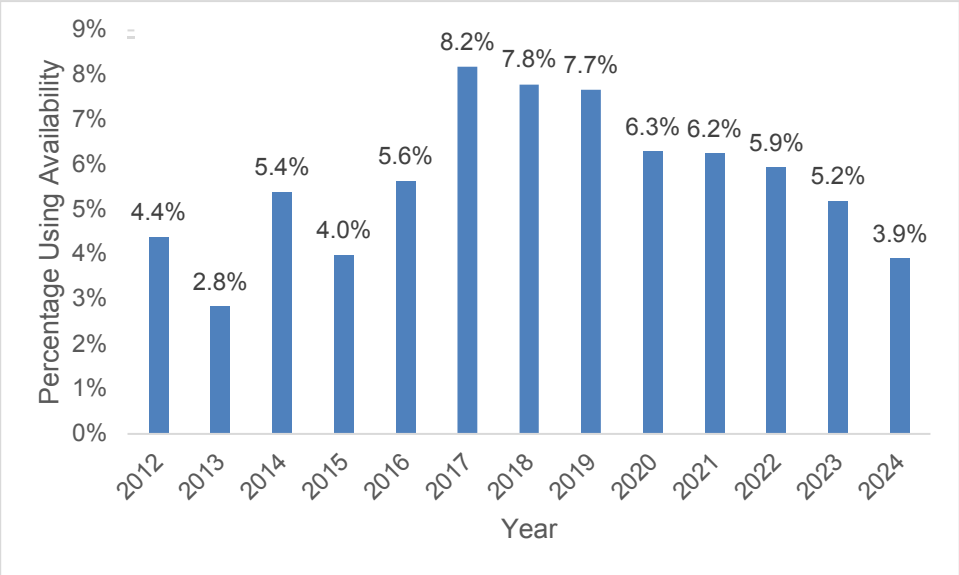
Table 7.6. Duration from Last Med-Legal Report to EAMS Case Closure, by Time Interval

Report Year	Average Duration	% Within 1 Year	% Between 1–2 Years	% Over 2 Years	No EAMS Close Date	N
2016	398	57.2%	16.5%	12.8%	13.4%	37,156
2017	367	59.9%	15.7%	10.8%	13.5%	38,075
2018	346	61.4%	14.2%	10.5%	13.9%	40,185
2019	346	59.5%	16.0%	10.4%	14.1%	40,957
2020	351	58.0%	17.4%	10.0%	14.6%	41,444
2021	337	56.5%	18.0%	8.7%	16.8%	42,576
2022	297	55.6%	17.7%	4.8%	21.9%	41,357
2023	243	51.3%	12.7%	N/A	35.7%	47,002

SOURCE: RAND analysis of linked EAMS-WCIS data.
NOTE: Durations reflect the time between the last observed Med-Legal report and EAMS case closure for claims reported from 2016 to 2023. N refers to the number of unique claim numbers (or Jurisdiction Claim Numbers [JCNs]) in each year. "N/A" indicates that for 2023 cohorts, closures occurring more than two years after the report date cannot yet be observed because the dataset extends only through 2024.

Figure 7.2 shows, by year, what percentage of QMEs used unavailability (i.e., had an unavailable status) for any portion of that year. The percentage of QMEs with an unavailable status was low, ranging from three percent to eight percent, depending on the year. However, the percentage of QMEs using unavailability doubled from 4 percent in 2012 to 8 percent 2017, then steadily decreased after 2017 to 4 percent in 2024. The relatively small fluctuations from year to year suggest that, while individual QMEs may move in and out of availability, the overall share of QMEs reporting unavailability has remained fairly stable over the past decade.

Figure 7.2. Percentage of QMEs Who Used Unavailability During Calendar Year



SOURCE: RAND analysis of QME data.
NOTE: Proportion is determined by dividing the number of QMEs who used unavailability for at least part of a calendar year by the number of QMEs who were active for at least part of the calendar year. N = 36,922 active QME years.

Are Remote Telehealth or Remote Health Evaluations Being Used Appropriately and Should Any Changes Regulating Their Use Be Considered?

Qualitative Results: Views on Use of Telehealth or Remote Health

In California, telehealth or remote health is allowable for evaluations if both parties agree. While no one we spoke with was for or against using telehealth or remote health in all circumstances, participants had different thoughts about the extent to which it should be used as well as the perceived benefits and drawbacks of its use in QME evaluations.

Theme: Participants Felt That Telehealth Could Be Appropriate for Psychiatry and Other Mental Health Evaluations.

Two defense representatives and one AA noted that they were generally opposed to telehealth evaluations but were willing to agree to psychiatry or other mental health evaluations in some circumstances. Similarly, an MMC representative noted that they were generally opposed to telehealth evaluations, with the exception of mental health evaluations.

Two active QMEs were highly supportive of the use of telehealth in mental health evaluations and wanted to see greater acceptance of it. However, they acknowledged that it may not be appropriate in all cases and thought both remote and in-person options should be offered by QMEs, unless the QME had a health consideration. One active QME in the psychiatry specialty noted, "Psychiatry is ripe for telemedicine. I offer everyone telehealth. Only about one-third of attorneys agree to it. I know there are doctors who refuse to see IWs in person. That is a big problem. You have to know how to do telehealth."

Theme: Telehealth Offers Flexibility When Parties Agree to Use It.

One active QME, one former QME, and one MMC representative noted that telehealth could be appropriate and potentially attract more doctors but that agreement of the parties was critical. As one MMC representative put it,

> I completely applaud that they maintained post-COVID telehealth policies. It completely makes sense that hands-on evaluation should not be telehealth. But if it doesn't require hands on, anything that improves efficiency of getting these cases resolved is a good thing. It will also attract more doctors. The regulation now works with mutual agreement. We don't default to it.

One AA noted that they had disagreements about when telehealth should be used, stating,

> Yeah, we get into fights sometimes about that . . . . Generally, the way that gets worked out between the parties is if someone really objects to it, that's the doctor they choose to strike on a panel. Usually, we can work it out . . . . If the last doctor standing is one that does remote and one side is adamantly opposed, then we just . . . get a replacement panel and hope for the best.
>
> Similarly, a defense representative noted that agreement on telehealth between the parties was essential. They also argued that the standard for the objection for telehealth should be lowered, saying, "You shouldn't have to go into court and prove . . . based on these scientific issues, this is the reason . . . I think it should be pro forma. You object, you get your in-person exam."

Theme: Cuing or Coaching Was a Concern.

Two active QMEs noted concerns about IWs being cued or coached on how to respond to questions during telehealth or remote health evaluations. One active QME noted that, while they wanted telehealth to be an option, they would not personally use it due to a negative experience saying, "When I did try it once, there appeared to be someone off-camera in the room who appeared to be coaching the applicant. I cannot do it in my field."

Theme: Telehealth Can Be Helpful for QMEs or Injured Workers with Extenuating Circumstances.

One active QME noted that, due to a personal health issue, the ability to work remotely was very important, stating,

> When COVID hit, I was not going to come face-to-face with a patient. I have continued it afterwards. I have lost some clients who want a hands-on examination. I know if I examined the patient, it wouldn't change much at all. It is flexible for both of us.

An AA also noted that some QMEs had medical reasons for which they could not do in-person evaluations, and two active QMEs noted that telehealth evaluations could be helpful for some patients who did not have transportation or who had trouble getting into an office.

Only one IW we spoke with had used telehealth for a QME evaluation. While the IW, who was represented, was not opposed to telehealth evaluations in general, they noted that in their particular case, they did not receive a choice, saying, "I just got the letter to inform me, so I just follow it. I cannot pick and choose." The IW, who also had separate in-person evaluations, noted that their health problems made telehealth visits difficult, saying, "Yes, I have head problems. I cannot look at the screen or phone all the time; if it is too noisy, it gives me a headache. One time I had to pause the evaluation because I had a terrible headache."

The two states we spoke with took different approaches to telehealth. In Texas, telehealth evaluations have never been allowed for exams. As one Texas workers' compensation agency representative explained,

> We don't do it . . . we allow telemedicine, telehealth, but not for the purpose of this exam . . . It already starts kind of on an adversarial sort of exam because there is no doctor-patient relationship. . . . Not to mention that if it is via telemedicine, telehealth could the parties, whether it's the injured employee or the carrier, if they're disputing it, are they going to want to bring the video, the whatever mechanism into play into the hearings and again it becomes more about the how and not the what.

By contrast, the Colorado workers' compensation agency allows telehealth evaluations, but noted limitations, stating,

> It became a little more interesting during the pandemic. Some individuals sought to be a tele-IME. Our rules don't prohibit that. They treat telehealth in complete parity with in-person. We are still on the third edition of the AMA guide. . . . That requires range of motion, which is hard to do remotely. There still are some tele-IMEs but mostly relegated to psychiatrists.

How Have Litigation Practices in the Med-Legal System Changed Since 2012?

Qualitative Results: Perceptions of Litigation Practices

We discussed with participants how litigation and factors affecting litigated workers' compensation cases have changed over time and what they saw as having led to these changes.

Theme: Stakeholders Felt That Litigation Has Gotten More Contentious in Recent Years.

An AA, three defense representatives, and an MMC representative felt that policy changes, particularly SB 863 and the 2021 fee schedule change, while put forth to address problems in the system, created additional layers of litigation. As one defense representative noted,

> There's a lot of rules in place, and when you have a lot of rules in place, people try to figure out how to find the exceptions to the rules and create case law so that there's more circumstances that they might be able to follow under to avoid the rules. [Under the old system] . . . I don't recall a lot of procedural litigation. You were just able to go get your QME, and that was your expert, and you were able to treat that expert as your own. There was no, you know, litigation regarding timeliness of sending records. There was no . . . striking process . . . I think it's amplified. I think there's just a lot more.

An AA similarly noted,

> I think a couple of things, the procedure sometimes becomes more important than the substance, right? We're fighting about, you know, who submitted the panel request first or who submitted in the appropriate panel request in the appropriate specialty, or was a QME late in reporting? And so you, we spent a lot of time having these fights that aren't really moving the case forward.

Theme: Use of Multiple Panels Leads to Additional Litigation.

More specifically, two DAs and four AAs noted that multiple panel requests led to additional litigation, which in turn led to additional time and costs. As one defense representative put it, "Start racking up all these QMEs that are very costly now. I just think that's unnecessary and I think it's, it doesn't help the applicant get them to the right doctor."

Another defense representative and an AA noted that unrepresented cases tended to not request multiple specialties as compared to represented cases. AAs agreed that requesting multiple panels could lead to additional litigation but pushed back against the idea that this was typically due to abuse of the system. As one AA put it,

> Now, let me just give you the flip side of the argument. The defendant would tell you, "Well, that means [AAs] could go file for every part or body under the sun and get all these QMEs and increase our costs." I don't think that's an appropriate assessment. . . . You can't tell someone they can't file something. So once it's filed, you got to deal with it. Now, there probably are some unscrupulous people that just file everything because they think they're driving up the cost. . . . I think it's terrible.

Three AAs suggested that it should be easier to obtain multiple QME panels more quickly, with two noting that the defense should be given a limited of time to object to an additional panel and another noting that it should be possible to get a panel in another specialty right away if there was "medical evidence showing that another body system has been affected or injured."

Theme: The Move Away from Using AMEs Has Created Friction.

Two defense representatives and three AAs specifically noted that decreased use of AMEs following SB 863, which no longer required parties to first attempt to agree on an AME, created additional frictions in the system. As one AA noted,

> The AME was the gold standard . . . most of the time we knew we were going to get a quality report. Now that has completely changed . . . The defendants now do not want to go to AMEs. I will put out an AME proposal, but the defendant will say, "My client has a policy that they will not use AMEs anymore."

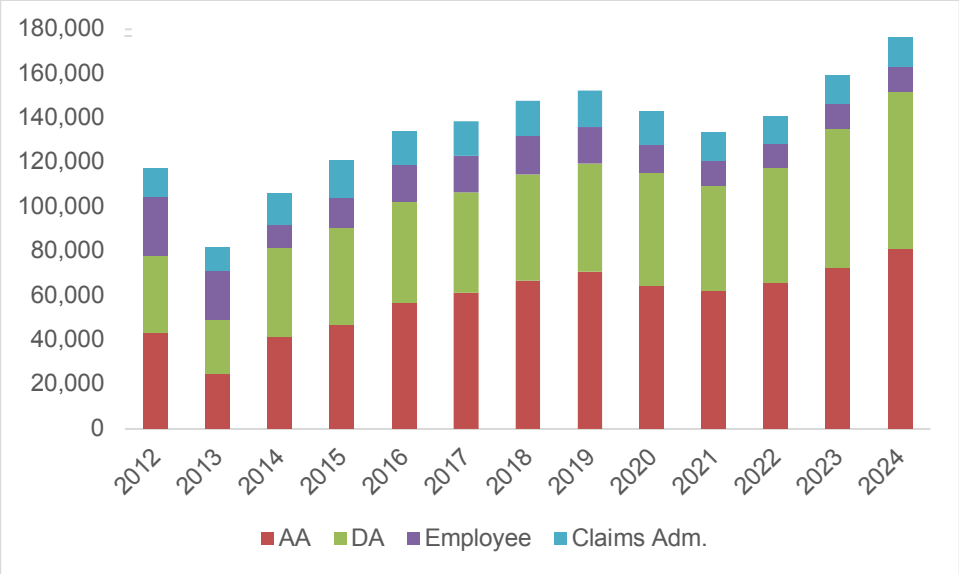
However, one defense representative offered an opposing perspective, noting a timeliness benefit of using QMEs as opposed to AMEs:

> Now we have to rely on the state panel physicians . . . the state panel doctors are mandated to get reports out within 30 days or 60 days on a supplemental basis, and that is attractive to most of our clients because under the AME system, although loosely bound by the same time frames, frequently, never got reports out, which would elongate, elongate cases and create more litigation than intended.

Quantitative Results: Analyses Exploring Changes in Litigation Practices

Figure 7.3 shows the number of panel assignments by requestor type over time. The number of panel assignments has been growing over time, led exclusively by an increase in panel assignments by AAs and DAs.

Figure 7.3. Number of Panel Requests, by Requestor Type, 2012–2024



SOURCE: RAND analysis of QME data.
NOTE: N = 1,752,554 assigned panels. Fewer than 10 requests with an invalid requestor type were dropped from the analyses. Year represents the year that the panel was assigned. Claims Adm. = Claims Administrator.

Figure 7.4 shows the yearly percentage of cases that had a QME panel assigned in more than one specialty during the year. Over 90 percent of cases had only one assigned specialty during a given year. The percentage of cases with two or more specialties during the year decreased, from approximately 11 percent in 2012 to 4 percent in 2015, and then remained steady around 4 to 5 percent from 2015 to 2024. While interviews with AAs and defense representatives suggested that requests for panels in multiple specialties may be increasing, our analysis shows that this has remained relatively stable over time.

Figure 7.4. Percentage of Cases with Panel Assignments in More Than One Specialty per Calendar Year

SOURCE: RAND analysis of QME data.
NOTE: N = 1,471,790 claim-years with at least one specialty requested during the year. Only filled requests are included. Claims are defined as a unique combination of claim number and injury date.

What Role Have MMCs Played in the Med-Legal Process?

Qualitative Results: Views of MCCs' Roles in the Med-Legal Process

We discussed the roles of MMCs in the Med-Legal process. Participants brought up their roles assisting with tasks, such as scheduling, billing, record management, navigating regulations, and mentorship.

Theme: If You Want to Have Multiple Offices, You Need to Use an MMC.

An active QME and two former QMEs noted that they felt that using an MMC was essential if you wanted to maintain multiple offices, with one active QME noting, "If I were on my own, I wouldn't have the ability to have offices all over."

Theme: MMCs Can Be Helpful Navigating Regulations.

Two MMCs highlighted their ability to help QMEs navigate complex requirements and timelines as an essential part of the system. One former QME noted of working with an MMC: "I felt you absolutely had to, just with all the rules and regulations they had . . . . And you were more or less at their mercy."

An MMC representative noted, "The California workers comp system requirements are so complicated and constantly changing. We keep the docs abreast of case law."

Theme: MMCs Can Help New Doctors Navigate the System and Provide Mentorship.

An MMC representative and three active QMEs emphasized that MMCs were particularly helpful for new doctors. As one active QME noted, "MMCs are helpful for people to learn the ropes." Another active QME noted, "I could not have been a QME without the mentorship of an MMC."

Offering a contrasting view, a different active QME noted that she was hoping that, as a newer QME, MMCs would be helpful with teaching or answering questions about the system, but they ended up mainly helping with the administrative side of being a QME as opposed to being an educational resource for writing reports.

Theme: MMCs Are Helpful with Administrative Tasks.

Of the QMEs who worked with MMCs, many endorsed their ability to help with administrative tasks, such as scheduling, billing, and finding office space. One former QME noted, "Yeah. I mean, they do a great job of providing the records, providing a summary of the records. For some things, there's a historian that kind of gathers the tedious stuff that is kind of a doctor's waste of time . . . so that's an excellent service." One AA offered a contrasting perspective, stating,

> You know, as with anything, some are better than others. I think that to the extent that they take away some of the administrative burdens from the doctors, they can be helpful. On the other hand, there are certain medical groups that I routinely see issues with records not being provided to the doctor when we have confirmation that we have sent the records to the medical management group.

Six active QMEs, one former QME, one AA, and one defense representative specifically highlighted that MMCs were helpful with scheduling and other administrative tasks. As one active QME noted, "So there's a scheduling part . . . in the sense of communicating with whether it be the applicant or the AA and then getting that onto the schedule . . . . So there's just that liaison aspect of it is so much easier."

A defense representative also agreed, highlighting that it was helpful to have administrative staff dedicated to Med-Legal scheduling, noting,

> I can say that some of the physicians who don't have management companies, you know, have to rely on their internal staff. And that creates a problem because if they're busy managing their patients during the day, they're not going to be communicating with my office or the applicant attorney's office.

However, two AAs offered contrasting perspectives, saying that MMCs had variable quality and that scheduling with some MMCs could be difficult. They noted that many QMEs had joined some of the larger MMCs saying, "I get it, but it just puts another layer between us and the doctor."

Theme: The Quality of MMCs Is Variable.

A defense representative and an active QME noted that quality of MMCs and of the QMEs they managed was variable, with one defense representative saying,

> I know some very good practice groups and . . . they're a bunch of doctors, have banded together just to pull the resources to get reports out. But you know, unfortunately . . . cases run through a number of these management companies that, you know they I think they recruit doctors . . . off of ads and things like that and . . . those doctors tend to write very, very bad reports. You know, there are good players and bad players.

Theme: MMCs Are Helpful with Compiling Aspects of the Report, but the Doctors Must Ultimately Be Responsible for Writing the Report.

A former QME noted that the MMC they worked with would help transcribe and compile their dictated notes, which was very helpful. A defense representative and an active QME noted that they had heard stories of MMCs interfering in report writing. The MMCs we spoke with emphasized that the doctor was ultimately responsible for the report, with one saying, "They should provide administrative support services. They can't be the doctor."

We also asked IWs if they were aware of an MMC's involvement in their case, and none were aware of whether the QME they saw used one.

Chapter 8. Considerations and Next Steps

In this chapter, we provide a summary of our results, limitations, and high-level recommendations, organized by high-level research question. For each high-level recommendation, we describe specific actions that could be considered to meet that goal, potential benefits and downsides of pursing those actions, and an assessment of whether the actions would require legislative, regulatory, or administrative changes.

Is There a Mismatch Between the Supply and Demand of QMEs Across Specialties and Geographic Areas?

Summary

Our quantitative results found that most panel requests resulted in panel assignments. Of assigned panels requested by IWs, the majority went on to utilize the panel, and the percentage of utilized panels has increased in recent years. This suggests that the overall supply of QMEs is meeting demand. Qualitative interview and focus group participants generally agreed with this assessment. However, both our quantitative and qualitative results suggest that there may still be an inadequate supply of QMEs in certain specialties and in rural areas. Our quantitative results support this perception. Although few panel requests are rejected each year due to insufficient number of QMEs in a specialty, panels have not been assigned for several specialties, including Oncology, Infectious Disease, and Endocrinology, since 2015. From 2012 to 2015, these three specialties, while requested much less frequently than others, still had, in total, hundreds of assigned panels each year. It is possible that attorneys know not to request these panels and opt to request general internal medicine panels or seek an AME evaluation instead. In cases where a general Internal Medicine specialty is requested, IWs still receive panel assignments but not necessarily from their preferred subspecialty.

Similarly, our quantitative results suggest a lower supply of QMEs in rural areas relative to demand. On average, rural areas have fewer QME offices per panel assignment as compared to metro areas. While IWs residing in rural areas can still reliably receive panel assignments, they are more likely to be required to travel outside their county to attend appointments. We also found that the increase in the number of QME offices that followed the 2021 fee schedule change was seen exclusively in metro areas, suggesting that the benefits of an increased supply of QMEs have not been equitably distributed.

Recommendations and Considerations

Our first high-level recommendation is to increase the number of QMEs with office locations in rural areas and in underrepresented specialties. The following several actions could be considered to meet this goal:

- **Increase recruitment efforts from underrepresented specialties and in rural areas:** DIR could increase recruitment efforts for underrepresented specialties, such as Oncology, Neurology, and Cardiovascular Disease. Similarly, DIR could target recruitment towards doctors already practicing in rural areas to become QMEs or encourage existing QMEs to open offices in rural areas. Strategies for recruitment are discussed further in the next section. This would not require any change to legislation or regulation but may require reprioritization of DIR resources. IWs requesting these underrepresented specialties face disproportionate challenges obtaining QME evaluations and tend to have complex, expansive cases, suggesting that better recruitment could be important for the system to deliver equitably to all IWs. However, the number of panel requests for these specialties are also relatively rare, so additional recruitment efforts would have to be traded off against current priorities in the absence of additional resources.
- **Include fee schedule modifiers for examinations in rural areas or for underrepresented specialties:** Increasing reimbursement could incentivize more doctors practicing in underrepresented specialties to become QMEs. This increased reimbursement could also compensate for the increased opportunity costs these doctors face (i.e., they could make more money practicing outside of the QME system) and help justify the larger ratio of fixed costs to revenue from becoming a QME (i.e., they incur the same annual costs of maintaining office locations, staying current on training, and paying administrative fees but do not receive as many panel assignments as other specialties do). Similarly, increased reimbursement could incentivize providers to maintain offices in rural areas and help offset travel costs to those locations. There is precedent for this in Texas, where the fee schedule includes a 10-percent incentive payment for evaluations in underserved areas. However, this would be more difficult to implement than the first option as it would require changes to California regulations. Drawbacks of this approach are that they would increase workers' compensation costs and could have the unintended consequence of discouraging the defense from requesting more expensive QME specialties.
- **Allow some number of offices beyond the ten-office limit for offices in rural areas:** One way to increase the number of offices in rural areas without increasing workers' compensation costs is to allow QMEs to register a set number of offices—for example, five—above the ten-office limit, provided those offices are opened in rural counties. This would be the most difficult change to implement, as it would require passing legislation. There could also be concerns that allowing more offices could spread QMEs more thinly and negatively impact quality.

In our quantitative analyses, evaluation and tracking of panel utilization using WCIS was hampered by the lack of a common unique identifier that appears in both WCIS and EAMS. DIR could also consider the following data improvement:

- **Include additional information for linkage between WCIS and EAMS:** WCIS records are linked using the JCN, which is not included in the QME data. While it is unrealistic and would increase burden for the QME process to require that IWs submit the JCN, the defense should have the JCN readily available and could be required to submit or confirm the JCN. This would make it much easier for DWC staff to link QME and WCIS data and monitor panel utilization and other issues. Similarly, physicians could be required to submit an NPI when they are registered as QMEs, which would make it easier to track Med-Legal services provided by QMEs. Currently, they are only required to submit a California Professional License Number. This would require a regulatory change.

What Is the Best Way to Recruit and Retain QMEs?

Summary

Through our qualitative interviews and focus groups, we learned about what made becoming a QME attractive and what could deter doctors from joining or staying in the QME program. In addition to California DWC's recruitment efforts, we also learned about the efforts of MMCs and of other states' efforts to recruit and retain QMEs.

According to the QMEs in our focus groups, key reasons for becoming a QME were the intellectually stimulating nature of the work, the ability to earn supplemental income, the flexibility of scheduling, and, in some cases, the ability to work remotely.

The QMEs in our focus groups also cited significant challenges associated with being QMEs that, in some cases, led to their departure from the program. The most commonly cited reason for departure was delay in payment for QME services. Other reasons cited included uncertainty around record delivery and depositions, frustrations related to prohibitions in recommending treatment, and time pressures associated with record review and report writing. Focus group participants generally did not find the certification or CME requirements to be particularly onerous.

Recommendations and Considerations

DIR can recruit and retain QMEs through active recruitment of new QMEs and by considering changes to the program that may make it more attractive to current or prospective QMEs. DIR already regularly communicates with several professional organizations and MMCs that play active roles in recruiting QMEs and place advertisements for the QME exam in specialty board websites and newsletters. These activities could be expanded. More specifically,

- Following the example of the Texas workers' compensation agency, DIR could also consider recruitment webinars and presentations at medical conferences.
- Like the Colorado workers' compensation agency, California could partner with medical schools to encourage new doctors to consider becoming a QME and a career in workers' compensation more broadly.

Our focus group participants noted the importance of social and professional networks in their decisions to become QMEs, with many learning about the program through trusted colleagues. Recruitment events could include the opportunity to speak with active QMEs about the program. The benefits of the program cited by focus groups could also be highlighted during recruitment events.

DIR could also consider changes to reduce the challenges associated with being a QME. Some of these actions are described in greater detail in subsequent sections but broadly, these include the following:

- **Allow QMEs to set a maximum number of panels per month:** While QMEs in many specialties may be able to control the number of requests they get solely by reducing their number of offices or indicating that they are unavailable for certain periods, this option could be helpful for in-demand specialists, such as orthopedic surgeons, who receive a very high number of annual panel assignments. Allowing this option may help retain QMEs and could have the added benefit of reducing the time from panel assignment to evaluation (discussed further in a subsequent section) if it leads to more panel assignments for QMEs with greater availability. This would require a regulatory change and could help to attract and retain QMEs, particularly those who want to maintain a treatment practice.
- **Address payment issues:** Given the emphasis of delays in payment from the focus groups, DIR could consider ways to ensure more timely payment for QME services. This could include greater enforcement of penalties for late payments, as authorized by 8 CCR 10111.1(a)(8) and CA Lab 4622, or revisions to the independent bill review process under 8 CCR 9794 and CA Lab 4603.6. DIR could also consider prohibitions on MMCs from collecting fees before payment is rendered to the QME, although it is unclear how common this practice is. This may also not be feasible without legislative action. We also note that some QMEs cited MMCs as being helpful in communicating with insurers on their behalf to obtain payment.
- **Address issues with record delivery and timelines:** QMEs discussed frustrations with medical record delivery, particularly with receiving records after conducting the evaluation. They also noted a desire for increased flexibility on timelines in a limited number of cases. Possible changes to these aspects of the QME system are discussed in greater detail in subsequent sections.
- **Keep telehealth as an option with reasonable guardrails:** Some QMEs expressed appreciation for telehealth flexibilities and cited these flexibilities as a reason for remaining in the QME system. However, the QMEs noted that telehealth was not appropriate in all cases and supported regulating when it could be used. The use of telehealth in QME evaluations is discussed in greater detail in a subsequent section.

How Have Recent Changes to QME Reimbursement Structure Impacted Overall Costs to the Workers' Compensation System and Should Additional Changes Be Considered?

Summary

Through interviews and focus groups, we received a wide range of feedback on the 2021 fee schedule change that restructured QME reimbursement. Several participants appreciated the simplicity of the new reimbursement structure and felt that it reduced gaming in billing. QMEs also noted reduced friction with insurers as the new fee schedule eliminated disputes related to time billed. Participants also felt that the higher average reimbursement rates were meeting the goal of attracting new QMEs. Quantitative results confirm that reimbursement for Med-Legal services increased substantially following the 2021 fee schedule change. Comparisons of total Med-Legal payments before and after the fee schedule change found a 57 percent increase in payments, far exceeding the 25 percent increase target. Most of this change came from increased record review fees. Quantitative results also revealed an increase in the number of QME offices and QMEs following the fee schedule change.

Other stakeholders perceived issues with the new reimbursement system. For example, some expressed frustration that compensation did not always reflect the time needed to complete a report. The fee for record review was intended to provide additional compensation for more complex cases. However, QMEs noted that complex cases could sometimes come with relatively small numbers of records, or, conversely, there could be simple cases with large numbers of irrelevant or duplicate records. Psychiatry and Psychology specialists in particular noted that they often received less compensation under the new fee schedule because their reports took longer to complete, and they felt that the two times multiplier for psychiatry and psychology under the new fee schedule was not sufficient to replace the time statements. QMEs also noted that the flat fee could be difficult for newer QMEs, who may need more time to write a report.

Some QMEs noted that insurers were not delivering complete sets of records to avoid paying the additional record review fee for pages beyond 200 records. However, QMEs also noted that they thought the situation had recently improved as insurers realized that they needed to pay for supplemental reports when QMEs were not able to address all the questions with the set of records they received. This is somewhat supported by the data, as we observe increases in record review fees in 2022 and 2023 beyond the initial 2021 jump. However, we note that the number of supplemental reports remained fairly consistent before and after the fee schedule change. By contrast, follow-up reports, which involve new evaluations, increased substantially following the new fee schedule change. It is not clear whether the increase in follow-up reports was directly related to the fee schedule change. It is possible that, with the influx of new, less experienced QMEs, more follow-up reports were needed to address questions not addressed in the initial reports.

QMEs also voiced concerns that, while there was an immediate jump in reimbursement following the new fee schedule, the reimbursement structure may not be sustainable without an adjustment for increased costs of living. In the two years of claims data we analyzed following the fee schedule change, total Med-Legal payments continued to increase after the initial fee schedule jump, even slightly outpacing increased payments in the rest of the California workers' compensation system. However, these increases were likely due to increases in follow-up reports and record review fees, which may not hold in future years. We also found that the increase in costs per Med-Legal report initially increased by a much greater percentage than did the MEI, but that in later years, the MEI increased more than did the average cost per Med-Legal report.

Recommendations and Considerations

Participants noted both benefits and drawbacks to both the old and new reimbursement structures for Med-Legal services. At this time, we do not see compelling justification to go back to the old QME reimbursement structure. Given the limited follow-up period we could study with complete data after the fee schedule changes, more time may be needed to understand where payment levels settle after the change. However, we suggest that DIR may want to consider the following monitoring and evaluation actions in the future:

- **Continue to monitor Med-Legal costs relative to the MEI and consider including a COLA in the fee schedule:** A COLA to account for inflation and other increased living costs was the most frequently requested change to the fee schedule made by participants. Texas workers' compensation recently implemented a similar change to their fee schedule, annually adjusting Designated Doctor rates according to the MEI. This could serve as a model for California. As this would involve a change to the fee schedule, if implemented, it would require a regulatory change.
- **Evaluate and reconsider modifiers for psychiatric and psychological evaluations:** Given the commonly cited concerns about Med-Legal payments for these types of evaluations, DIR could consider more specific analyses of the time needed to write these types of reports and associated Med-Legal payments over time. Depending on the results of these analyses, DIR could consider increasing the value of the psychiatric and psychological evaluation modifiers. If implemented, this would require a regulatory change.
- **Monitor rates of supplemental and follow-up reports:** The large increase in follow-up reports following the fee schedule change was notable and contributed to increased Med-Legal costs. It may be that, as the new influx of QMEs gain experience and the quality of their reports improve, the number of follow-up reports will return to pre-2021 levels. If rates of follow-up reports remain high, it may be important to investigate the reasons for increased follow-up reports and potentially consider changes to reimbursement structures when follow-up reports are a result of inadequate report quality. We did not see large increases in supplemental reports following the fee schedule change, but these could also be monitored given the concerns from some QMEs about receiving incomplete records.

What Have Been the Impacts of Structural Changes to QME Selection and Should Additional Changes Be Considered?

Summary

Interview and focus group participants noted a wide range of perspectives on the process of requesting specialties for QME panels. Some attorneys noted that the "race" to select a QME specialty could be frustrating and often involved gamesmanship, with attorneys choosing specialties that they felt would be likely to provide reports more favorable to their cases rather than selecting the specialty most relevant to the questions in the case. IWs noted that the specialty selection process could be opaque, and they did not always understand why they were being evaluated by a particular specialist. A few participants noted that it would be preferable to select QMEs by matching QME qualifications with the specific medical knowledge needed for the case rather than have the applicant or defense select the specialty. Some participants suggested that an outside party with more generalized medical knowledge could play a role in selecting the specialty or perform evaluations with input from specialists as needed. Participants provided few specifics on how this would work in practice, but Colorado and Texas provide possible examples on how QME assignments could be made based on scope of practice rather than by selecting a specific specialty. These assignments could be made either through policies requiring different licenses in order to evaluate specific types of injuries and randomly assigning an evaluator with the relevant license, as in Texas, or by allowing doctors to provide a self-assessment of their scope of practice and making assignments based on that self-assessment.

Participants also discussed the possibility of using different panel structures. Participants did not specifically note a preference for an increased or decreased number of doctors on the panel, but some participants noted the importance of being able to strike QMEs that they viewed as being "applicant QMEs" or "defense QMEs," meaning that they anticipated the QME would write a report that was more favorable to one party, which they could not do with a smaller panel size. However, they also noted the difficulty of fielding a panel for rarer specialties and in rural areas, a problem that could be exacerbated by increased panel size.

Participants did not suggest any other structural changes to the QME panel system, such as having separate panels for different types of Med-Legal questions (e.g., whether the injury is work-related and making determinations as to temporary or permanent disability). Some participants noted that the time involved with requesting multiple QME panels and evaluations could significantly add to the overall time for the case.

Recommendations and Considerations

In our discussions, participants acknowledged that the current system was complex, but they felt that it was generally fairer than the prior system of dueling QMEs. We did not find evidence to recommend changes to the number of QMEs on a panel or to have separate panels for

different types of Med-Legal evaluations. One action that DIR could consider is to make QME assignments based on scope of practice rather than selecting a specific specialty. Benefits of moving to such a system include reduced gamesmanship via specialty selection and potentially expanding the pool of QMEs who could serve on a certain panel, which might increase efficiency and lead to a more even distribution of panels to cases. The change could also be beneficial for QMEs in certain specialties, such as emergency or family medicine, that may have relevant knowledge but are rarely selected for QME panels. This system also has potential downsides. Setting overly broad scope of practice categories may not allow for nuance when having a QME from a specific specialty is important for a specific case. Setting narrower scope of practice categories may not be practical. Allowing QMEs to select their own scope of practice, like in Colorado, may provide more nuance but could also be subject to gaming. QMEs could be incentivized to indicate a broad scope of practice in order to be included on more panels, even if they do not possess the necessary qualifications. This could be harder to monitor in a state as large as California. This would require a change to legislation. Two additional specific actions that could be considered are as follows:

- **Clarify which subspecialties do not have sufficient numbers of QMEs on request forms and provide alternatives:** We note that five subspecialties—Endocrinology Diabetes & Metabolism, Hematology, Infectious Disease, Nephrology, and Medical Oncology—have not been assigned panels since 2015 due to insufficient numbers of QMEs, but there is no indication of this on panel request forms, which could be frustrating for requestors who may not realize that their request will be rejected. DIR could consider including a note on the QME request forms or in FAQs stating which specialties are unlikely to have sufficient numbers and suggest alternatives (e.g., requesting a general Internal Medicine specialty). This would require a change to regulations if the request form changed and a change to online resources if FAQs were changed.
- **Consider allowing QMEs struck from panels to be included in replacement panels, with the parties' approval:** Our analyses find that thousands of QMEs each year are ineligible for replacement panels because they were struck by an AA or DA in a prior panel. This reduces the number of QMEs available and could potentially slow down the process or necessitate additional travel for IWs to QME appointments if the geographic area must be expanded to fill a panel. With the agreement of both parties, struck QMEs could be returned to the pool and randomly selected for replacement panels. This would require a regulatory change.

How Can Medical Record Delivery to QMEs Be Improved?

Summary

In our discussions with participants, one of the most commonly cited issues with medical record delivery was that QMEs frequently did not receive medical records in a reasonable amount of time before the evaluation. They noted that, without the records, they were unsure

where to focus their evaluations and unable to ask patients appropriate follow-up questions about their medical history. However, participants did note that requiring medical record delivery prior to the evaluation could further delay reports.

Participants acknowledged the complexity of determining which medical records were relevant to a case and should be reviewed by the QME. Some participants noted that it may be appropriate to exclude some medical records that were clearly not relevant to the case, while others argued that all medical records should be delivered, as only the QME could determine what was relevant. Participants agreed that duplicate records could be removed, which could reduce record review costs and save QMEs time. Several participants mentioned the potential of AI to remove duplicate records, although experiences from Colorado caution that this could be more complex than anticipated. Others noted that administrative assistants or MMCs could play a role in removing duplicates and putting records in chronological order.

We discussed several topics related to efficient record delivery with participants. Participants broadly appreciated electronic medical record delivery but had mixed views on whether electronic delivery should be required. Multiple participants emphasized that the timing of record delivery was much more important than the manner of delivery. Participants also discussed the possibility of a central, electronic record repository. Views on such a repository varied widely. Some participants enthusiastically supported the idea, particularly if it could allow all relevant parties to access the same records at the same time and track when the records were uploaded. Other participants were strongly opposed to the idea of a central repository, citing logistical and privacy concerns.

Recommendations and Considerations

The following three actions emerged as actions to consider for improving record delivery:

- **Require that medical records be available prior to the evaluation:** QMEs felt strongly that they needed to receive medical records prior to the evaluation in order to conduct a thorough evaluation and write a high-quality report. While some participants expressed concern that this would delay cases further, records are already required to be delivered within ten days following the evaluation, so the amount of time that late record review could delay the case is limited in comparison to other aspects of the timeline, such as scheduling appointments and writing reports. It is also possible that this requirement could save time overall if it reduces the need for follow-up or supplemental reports. This action would require a regulatory change.
- **Collect data on medical record delivery and completeness:** For this study, we were not able to analyze data on when medical records were received by the QME and whether the QME assessed the medical records as complete. Collecting these data or compiling them in a central location could allow for monitoring of record delivery times by insurer, attorney, or MMC. Simply collecting and centralizing these data could be enough to encourage more timely record delivery, and analysis of the data could inform future policy decisions.

- **Explore ways to improve record delivery:** Views among participants varied considerably on such topics as determining the relevance of records, mandating electronic record delivery, and using a central electronic repository for records. There was enthusiasm to explore tools to remove duplicates, organize records, and better track record delivery. However, logistical concerns expressed by participants suggest that more work is needed before these options could be implemented in California. Colorado has recently started to take a central role in medical record delivery, and it may be helpful to communicate with them in the future to learn from their early implementation experiences. Depending on the specific actions taken, administrative and/or regulatory changes may be needed.

How Has the Quality of Med-Legal Reports Changed Since 2012 and What Is the Best Way to Ensure the Quality of QME Reports?

Summary

In our focus groups with QMEs, participants expressed the desire for more mentorship opportunities. Some QMEs noted that they received helpful mentorship through their MMC. They noted the desire to receive mentorship on Med-Legal topics but also on such aspects as navigating DIR processes and dealing with insurance companies.

DAs, AAs, MMCs, and QMEs all noted the importance of practical experience in training. While they noted that the required training had some practical elements, such as practicing report writing, they would have liked to see more of this in the training. Of note, recent regulatory changes now require additional practical experience writing and reviewing reports. At the time of the focus groups, some participants were aware of these new changes but had not yet experienced them as part of their reappointment or continuing education.

DAs, AAs, and QMEs all noted that they would like to see more opportunities for QMEs to receive feedback on their reports. DIR is starting to take a more formal role in providing feedback on QME reports. In 2024, they required QMEs applying for reappointment to submit their two most recent reports for review. At the time of the focus groups, no QMEs we spoke with had received feedback through this process. QMEs who were aware of the change were optimistic that this could be a good avenue for receiving feedback, but at the time of writing this report, it is too early to assess the impacts of this change.

While the data available for this study did not allow for a direct analysis of report quality, we noted substantial increases in the number of follow-up reports and depositions from 2020 to 2021. A follow-up report or deposition generally means that the QME report did not address all of the Med-Legal questions in a case. This could sometimes, but not always, arise from an issue with report quality. However, we caution that some of the increases in the number of follow-up reports could have been due to the extended time period over which a report can be considered a follow-up report. It is possible that, with the increase in new, less experienced QMEs in 2021,

issues with report quality also rose. This mirrors some of the feedback we received from AAs and DAs.

Recommendations and Considerations

- **Provide more formal and informal mentorship opportunities:** DIR could consider implementing a voluntary program where new QMEs are paired with more experienced QMEs in the same specialty to provide advice. This would not require regulatory or legislative changes but may require additional internal resources.
- **Evaluate the impacts of Tit. 8 §55.1 on report quality and consider further emphasis of practical experience in training courses:** DIR could assess how report quality for QMEs changed before and after courses and get feedback from QMEs who take the courses on potential improvements. This would not require regulatory or legislative changes but could be more resource intensive to administer.
- **Consider providing more early and targeted formal feedback:** Participants emphasized the importance of getting feedback early on in their QME career, so they may appreciate getting feedback earlier than at their first reappointment, which could be more than two years after first becoming a QME. Colorado's approach of providing feedback on DIMEs first reports could be considered. California DIR also plans to ask committees to review and comment on the quality of a selection of Med-Legal reports that come randomly from the EAMS and from investigation files of the QME Discipline Unit. Instead of or in addition to these reviews, California could consider using objective criteria to flag evaluators for additional feedback, using a system similar to Texas. However, DIR should consider that this may receive pushback from QMEs if they feel that they are being unfairly targeted.

Are the Time Frames Built into the QME Process Appropriate and Being Met?

Summary

Interview and focus group participants generally felt that the time periods for requesting and assigning QME panels were appropriate but noted that they felt timelines were not always well enforced.

Our quantitative analyses found that, prior to 2016, time to initial panel assignment could add considerable time to the Med-Legal process, with more than half of initial panel assignments taking more than 30 days. However, with the advent of maximum time to panel assignment requirements and the requirement for initial, represented panel requests to use the online form, the amount of time to panel assignment was drastically reduced from 2016 onward. In 2024, all initial, online panel assignments were made instantaneously (registering as assigned within one day of receipt in our analysis) and 99 percent of filled initial panel requests were assigned within 30 days of requests. Time to panel assignment for subsequent panel requests, which still require a mail-in form, decreased much more modestly from 2012 to 2024.

Our quantitative analyses also found that the time from filing a report of injury with the claims administrator to the first panel request decreased substantially over time. The time from the date of panel assignment to the date of the QME evaluation also decreased modestly from 2016 to 2023. We did not see increased time to evaluation from 2022 to 2023 with the 2023 change in scheduling requirements time frame, although our follow-up time frame was limited. Even with the modest decrease in time to evaluation, this time remains high, with the average time in 2023 exceeding both the 90-day and 120-day time frames.

Recommendations and Considerations

Several of the individual time frames associated with the Med-Legal process, such as time to panel assignment, have improved since 2012. However, many participants still expressed frustration with the overall time it takes to resolve cases. QMEs also felt that, in some circumstances, it was difficult to complete reports on time. To address these challenges, DIR could consider the following actions:

- **Give unrepresented IWs the option of requesting a panel online:** The mail-in option should remain, but for some IWs, an online form would be faster and easier. This would require a regulatory change.
- **Add additional time for report writing for cases with large numbers of medical records:** In general, QMEs felt that the amount of time to write reviews was appropriate. However, some participants noted that allowing more time when the records in a case were extensive or arrived late would be helpful. It is possible that this would not be necessary if other previously described actions, such as requiring record delivery prior to the appointment, improving record delivery, or allowing QMEs to set the maximum number of panel assignments they receive in a month, were implemented. Modifying the timeline for report writing would require a change to legislation.

Are Remote Telehealth/Remote Health Evaluations Being Used Appropriately and Should Any Changes Regulating Their Use Be Considered?

Summary

During the COVID-19 public health emergency, regulations allowed for increased use of telehealth for QME evaluations. We discussed the use of telehealth for QME evaluations in interviews and focus groups. Participants generally felt that telehealth evaluations were appropriate in some circumstances, particularly for psychiatric and psychological evaluations. QMEs appreciated having the flexibility to conduct telehealth evaluations, when appropriate. AAs and DAs also felt that telehealth evaluations could be appropriate in limited circumstances and as long as both parties agreed.

In our quantitative analyses, we examined the reasons for replacement panels. Telehealth disagreements made up a very small percentage, around 1.2 percent, of reasons for replacement panels between 2012 and 2022, but rose to 1.8 percent in 2023 and 2.4 percent in 2024. While disputes over the appropriate use of telehealth remain low, they do appear to be increasing following the end of the COVID-19 public health emergency.

Recommendations and Considerations

We do not recommend any policy changes related to telehealth at this time. However, DIR could consider the following actions:

- **Compare report quality for telehealth and in-person evaluations:** When DIR conducts their quarterly reviews of QME reports to assess quality, they could randomly select a sample of reports for IWs with similar injury types based on evaluations conducted via telehealth or in person. If they find significant differences in report quality, they could consider placing additional restrictions on the use of telehealth evaluations.
- **Monitor the number of panel replacements due to disputes over telehealth:** Our qualitative and quantitative analyses indicate that disputes over telehealth evaluations are not widespread. However, the uptick in the percentage of telehealth cases that cite telehealth disagreements as a reason for replacement in 2023 and 2024 indicate that further monitoring is warranted. If disagreements over telehealth evaluations continue to increase, DIR could consider changes to the system, such as allowing the parties to request ahead of time that only QMEs willing to evaluate in-person be considered for panel assignment.

How Have Litigation Practices in the Med-Legal System Changed Since 2012?

Summary

AAs, DAs, and QMEs all shared their perspectives on how litigation practices have changed since 2012. Broadly, participants felt that the Med-Legal process was becoming more litigious, with conflicts over QME specialty selection, use of multiple QME panels in different specialties, decreased use of AMEs, and disputes over record inclusion all contributing to the increased litigation.

In our quantitative analyses, we saw an overall increase in panel assignments, driven by represented cases, about equally from AAs and DAs from 2012 to 2024. The number of panel assignments requested by unrepresented IWs slightly decreased over the same time period. We found that the percentage of cases with multiple panel requests in different specialties remained consistent in recent years, contrasting with the perspectives of attorneys that panel requests for multiple specialties were increasing.

Recommendations and Considerations

We do not have recommendations regarding changes to litigation practices. However, we note that attorneys suggested such actions as encouraging use of AMEs, making requesting panels in multiple specialties easier by allowing multiple specialty requests at the same time, and making requesting multiple specialties more difficult. These changes could be explored further.

What Role Have MMCs Played in the Med-Legal Process?

Summary

We discussed the role of MMCs in the Med-Legal system during interviews and focus groups. Interview and focus group participants generally appreciated the assistance MMCs provided in terms of scheduling and providing office space, noting that these services were essential for QMEs who wanted to have ten offices. Participants noted that some MMCs provided additional services, such as record management, report review, assistance with keeping abreast of policy changes, recruitment, and mentorship. Several participants commented on the variable quality of QMEs.

Recommendations and Considerations

MMCs can be a valuable resource to the Med-Legal system, performing key administrative functions that allow QMEs to maintain multiple offices. This, in turn, allows IWs to receive QME evaluations closer to their home. Some MMCs also provide mentorship and report review, which, if done well, could contribute to improved quality of reports. MMCs also may help recruit new QMEs. However, participants felt that the quality of MMCs varied, suggesting that additional research could be warranted. DIR could consider the following actions:

- **Collect data on role of MMCs in the Med-Legal system:** DIR could consider conducting surveys of QMEs that include questions about their use of MMCs. Colorado recently conducted a similar survey of DIMEs, including questions about their use of MMCs, what percentage of fees the MMCs took, and what services the MMCs provided DIMEs. Alternatively, DIR could ask QMEs whether they work with an MMC as a question during the appointment or reappointment process. Administering a voluntary survey would likely not require any changes to legislation or regulations but would require DIR resources and could have a low response rate. Adding a question about use of MMCs to the appointment and reappointment forms would likely have a higher response rate but would require a regulatory change.
- **Evaluate difference in quality of reports between QMEs who likely do and do not use MMCs:** While we are not aware of a way to directly identify which QMEs work with MMCs in DIR's existing QME database, we found in our focus group that QMEs with exactly ten offices all worked with MMCs, while QMEs with only a couple of offices did not work with MMCs, indicating that number of offices may be a good predictor of whether a QME works with an MMC. When DIR conducts its random assessment of

QME reports for quality, they could consider purposively sampling QMEs with one to three offices and QMEs with exactly ten offices and compare report quality. This would not require legislative or regulatory changes.

Conclusion

We evaluated California's Med-Legal process through qualitative interviews and focus groups with key participants. We also conducted quantitative analyses of DIR's QME, WCIS, and EAMS data. Overall, we found that the system was serving its purpose to match IWs with QMEs to address Med-Legal questions and resolve cases. We also noted improvements to some time frames within the Med-Legal process, such as time to panel request and time to panel assignment. We also found that, following the 2021 fee schedule change, there was a substantial increase in the number of QME offices and unique QMEs. However, the supply of QMEs may still not be sufficient in certain specialties and in rural areas.

We also note some concerns about the long-term sustainability of the system and report quality. While payments to QMEs increased substantially following the 2021 fee schedule change, it is possible that these payments will not keep pace with inflation and QMEs could leave the system. Furthermore, QMEs cite concerns with record delivery, delays in payment, and time pressures as reasons that newly recruited QMEs could leave the system. Other participants cite concerns with the quality of QME reports, particularly from new QMEs.

To address these concerns about sustainability and quality, we provide several high-level recommendations along with specific actions for consideration. Some of these actions would require legislative or regulatory changes. Others would likely only require administrative or process changes but may still require additional internal resources.

Appendix A. Other State Results

Arizona

- **Evaluator Selection Process:** The employee may select their treating physician unless the employer is self-insured, in which case the employer may select the treating physician (Arizona Administrative Code, Section R20-5-113, 2025). The treating physician and the Industrial Commission of Arizona (ICA) make determinations about compensability and disability. The ICA or the employer may request an IME at a time and place reasonably convenient for the employee if they disagree with the decision of the treating doctor (Arizona Revised Statutes, Section 23-1026, 2021; Arizona Revised Statutes, Section 23-908, 2022). If the employee believes the IMEs are overly burdensome, repetitive, or unnecessary, they can request a protective order from the ICA. If granted, they do not need to attend evaluations (*Tyree v. Industrial Commission of Arizona,*, 1988).
- **Evaluator Compensation:** The party requesting the evaluation (usually the employer) must pay for the evaluation and the employer must pay all related expenses. The fees for the evaluation are not set by the ICA but are set by the provider (Industrial Commission of Arizona, 2025a; Industrial Commission of Arizona, 2024; Industrial Commission of Arizona, 2025b)
- **Required Qualifications:** There are no specific qualifications outside of licensure.
- **Evaluator Quality Assurance and Discipline:** None specified.
- **Other notable features:** A medical examination may be conducted via telehealth if agreed upon by the applicant and defense (Arizona Revised Statutes, Section 23-1026, 20212025b).

Colorado

- **Evaluator Selection Process:** If there are disputes as to the impairment rating by the treating physician or whether an IW has reached MMI, the applicant or defense may request an IME (Colorado Code, Title 8, Section 8-42-107, 2022). The requesting party shall propose one or more IME candidates (Colorado Code, Title 8, Section 8-42-107, 2022). The parties then have 30 days to negotiate over a selection of the IME (Colorado Code, Title 8, Section 8-42-107, 2022). If the parties are unable to come to an agreement or the other party did not respond to the proposal, the Colorado Workers' Compensation Division will select a panel of three physicians, called DIMEs, from a list maintained by the division (Colorado Code, Title 8, Section 8-42-107.2, 2022). The selection of the panel is based on such factors as the DIME's specialty and when the DIME was last selected for a panel (Colorado Code, Title 8, Section 8-42-107.2, 2022). The requesting party has the first opportunity to strike a DIME, followed by the opposing party, and the remaining physician will conduct the examination (Colorado Code, Title 8, Section 8-42-107.2, 2022). If a party does not strike a physician, the division will select the physician from those remaining on the list. Both parties must have an opportunity to review a

summary statement of business, financial, employment, and advisory relationships before making a decision to strike (Colorado Code, Title 8, Section 8-42-107.2, 2022).

- **Required Qualifications:** All IMEs must "be licensed by the Board of Dental Examiners, the Board of Chiropractic Examiners, the Colorado Podiatry Board, the Board of Medical Examiners, and board certified (or board eligible) by the American Board of Medical Specialties or the American Osteopathic Association or the National Board of Physicians and Surgeons," have an active unrestricted license, and at least 384 hours of direct patient care (Code of Colorado Regulations, Section 7 CCR 1101-3, 2025). The Colorado DWC has a two-level accreditation system (Colorado Code, Section 8-42-10). The first level is required for chiropractors and optional for other physicians to make determinations of MMI, and the second level is required of all IMEs to make impairment ratings (Colorado Code, Section 8-42-10). If a physician has at least 384 hours of direct patient care (including medical/legal evaluations) in the previous 10 years but not 384 hours (excluding medical/legal evaluations) in the past calendar year, the physician must additionally be certified by the American Board of Independent Medical Examiners, the International Academy of Independent Medical Evaluators, or equivalent CME courses to make impairment ratings (CO 7 CCR 1101-3, Rule 11-1). Additionally, DIMEs seeking appointment to the DIME panel must be Level II accredited, apply to the division, and be accepted to the panel (CO 7 CCR 1101-3, Rule 11-2).

  Additionally, DIMEs seeking appointment to the DIME panel must be Level II accredited, apply to the division, and be accepted to the panel (Code of Colorado Regulations, Section 7 CCR 1101-3, 2025Colorado Department of Labor and Employment, undated).

- **Evaluator Compensation:** The requesting party must pay the base fee for the IME and must do so at least ten days prior to the exam (Colorado Code, Title 8, Section 8-42-107.2, 2022). However, the IW does not need to pay the cost of the IME if it is established that they are indigent (Colorado Code, Title 8, Section 8-42-107.2, 2022). IMEs are compensated according to a fee schedule determined by the Colorado DWC. The requesting party pays the DIME a $1,000 base fee. The insurer or employer pays the remaining DIME fee based on the time taken to examine the patient (Code of Colorado Regulations, Section 7 CCR 1101-3, 2025). Additional fees are assessed for cancelled appointments and for testifying (Code of Colorado Regulations, Section 7 CCR 1101-3, 2025).
- **Evaluator Quality Assurance and Discipline:** A DIME can be suspended for misrepresentations on their DIME application or for not complying with provisions from the Workers Compensation Act or Division rules (Colorado Code, Title 8, Section 8-42-107.2, 2022).
- **Other notable features:** Medical records must be delivered electronically to the IME at least 14 days prior to the IME (Colorado Code, Title 8, Section 8-42-107.2, 2022). The insurer is responsible for paying for an interpreter, if needed (Code of Colorado Regulations, Section 7 CCR 1101-3, 2025).

Florida

- **Evaluator Selection Process:** If there are disputes about care utilization, medical benefits, compensability, or disability, the applicant or defense may select an IME. The employer and employee can each only request one initial IME per accident, not per specialty. However, an alternate examiner can be called if certain conditions are met—for example, if the examiner cannot comment on an issue outside of their specialty or both parties agree on an alternate examiner. If there is further disagreement, the parties can agree on an Expert Medical Advisor (EMA), or a judge can select one from the relevant specialty (Florida Legislature, Section 440.13, 2025). The Florida DWC or Judge of Compensation Claims is responsible for arranging the EMA services (Florida Administrative Code, Rule 69L-30.005, 2016).
- **Required Qualifications:** The IME may only provide opinions within their area of expertise "as demonstrated by licensure and applicable practice parameters" (Florida Legislature, Section 440.13, 2025). EMAs have additional qualification requirements. They must apply to Florida DWC, pass a test, have worked previously as an IME, submit two recent IME reports for approval (Florida Administrative Code, Rule 69L-30.005, 2017), and complete specific continuing education requirements. EMAs must be recertified every two years.
- **Evaluator Compensation:** The party requesting the IME must pay for it. However, if the IME finds in favor of the applicant, the costs of the IME must be paid by the defendant. If the IW does not come for an evaluation, they must pay 50 percent of the evaluation fee (Florida Legislature, Section 440.13, 2025). IME services are paid according to an agreed upon contract price, not set by DWC (Florida Administrative Code, Rule 69L-7.020, 2025). EMAs are paid based on time spent conducting the evaluation, reviewing records, and writing the report, with a maximum of $300/hour. Fees for EMA deposition testimony are limited to $200/hour, although there is a 2025 proposed amendment to this rule to increase that to $300/hour, pursuant to SB 362(2024) (revising Fl St 440.13(10)) (Florida Administrative Code, Rule 69L-30.008, 2016)
- **Evaluator Quality Assurance and Discipline:** Overbilling, failing to report conflicts of interest, and standard of care violations may result in decertification (Florida Administrative Code, 2017).
- **Other notable features:** None noted.

Georgia

- **Evaluator Selection Process:** The employer may request an IME designated and paid for by the employer. The employee also has a right to a one-time IME within 120 days of receipt of income benefits, selected by the employee and paid by the employer (sometimes referred to as a second-opinion IME) (Georgia Code, Section 34-9-202, 2007; Georgia Code, Section 9-11-35, 2024). The examination must be in Georgia or within 50 miles of the IW's residence. The members of the Georgia State Board of Workers' Compensation may also appoint a "disinterested and duly qualified physician" to examine the patient and to report or testify (Georgia Code, Section 34-9-101, 2021).
- **Required Qualifications:** No specific qualifications outside of being a licensed physician or surgeon (Georgia Code, Section 34-9-202, 2007; Georgia Code, Section 34-

9-201, 2025). Case law has established circumstances that would prevent a conflict of interest (*Wiley v. Bituminous Casualty Co.*, 1948).

- **Evaluator Compensation:** The employer must pay for the examination as well as travel expenses, regardless of who requested it (Georgia Code, Section 34-9-202, 2007). Fees are paid according to the Georgia's workers compensation fee schedule based on an hourly rate (Georgia Code, Section 34-9-202, 2024).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** The employee may pay for their own physician or surgeon to come to an employer requested exam (Georgia Code, Section 34-9-202, 2007). This is in addition to the employee's one-time right to their own selected IME.

Hawaii

- **Evaluator Selection Process:** The employer or employee may request an IME (Hawaii Revised Statute, Section 386-79, 2024). The employer may not request more than one evaluation per case without good reason (Hawaii Revised Statute, Section 386-79, 2017). The director of labor and relations may also appoint a "duly qualified impartial physician" to examine the injured employee, paid for the Department of Labor and Industrial Relations (Hawaii Revised Statute, Section 386-80, 2024). The Director of the Hawaii Department of Labor and Industrial Relations may determine that an advisory panel is needed to respond to complaints about a health care provider (Hawaii Administrative Rules § 12-15-20).
- **Required Qualifications:** There are no requirements other than being licensed or certified to practice in Hawaii (Hawaii Administrative Rules, Section 12-15-12, 2024).
- **Evaluator Compensation:** The party requesting the IME must pay for the evaluation. IME fees are billed as complex consultation charges according to Hawaii's workers' compensation supplemental medical fee schedule, unless the IME resides outside the state (Hawaii Revised Statute, Section 431:10C-308.5, 2024).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** The employee may record the IME evaluation (Hawaii Revised Statute, Section 386-79, 2017).

Illinois

- **Evaluator Selection Process:** An employer may request an IME by a medical practitioner or surgeon selected by the employer to determine the nature, extent, and probable duration of the injury. The employee may bring a medical practitioner or surgeon to the exam (Illinois Statute, Section 820 ILCS 305/12, 2024).
- **Required Qualifications:** Must be "medical practitioner or surgeon" (Illinois Statute, Section 820 ILCS 305/12, 2024).
- **Evaluator Compensation:** The employer is responsible for paying for the IME and reasonable travel expenses. If the employee wishes to have another provider present during the examination, it is at the employee's expense (Illinois Statute, Section 820 ILCS 305/12, 2024). IMEs are not covered in the Illinois fee schedule, and payment rates

are determined by agreement between the provider and the payer (Illinois Workers' Compensation Commission, undated).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** IME reports must be delivered in person or by registered mail.

Maryland

- **Evaluator Selection Process:** The Maryland Workers' Compensation Commission or either party may request a medical examination (Maryland Administrative Code, Section 14.09.03.08, 2025).
- **Required Qualifications:** Must be a "physician, psychologist, or psychiatrist" (Maryland Administrative Code, Section 14.09.03.08, 2025).
- **Evaluator Compensation:** The party requesting the medical examination must pay for it, unless the employee fails to appear, in which case the requestor may be able to recoup some of the costs (Maryland Administrative Code, Section 14.09.03.08, 2025). Evaluator compensation is set by the Maryland Workers' Compensation fee schedule based on time spent including for record review (Maryland Workers' Compensation Commission, 2024).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** None noted.

Michigan

- **Evaluator Selection Process:** An employer may request an IME to determine the nature, extent, and probable duration of the injury. The employee may bring a medical practitioner or surgeon to the exam (Michigan Compiled Laws, Section 418.385, 2022).
- **Required Qualifications:** A practitioner other than the treating practitioner (Michigan Administrative Code, Section R. 418.10101, 2025).
- **Evaluator Compensation:** The employer is responsible for paying for the IME. If the employee wishes to have another provider present during the examination, it is at the employee's expense (Michigan Compiled Laws, Section 418.385, 2022). Compensation for IMEs is not determined by the Michigan Workers' Compensation Agency and is determined by agreement between the provider and the payer (Michigan Administrative Code, Section R. 418.10101, 2025).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** None noted.

Nevada

- **Evaluator Selection Process:** A panel of Rating Physicians and Chiropractors is maintained by the Nevada DIR workers' compensation division. Rating Physicians and Chiropractors serve a more limited role than do QMEs: They may determine whether employees have a ratable condition and make permanent partial disability ratings (Nevada Administrative Code, Section 616C.021, 2024). The Rating Physician or Chiropractor is selected at random from the panel unless the employer and employee can

agree to the use of a specific Rating Physician (Nevada Revised Statutes, Section 616C.360, 2022). An employer can also request an IME to resolve other types of disputes, such as determining whether injuries are work-related or determining whether the worker can return to work (Nevada Administrative Code, Section 616C.1162, 2024; Nevada Revised Statutes, Section 616C.140, 2024). An employee can also request an IME (no more than one a year) by a Rating Physician or Chiropractor if they dispute the initial rating. This IME also is selected at random from the panel (Nevada Revised Statutes, Section 616C.145, 2024).

- **Required Qualifications:** Rating Physicians must be in good standing with the relevant state regulatory bodies (Nevada Administrative Code, Section 616C.003, 2024), have at least three years of experience practicing in industrial health as a physician or a chiropractic physician, take an approved course on evaluation of permanent impairment, pass a Nevada rating test administered by the American Board of Independent Medical Examiners, submit an application, and demonstrate understanding of Nevada statutes and regulations on ratings (Nevada Administrative Code, Section 616C.021, 2022). The Nevada DIR Administrator may exempt ophthalmologists and psychiatrists who are licensed to practice within their specialty in Nevada from the qualifications, but this exemption will end in July 2026.
- **Evaluator Compensation:** The insurer must cover the cost of the evaluation unless the employee requested a second examination and this examination does not result in a higher disability rating than previously given, in which case they can recover costs from employees (Nevada Revised Statutes, Section 616C.145, 2024). This includes charges if the employee fails to attend appointment. The maximum compensation rates for IMEs are set by an established fee schedule that is annually adjusted depending on changes in the Consumer Price Index, Medical Care Component (Nevada Revised Statutes, Section 616C.260, 2025).
- **Evaluator Quality Assurance and Discipline:** The Nevada DIR Administrator may issue a warning, suspension, or dismissal of Rating Physicians for refusing to serve as a panel member, refusing to attend panel meetings, or making an excessive number of errors in rating evaluations as determined by the Administrator (Nevada Administrative Code, Section 616C.024, 2022).
- **Other notable features:** None noted.

New Jersey

- **Evaluator Selection Process:** The employer can select the treating physician. The employer may also request an IME at any reasonable time, place, and frequency (New Jersey Workers' Compensation Law, Section 34:15-64, 2024; New Jersey Workers' Compensation Law, Section 34:15-19, 2024).
- **Required Qualifications:** No special qualifications are required.
- **Evaluator Compensation:** While not explicitly stated, customarily the employer is required to pay for IMEs requested. The judge may also order the employer to pay all or part of an expert hired by the worker for an opinion regarding the need for medical treatment or for an estimation of permanent disability, up to a cap of $1,000 (New Jersey Workers' Compensation Law, Section 34:15-64, 2024). The employer is not expressly

required to pay for travel to the examination (New Jersey Workers' Compensation Law, Section 34:15-19, 2024).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** The employee may have their personal physician present at an IME. The employee may request a physician of the same sex (New Jersey Workers' Compensation Law, Section 34:15-69, 2024).

New Mexico

- **Evaluator Selection Process:** The employer has first choice of treating physician unless they defer to the employee. The selected provider is authorized for 60 days after which point the party that did not choose the doctor may select another doctor (New Mexico Statutes, Chapter 52, Section 52-1-49, 2024). If a party exercises this right, the other party may subject the worker to periodic examination by the previous provider (New Mexico Statute, Chapter 52, Section 52-1-51, 2024). All selections of a treating physician are subject to objections by the opposing party on the grounds that the care being offered by the physician is unreasonable. If the parties cannot agree on an independent examiner, either party may petition the judge to appoint an IME. While neither New Mexico statute nor regulation addresses the quantity of IMEs in a case, New Mexico's Workers Compensation Administration's 2019 Worker Guidebook states that "IMEs can be performed by a single physician or by a panel of physicians" (New Mexico Workers' Compensation Administration, 2019, p 24).
- **Required Qualifications:** IMEs assigned by a workers' compensation judge must apply and be approved by the IME Provider Selection Committee (New Mexico Statute, Chapter 52, Section 52-1-51, 2024). The committee includes representatives from both labor and industry (New Mexico Workers' Compensation Administration, 2025). The IME must submit three recent IME reports, be licensed to practice in New Mexico, and submit a curriculum vitae and references (New Mexico Workers' Compensation Administration, 2022). Applicants are required to disclose whether they are certified with the International Academy of Independent Medical Examiners or a similar organization, but this certification is not required (New Mexico Workers' Compensation Administration, 2022).
- **Evaluator Compensation:** The employer pays for the IME and related travel expenses (New Mexico Statute, Chapter 52, Section 52-1-51, 2024), but the employee must pay 60 percent of the fee for missed appointments (New Mexico Workers' Compensation Administration, 2024, p. 12). The IME fees must be agreed upon by the employer and the evaluator. If they cannot agree on a fee, the judge may set the fee or "take other action to resolve the fee dispute" (New Mexico Administrative Code, Title 11, Section 11.4.7.9, 2025).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** None noted.

New York

- **Evaluator Selection Process:** IWs, employers, and carriers are each allowed to request an IME to evaluate the nature of the injuries, the degree and extent of disability, or the IW's ability to return to work (New York Workers' Compensation Board, 2019; New York Workers' Compensation Law, Section 137, 2024). The IME is usually requested by the IW or employer but may be appointed by the New York Workers' Compensation Board in some instances (New York Workers' Compensation Board, 2019; New York Workers' Compensation Law, Section 137, 2024).
- **Required Qualifications:** An IME must be a physician, surgeon, podiatrist, chiropractor, or psychologist to examine or evaluate injury or illness by the New York Workers' Compensation Board. The IME must be licensed and board certified in New York state and must submit a recommendation from the relevant medical society or board (New York Workers' Compensation Law, Section 137, 2024). IME entities must be registered with the New York Workers' Compensation Board (New York Workers' Compensation Board, undated). If an IW resides out of state, the New York Workers' Compensation Board may authorize another provider to conduct the examination (New York Workers' Compensation Law, Section 137, 2024). In certain cases where it would place an unreasonable burden upon the employer or claimant for an IME to be performed by an authorized provider, the IME may be performed by a qualified provider, arranged by the employer (NY Workers' Compensation Law, Section 13-b).
- **Evaluator Compensation:** IMEs are paid for by the party requesting the examination and according to the New York Workers' Compensation fee schedule. However, where a claimant can demonstrate that she made a good faith effort to obtain an opinion from her attending provider but was unsuccessful, the carrier must pay for the IME(New York Workers' Compensation Law, Section 137, 2024; New York Workers' Compensation Law, Section 13, 2024).
- **Evaluator Quality Assurance and Discipline:** The New York Workers' Compensation Board may remove providers from the approved list of IMEs for reasons such as fraud, abuse, or failing to testify or submit depositions (New York Workers' Compensation Law, Section 13-D, 2024).
- **Other notable features:** The employee and examiner may record the examination. Exams must be conducted in a suitable medical facility that allows for patient privacy and is a reasonable distance from the injured workers' residence. Travel expenses are reimbursed (New York Workers' Compensation Law, Section 137, 2024). A 2019 report on utilization of IMEs covered topics such as timing of IME evaluations, injured workers' experiences, and quality of IME reports (New York Workers' Compensation Board, 2019). New York considered setting up a panel process similar to California's in 2019, but did not reach consensus on the topic and has not implemented such a system (New York Workers' Compensation Board, 2019).

North Carolina

- **Evaluator Selection Process:** The employer can request an IME and select the doctor, but the employee may request another physician that the employee selects present at the examination (North Carolina General Statutes, Section 97-27, 2012). The employee may also request a separate second-opinion examination, selected by the employee but paid by the employer, solely to evaluate the percentage of permanent disability (North Carolina General Statutes, Section 97-27, 2012).
- **Required Qualifications:** The evaluator must be a qualified physician who is licensed and practicing in North Carolina. The limited second-opinion employee-selected physician may be licensed out of state if agreed by the parties.
- **Evaluator Compensation:** The employer must pay for the exams, but the employee must pay for any doctor they request to be present during the employer-selected exam. The employee must pay for travel if the employee requested the evaluation (North Carolina General Statutes, Section 97-27, 2012).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** None noted.

Ohio

- **Evaluator Selection Process:** Ohio is a monopolistic workers' compensation insurer, meaning that, if not self-insured, employers typically purchase workers' compensation insurance through the state, not through private insurance companies. The employer may request an IME one time for any reason (Ohio Revised Code, Section 4123.651, 2024). The employer must compensate the employee for travel expenses as well as any lost wages associated with the exam. (Ohio Administrative Code 4123-3-09). The workers' compensation administrator or industrial commission may also request an evaluation of an employee to "determine the employee's continued entitlement to such compensation, the employee's rehabilitation potential, and the appropriateness of the medical treatment the employee is receiving" (Ohio Revised Code, Section 4123.53, 2024). Employees must be reimbursed for travel expenses if this exam is outside of the place of the employee's residence (ORC, Section 4123.53, 2024). The industrial commission may also request an independent specialist examination to address issues of permanent total disability, original or additional allowance, temporary total disability, and permanent and partial disability (Ohio Industrial Commission, 2024a).
- **Required Qualifications:** The IME must be a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner (Ohio Revised Code, Section 4123.651, 2024). To become an Independent Specialist Examiner, a specialist candidate must have additional qualifications such as a current, unrestricted license with the relevant state licensing board and continuing medical education (CME) credits specific to impairment rating (Ohio Industrial Commission, undated). Independent Specialist Examiners must apply and attend an Ohio Industrial Commission orientation (Ohio Industrial Commission, undated).
- **Required Qualifications:** The IME must be a physician, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner (Ohio Revised Code, Section 4123.651, 2024). To become an Independent Specialist Examiner, a specialist candidate must have

additional qualifications such as a current, unrestricted license with the relevant state licensing board and continuing medical education (CME) credits specific to impairment rating (Ohio Industrial Commission, undated). Independent Specialist Examiners must apply and attend an Ohio Industrial Commission orientation (Ohio Industrial Commission, undated).

- **Evaluator Compensation:** The requestor (employer or Ohio Bureau of Workers' Compensation) must pay for examinations and reasonable related costs (Ohio Revised Code, Section 4123.651, 2024); (Ohio Revised Code, Section 4123.53, 2024). If the original report was incomplete or inadequate, the specialist must complete addenda at no cost (Ohio Industrial Commission, 2024a). Fees are set by the Ohio Industrial Commission and are based on number of body parts or organ systems examined and include record review up to 90 pages with additional record review reimbursed at $2 per page (Ohio Industrial Commission, 2024b). Separate fees are paid for depositions and no-shows (Ohio Industrial Commission, 2024b).
- **Evaluator Quality Assurance and Discipline:** The Ohio Industrial Commission is responsible for developing and disseminating guidance for conducting Med-Legal evaluations (Ohio Revised Code, Section 4121.38, 2022). The Industrial Commission also is required to develop a method of peer review for medical reports and employs staff trained in Med-Legal analysis (Ohio Revised Code, Section 4121.38, 2022). When independent specialists first begin, they have provisional status and conduct a limited amount of examinations that are reviewed by the Ohio Industrial Commission Medical Advisor and Director of Medical Services (Ohio Industrial Commission, undated). Specialists who do not submit reports within 10 days of the examination may be suspended or dismissed (Ohio Industrial Commission, 2024a).
- **Other notable features:** A relative may be present during the examination but may only quietly observe (Ohio Industrial Commission, 2024a). Legal representatives may not be present at the examination and recording is prohibited (Ohio Industrial Commission, 2024a). Interpreters must be provided at no cost (Ohio Industrial Commission, 2024a).

Pennsylvania

- **Evaluator Selection Process:** The employer may request an IME, selected and paid for by the employer, to determine the status of impairment. The employer may request a workers' compensation judge to order additional examinations, and if so ordered, the employer must pay for the employee's travel expenses and loss of wages in addition to the examination. At any examination, the employee has the right to have his or her own health care provider present (Section 314 PA Workers Compensation Act). In addition, when an employee has been receiving total disability compensation for two years, the employee is required to submit to an Impairment Rating Evaluation to determine if the employee continues to have a whole-body impairment due to the compensable injury. Pennsylvania maintains a list of designated Impairment Rating Evaluation physicians (Commonwealth of Pennsylvania, 2025). The degree of impairment is determined by an evaluation by a qualifying physician chosen by agreement of the parties or by the Pennsylvania Department of Labor and Industry (Pennsylvania Workers' Compensation Act, Section 306(a)(2)).

- **Required Qualifications:** Impairment rating evaluators must be certified by an American Board of Medical Specialties approved board or its osteopathic equivalent and be active in clinical practice for at least twenty hours per week (Pennsylvania Workers' Compensation Act, Section 306(a)(2)). There are no specific qualification requirements to become an IME.
- **Evaluator Compensation:** Evaluations are paid for by the employer (Pennsylvania Workers' Compensation Act, Section 306(a)(2)).
- **Evaluator Quality Assurance and Discipline:** None noted.
- **Other notable features:** Employees may not be required to submit to more than two employer-requested examinations during a 12-month period (Pennsylvania General Assembly, 2018). Pennsylvania requires that the most recent AMA Guide to impairment be used (Pennsylvania Workers' Compensation Act, Section 306(a)(2)).

Texas

- **Evaluator Selection Process:** The Texas DWC, IW, or insurer may request a medical examination by a Designated Doctor to resolve issues regarding level of impairment, the attainment of MMI, the extent of the employee's compensable injury, whether the impairment is caused by a compensable injury, and the employee's ability to return to work. Such examinations may not normally be conducted more often than every 60 days. Both parties can agree to use a specific designated doctor, or the Texas DWC will assign the next available doctor meeting requirements (Texas Labor Code, Title 5, Section 408.0041, 2024). The employee and the employer can select an additional examination by a doctor of their choosing if they disagree with the Designated Doctor report, but the report of the Designated Doctor has presumptive weight unless the preponderance of the evidence is to the contrary (Texas Labor Code, Title 5, Section 408.0041, 2024).
- **Required Qualifications:** The Designated Doctor must be a physician or chiropractor whose credentials are appropriate for the area of the body affected by the injury and the injured employee's diagnosis as determined by commissioner rule (Texas Labor Code, Title 5, Section 408.0043, 2024) or a licensed chiropractor (Texas Labor Code, Title 5, Section 408.0045, 2024; Texas Administrative Code, Title 28, Section 127.130, 2025). Designated Doctors must take required training and pass a test (Texas Department of Insurance, undated-b). Designated Doctor certification is required every two years, and a two-day online training must be completed (Texas Department of Insurance, undated-a).
- **Evaluator Compensation:** The defense is required to pay for the examination and reasonable expenses for the IW to attend the examination (Texas Labor Code, Title 5, Section 408.0041, 2024). The insurer or employee must pay a fee to the Designated Doctor for a missed appointment. Designated Doctors are paid according a specified fee schedule (Texas Labor Code, Title 5, Section 408.0041, 2025; Texas Administrative Code, Title 28, Section 134.240, 2025), with compensation based on the type of examination and the number of body parts examined. A 10-percent incentive payment is added for evaluations that are performed in designated workers' compensation underserved areas and is adjusted annually based on the MEI (Texas Administrative Code, Title 28, Section 134.210, 2025).
- **Evaluator Quality Assurance and Discipline:** Texas DWC is required to evaluate the quality and timeliness of decisions made by Designated Doctors (Texas Labor Code,

Title 5, Section 413.002, 2024). To do this, Texas DWC has a Designated Doctor Certification Review Committee. There are eight performance factors that can trigger a performance review towards the end of a two-year performance period. These performance factors are based on such factors as the percentage of exams that receive complaints, the percentage of exams that require letters of clarification, and the percentage of reports that are not adopted at contested case hearings (Texas Department of Insurance, 2019). If one of these performance factors is triggered, five random reports are selected for review by the DWC. The committee reviews the five reports and recommends denial. The committee also has discretion to review five reports from Designated Doctors who do not meet the threshold (Texas Department of Insurance, 2019).

- **Other notable features:** Designated Doctor reports are filed online (Texas Department of Insurance, undated-b).

Washington

- **Evaluator Selection Process:** Washington is a monopolistic workers' compensation insurer, meaning that employers, if not self-insured, typically purchase workers' compensation insurance through the state, not through private insurance companies. IMEs can be requested by the Washington State Department of Labor and Industries.
- **Required Qualifications:** To be an IME in Washington, examiners must submit an application to the Department of Labor and Industries and be approved. The full list of qualifications is described in Washington Administrative Code 296-23-317. Briefly, the applicant must be licensed, accredited, and in good standing in Washington State or another jurisdiction where the applicant would conduct an examination. Chiropractors must be licensed in Washington State. Physicians must have relevant board certification and residency requirements, and chiropractors must be chiropractic consultants for the department and attend an IME seminar by the department. Dentists must meet relevant practice requirements. All examiners must meet continuing education requirements applicable to their specialties. IMEs must reapply every three years (Washington Administrative Code, Title 296, Section 296-23-322, 2025).
- **Evaluator Compensation:** IMEs are paid by the Washington State Department of Labor and Industries or the self-insured employer, according to the Washington Department of Labor and Industries IME Fee Schedule, and include fees for conducting the exams with additional payments for four or more body parts or systems, complex cases, physician travel, and file review over 400 pages (Washington State Department of Labor & Industries, 2024b). IMEs are also paid for terminated and no-show exams. There are also higher rates for psychiatry and rare specialty exams.
- **Evaluator Quality Assurance and Discipline:** The department may automatically terminate IMEs whose license has been revoked in any jurisdiction, who have received conduct charges, or who have failed to reapply every three years or when required (Washington Administrative Code, Title 296, Section 296-23-337, 2025).
- **Other notable features:** Workers are allowed to record IMEs (Washington State Department of Labor & Industries, 2024a). IMEs must be conducted in a medical facility (Washington Administrative Code, Title 296, Section 296-23-317, 2025). IMEs may be conducted via telehealth but only for certain specialties, unless agreed up by the parties

(Washington Administrative Code, Title 296, Section 296-23-359, 2025). The number of IMEs is generally limited to one per claim from all specialties, unless the prior examination determined a rating was premature or a new claim is made (WAC 296-23-309, 2025). The worker may bring an accompanying adult to the IME, but the adult may not be the worker's treating provider (WAC 296-23-362).

Appendix B. Interview and Focus Group Discussion Topics

NOTE: Parentheticals describe with which groups each topics were discussed: AAs, active QMEs, DAs or insurer or employer representatives, former QMEs, IWs, MMCs, and other states.

1. Background
    a. **(AA, DA, MMC, OS)** Introduction and role at organization
    b. **(Active QME, Former QME)** Introduction, length of time as QME, reasons for becoming QME
    c. **(Former QME)** Reasons for not seeking reappointment
    d. **(IW)** Overall experience with the Med-Legal process
    e. **(MMC)** Services provided to QMEs
2. **(MMC)** Payment structure and ownership
3. **(AA, Active QME, DA, Former QME, MMC, Other States)** Role of MMCs (or similar organizations in other states) in Med-Legal process
4. **(AA, Active QME, DA, Former QME, MMC)** Changes to litigation practices over time
5. **(IW)** Resources used in navigating the Med-Legal process
6. (AA, Active QME, DA, Former QME, MMC) Legislative factors and changes
7. **(AA, Active QME, DA, Former QME, IW, MMC)** Time frames in the Med-Legal process (e.g., requesting QMEs, scheduling appointments, submitting reports)
8. **(AA, Active QME, DA, Former QME, MMC)** Adequacy of QME supply (overall and by specialty and geographic location)
9. **(AA, Active QME, DA, Former QME, MMC)** Availability of educational resources for QMEs
10. **(AA, Active QME, DA, Former QME, MMC)** QME reimbursement and changes to the Med-Legal fee schedule
11. **(OS)** Evaluator reimbursement structures
12. **(AA, Active QME, DA, Former QME, MMC, Other States)** Factors influencing QME (or other state equivalent) recruitment and retention
13. Medical records used in QME (or other state equivalent) evaluations
    a. (AA, Active QME, DA, Former QME, IW, MMC, Other States) Medical record delivery mode and timeliness
    b. (AA, Active QME, DA, Former QME, IW, MMC, Other States) Determining the relevancy of QME records
    c. (AA, Active QME, DA, Former QME, MMC, Other States) Use of a central record repository

14. **(AA, Active QME, DA, Former QME, IW, MMC, Other States)** Appropriateness of telehealth or remote health in QME evaluations
15. Structural Improvements to the Med-Legal process
    a. **(AA, Active QME, DA, Former QME, IW, MMC, Other States)** Process of determining QME (or other state equivalent) specialty
    b. **(AA, Active QME, DA, Former QME, IW, MMC)** QME panel structure and potential improvements
16. (AA, Active QME, DA, Former QME, MMC, Other States) Quality assurance of QME reports
17. **(AA, Active QME, DA, Former QME, IW, MMC, Other States)** Other comments or recommended changes to the QME process

Appendix C. Additional Quantitative Methods

Dataset Linkage

To answer a set of related research questions, we linked QME, WCIS, and EAMS data at the panel, physician, and case levels. Because these data sources do not share a single unique identifier and individual injury incidents may be associated with multiple panels or cases, we used multiple versions of merges to link the datasets but subsequently needed to distinguish lower- from higher-quality matches.

We merged each pair of datasets using six alternative match "versions," each relying on a different combination of name matches, claim numbers, dates of injury, and zip codes. We detail the specifics of these merge versions in Table C.1. These versions ranged from requiring strict matches between exact claim number matches to looser name-based matches requiring only that names resembled one another phonetically. As a result, the merged files contained both likely true links and plausible but incorrect ones. For example, we saw more evidence for a true link among matched rows where all six merge versions indicated a specific JCN-Panel ID combination was a true match. However, we were less confident in candidate matches where only the sixth merge version (first name, month of injury, and zip code) indicated this row was a match.

Table C.1. Summary of Merge Versions Used to Link Administrative Datasets

Version	Match Description
1	Exact claim number match, with month-level date of injury match and exact 5-digit zip match
2	Numeric-only claim number match, with month-level date of injury match and exact 5-digit zip match
3	Full Soundex match on last name and first name, with month-level date of injury match and exact 5-digit zip match
4	Two-character Soundex match on last name and first name, with month-level date of injury match and exact 5-digit zip match
5	Full Soundex match on last name only, with month-level date of injury match and exact 5-digit zip match
6	Full Soundex match on first name only, with month-level date of injury match and exact 5-digit zip match

NOTE: *Soundex* is a phonetic encoding algorithm that groups together names that sound similar but may be spelled differently (e.g., "Smith" and "Smyth"). *Full Soundex* uses the complete Soundex code, while *two-character Soundex* uses a shortened version that allows for looser matching. *Month-level date of injury alignment* requires the month and year of the date of injury to match across datasets, rather than the exact day. *Numeric-only claim number matching* removes non-numeric characters prior to comparison to account for formatting differences across systems.

For each dataset pairing, we distinguished the high-quality from the low-quality matches using a two-stage selection process. We ranked candidate matches using (1) the absolute

difference in the reported date of injury and (2) a categorical "merge confidence" score that summarized how strongly the records aligned across the multiple merge versions.

For QME-WCIS linked datasets, we first selected a single best-matched WCIS claim number (the JCN) for each IW identifier by choosing the candidate with the smallest date of injury difference and strongest merge confidence. When multiple JCNs were tied on both criteria, we selected among them at random using a consistent rule so that results could be replicated. We then reversed the perspective and, within each JCN, identified the best-matched panel record using the same criteria. Because panels are organized by a claim number in the QME database, we also flagged all panels associated with the best-matched panel's claim number as valid matches. For the analysis dataset, we removed JCNs that were never selected as a best match for any panel as well as sets of panels never selected as the best match of any JCN.

For WCIS-EAMS and QME-EAMS linked datasets, where a single claim or panel could correspond to multiple adjudication cases in EAMS, we applied the same two-stage ranking logic to select the best-matched EAMS case for each JCN or panel. Since most research questions for these datasets focus on case closure, we wanted to retain as much information as possible regarding the potential closure date. Therefore, when multiple EAMS cases tied as equally good matches, we summarized closure timing by taking both the earliest and the latest closure dates observed across those cases for sensitivity analysis (rather than randomly selecting among ties).

Table C.2 shows the counts of unique identifiers as the data move from the raw source files through the merged candidate datasets and into the final analysis datasets. For the QME-WCIS linkage, we began with 1.7 million unique QME panels and 13.2 million WCIS claims. By iterating through the six merge versions, we were able to merge 76 percent of panels and 12 percent of claims. About one-third of these links were one-to-one matches, while the remainder required additional selection among multiple candidate claims or panels. After applying the match-selection procedure, the final QME-WCIS dataset included 1.2 million panels (95 percent of the linked panels) linked to just under 1 million unique claims (62 percent of the linked claims).

For the WCIS-EAMS linkage, we began with 13.2 million WCIS claims and 2.7 million EAMS adjudication cases. By iterating through the six merge versions, we linked 2.31 million WCIS claims (about 18 percent of all WCIS claims) to 1.32 million EAMS cases (about 48 percent of all EAMS cases). Only a negligible share of these links were one-to-one matches (fewer than 0.1 percent), and nearly all linked claims required selection among multiple candidate adjudication cases. After applying the match-selection procedure, the final WCIS-EAMS dataset retained all linked WCIS claims and 1.28 million unique EAMS adjudication cases (about 97 percent of the linked EAMS cases).

For the QME-EAMS linkage, we began with 1.75 million unique QME panels and 2.7 million EAMS adjudication cases. Using the six merge versions, we linked 1.02 million panels (about 58 percent of all panels) to about 700,000 EAMS cases (about 27 percent of all EAMS cases). Approximately 37 percent of linked panels formed one-to-one matches with a single

adjudication case, while the remainder required selection among multiple candidate cases. After applying the match-selection procedure, the final QME-EAMS dataset retained all linked panels and 661,810 unique EAMS adjudication cases (about 91 percent of the linked cases).

Table C.2. Record Counts Through Data Linkage and Match Selection

Dataset Pair	Description	Unique Panels (Panel ID)	Unique Claims (JCN)	Unique EAMS Adjudication Cases
QME-WCIS	Raw QME panel data	1,752,535	—	—
	Raw WCIS claim data	—	13,152,809	—
	All merged candidate matches	1,338,367	1,557,311	—
	One-to-one matches	419,532	419,532	—
	Ambiguous matches requiring selection	918,835	1,137,779	—
	Final matched dataset after selection	1,273,127	958,115	—
WCIS-EAMS	Raw WCIS claim data	—	13,152,809	—
	Raw EAMS adjudication data	—	—	2,733,221
	All merged candidate matches	—	2,311,878	1,321,524
	One-to-one matches	—	652	652
	Ambiguous matches requiring selection	—	2,311,226	1,320,872
	Final matched dataset after selection	—	2,311,878	1,284,135
QME-EAMS	Raw QME panel data	1,752,535	—	—
	Raw EAMS adjudication data	—	—	2,733,221
	All merged candidate matches	1,015,851	—	724,855
	One-to-one matches	373,388	—	373,388
	Ambiguous matches requiring selection	642,463	—	351,467
	Final matched dataset after selection	1,015,851	—	661,810

SOURCE: RAND analysis of EAMS, WCIS, and QME data.
NOTE: QME data come from the “Injured Worker” table, WCIS data come from FROIs, and EAMS data come from adjudication case event files. “All merged candidate matches” includes all links identified using any of the merge versions described in the Methods. One-to-one matches refer to identifiers that link uniquely across datasets without ambiguity. Ambiguous matches involve multiple plausible links and required selection based on proximity in date of injury and overall match quality. Final analytic samples vary by research question due to missing fields and right-censoring near the end of the data period; these restrictions are documented in the footnotes to each table and figure.

Detailed Methods by Research Question

This section documents the analytic samples, variable construction, and inclusion criteria used for the research question that required linkages between datasets. While Table C.2 summarizes the universe of identifiers retained after the merge and match-selection process, each analysis imposes additional requirements tailored to its specific outcome and data needs. Analytic samples are smaller than the linked identifier counts reported in Table C.2 because each analysis applies additional, question-specific restrictions, including required field availability (e.g., dates, specialties, provider identifiers) and exclusions to address the WCIS medical billing dataset's complete observation period.

Percentage of Panels Utilized

This analysis measures the share of QME panels issued between 2016 and 2023 that resulted in at least one observed Med-Legal service. We identified QME panels using panel assignment records and linked them to WCIS medical billing data using the merge procedure described previously. To attribute billed services to specific panel physicians, we further linked QME physicians to WCIS billing records using NPIs obtained from the NPPES. We classified a panel as utilized if at least one Med-Legal procedure or report billed in WCIS could be attributed to a QME listed on the issued panel for the associated claim and if the WCIS service date occurred after the panel request date. This definition ensures that observed services reflect activity generated by the issued panel rather than prior Med-Legal work. The analytic sample includes 510,949 panels that were linked to 371,318 WCIS medical billing records, a subset of the linked panels in Table C.2 because utilization can only be assessed for panels with identifiable post-issuance Med-Legal services billed by panel-listed physicians. For each calendar year, defined by the year of panel issuance, we calculated the percentage of panels that were utilized using the total number of panels issued in that year as the denominator.

Percentage of Injured Workers Who Requested Panels but Did Not Secure Services of a Panel QME

This analysis examines the share of IWs who requested QME panels between 2016 and 2023 and did not receive services from a QME. IWs were defined as unique claim numbers in the QME data where the requestor field indicated that the IW initiated the panel request. The analytic sample includes N = 54,699 IWs linked to N = 51,751 WCIS medical billing records, the subset of linked claims where the panel was requested by the IW and where sufficient post-request billing data could assess whether services occurred. We linked panel requests to WCIS billing data to identify whether any Med-Legal services were billed or paid by QMEs listed on the issued panel. We classified a claim as not securing QME services if no Med-Legal procedures or payments attributable to a QME were observed, either at any time following the panel request or within one year of the panel assignment date. Claims subject to right-censoring

near the end of the WCIS extract were excluded to avoid misclassifying services that may not yet have been observed. Annual percentages were calculated using the year of the panel request as the reference year.

Percentage of Replacement Panel Cases with Med-Legal Expenses Paid at Time of Panel Replacement

This analysis assesses whether replacement panel requests occurred after Med-Legal activity had already taken place on the claim. The denominator includes 106,106 replacement panels linked to 81,234 unique WCIS claim numbers (JCNs), representing the subset of the linked panels that were replacement panels with sufficient billing history in WCIS. We restricted the sample to replacement panels associated with claims that either had at least one positive Med-Legal payment or had no observed payments, and we excluded panels linked to claims with injury dates prior to 2017 to mitigate left-truncation concerns arising from limited pre-2016 billing data coverage. We classified a replacement panel as having prior Med-Legal activity if any WCIS Med-Legal payments were recorded before the replacement request date. We further categorized payments based on whether they occurred within one year, one to two years, or more than two years prior to replacement. Annual percentages were calculated using the year of the replacement request as the reference year.

Distribution of Reasons for Replacement by Year

This analysis describes the distribution of reported reasons for QME panel replacement by panel assignment year for replacement requests observed between 2012 and 2024. In the table of the main text, we excluded records with missing or unknown replacement codes and removed replacement requests coded as “Struck by DA or AA,” which reflect procedural panel strikes rather than substantive issues related to QME availability, timeliness, or conflicts. To reduce administrative variation, we consolidated closely related replacement codes into broader categories, such as report time frame infractions and conflicts of interest. After these exclusions and consolidations, most replacement panels had a single reported reason. Approximately 10 percent of panels had multiple reported reasons, which we classified into a single “Multiple Reasons” category. Percentages were calculated within each panel assignment year.

Correspondence Between Replacement Reason and EAMS Case Events

This analysis examines the relationship between reported reasons for QME panel replacement and observed EAMS case activity for replacement panels issued between 2012 and 2024. We applied the same exclusions and code consolidations used in the distribution analysis, including removal of unknown codes and procedural strikes and consolidation of related replacement reasons. Using merged QME-EAMS data, we identified whether the EAMS case associated with each panel ever exhibited replacement-related judicial orders or petitions, medical report rejection activity, or other QME panel-related events during the observation

period. For each replacement reason category, we calculated the share of panels whose associated EAMS case exhibited at least one such event, allowing us to assess whether reported replacement reasons align with observed litigation activity.

Duration from Date Claim Filed with Claim Administrator to Panel Request

This analysis measures the time from claim filing to panel request using 528,755 WCIS claims (JCNs) linked to 706,638 QME panels, a subset of linked claims and panels because the analysis required complete claim filing and request dates. We calculated durations as the difference between the date the claim was filed with the claim administrator and the panel request date. Annual averages were calculated using the year of the panel request as the reference year. For each year, we also computed the proportion of cases falling into each duration category to describe changes in the distribution over time.

Duration from Panel Assignment Date to QME Exam Date

This analysis measures the time from panel assignment to QME examination for panels that resulted in observed exams. The analytic sample includes 235,950 panels linked to 219,828 WCIS claims for which we observed Med-Legal exams performed by QMEs listed on the issued panel, the subset of linked records in which we could identify a Med-Legal exam billing by a physician listed on the issued panel and occurring after that panel assignment date but before any replacement panel was assigned. Exams were required to occur after the index panel's assignment date and before the assignment date of any subsequent panel. When claims had multiple panel assignments, we attributed exams to the most recent panel preceding the exam, so durations are measured from the panel that plausibly generated the exam rather than from earlier panels. Annual averages were calculated using the year of panel assignment as the reference year. For each year, we also computed the proportion of cases falling into each duration category to describe changes in the distribution over time.

Duration from Panel Assignment Date to EAMS Case Closure Date

This analysis reports the average time from QME initial panel assignment to EAMS case closure. The sample includes 901,870 QME panels linked to 592,249 EAMS adjudication cases, with panel assignments observed between 2012 and 2023. We identified case closure using closing orders and other closure events recorded in the EAMS adjudication case event data. When multiple adjudication cases were associated with a panel, we defined the closure date as the average of the earliest and latest closure dates observed. Annual averages were calculated using the year of panel assignment as the reference year. For each year, we also computed the proportion of cases falling into each duration category to describe changes in the distribution over time.

Duration from First and Last Report Dates to EAMS Case Closure Date

This analysis measures the time from Med-Legal reporting to EAMS case closure. The analytic sample includes 264,746 WCIS claims linked to 253,543 EAMS adjudication cases observed between 2016 and 2023. We identified first and last Med-Legal report dates using WCIS medical billing records with report-related procedure codes. We identified case closure as discussed in the panel assignment to closure date analysis. Annual averages were calculated using the year of the Med-Legal report as the reference year. For each year, we also computed the proportion of cases falling into each duration category to describe changes in the distribution over time.

QME Panel Specialty Requested by Injured Body Part Category

This analysis examines the distribution of requested QME panel specialties by injured body part category. We identified QME panels using panel request records and linked them to WCIS FROIs (DWC-1) to obtain information on the reported nature of injury and injured body part. The analytic sample includes 1,752,535 panels linked to 943,733 JCNs. We mapped detailed injury descriptions into standardized body part categories and grouped requested QME specialties into broader specialty categories to improve interpretability and ensure adequate cell sizes. The analysis is restricted to claims with panel requests between 2016 and 2023, and counts reflect the number of claims within each body part and specialty category using the year of the panel request as the reference year.

Appendix D. Additional Quantitative Results

This appendix includes additional quantitative tables and figures to supplement the main results in Chapters 5-7.

Table D.1. Series Number of Request Within Specialty, by Request Year

Request Number	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
1	101,322	72,587	89,006	98,297	105,145	107,510	112,900	116,513	114,114	113,506	122,193	140,458	155,632
2	12,079	7,468	13,736	17,533	20,957	22,343	24,169	24,597	20,543	15,607	15,165	15,359	17,331
3	2,895	1,359	2,584	3,706	5,421	5,885	6,859	7,115	5,352	3,236	2,627	2,437	2,647
4	848	366	613	948	1,694	1,801	2,409	2,529	1,756	829	659	526	548
5	248	105	161	317	588	597	908	1,040	654	289	161	153	126
6	74	31	46	115	197	229	356	407	278	120	62	47	53
7	33	10	20	40	83	105	158	164	114	40	31	22	25
8	12	<10	<10	11	38	45	82	72	53	11	<10	10	10
9	<10	<10	<10	<10	13	14	44	24	23	<10	0	<10	<10
10	0	0	<10	<10	<10	<10	19	13	12	<10	0	<10	<10
11	0	0	0	<10	<10	<10	<10	<10	<10	<10	0	0	0
12	0	0	0	0	<10	<10	<10	<10	<10	<10	0	0	0
13+	0	0	0	0	0	0	<10	<10	<10	<10	0	0	0

SOURCE: RAND analysis of QME data.
NOTE: The request number refers to the series number of the request for a given case and specialty. The year refers to the year that the request with that series number was made (prior requests in the series may have been made in prior years, including in years prior to 2012). Observations <10 are censored to preserve confidentiality.

Table D.2. Panel Assignments, by Specialty

Specialty Code	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
ACA	60	54	28	39	42	122	209	158	110	163	186	127	20
DCH	6,062	3,865	6,220	5,484	6,113	6,776	7,434	8,989	10,177	11,617	13,977	17,619	20,154
DEN	667	413	486	465	532	686	733	939	880	1,017	1,113	1,135	1,465
MAA	0	0	0	<10	43	37	70	108	349	563	648	784	960
MAI	162	111	101	132	141	159	147	152	104	99	108	82	45
MDE	640	438	481	582	635	634	704	802	667	598	709	799	870
MFP	243	223	229	170	144	139	181	131	129	115	131	102	113
MHH	6,693	5,164	4,808	6,081	7,304	7,660	7,684	7,717	6,650	5,527	5,187	5,433	5,298
MME	180	115	141	61	0	0	0	0	0	0	0	0	0
MMG	720	453	584	753	715	661	754	906	1,151	1,260	1,198	1,352	1,510
MMH	79	61	63	32	0	0	0	0	0	0	0	0	0
MMI	315	219	232	18	0	0	0	0	0	0	0	0	0
MMM	7,772	4,447	5,064	4,755	5,296	5,856	6,280	5,805	5,427	6,190	6,180	5,729	5,886
MMN	54	48	31	30	0	0	0	0	0	0	0	0	0
MMO	358	267	224	144	0	0	0	0	0	0	0	0	0
MMP	662	460	488	600	791	882	828	802	1,013	1,761	1,760	1,427	1,225
MMR	397	249	298	347	364	475	456	440	350	339	352	369	376
MMV	1,234	986	1,038	1,258	1,442	1,442	1,637	1,709	1,724	1,765	2,129	2,460	2,541
MNB	10,033	7,396	8,491	9,993	10,905	10,769	10,470	10,141	8,912	7,002	6,200	6,151	6,401

Specialty Code	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
MNS	282	204	205	208	238	223	206	191	152	143	155	179	183
MOP	849	529	782	925	1,139	1,174	1,307	1,351	1,273	1,263	1,366	1,512	1,668
MOS	37,218	28,000	42,230	53,700	59,240	61,473	65,258	67,541	66,081	58,627	60,568	69,043	76,347
MPA	7,270	5,992	9,658	10,314	12,378	12,510	13,384	13,509	9,952	8,089	8,248	9,658	9,745
MPD	12,360	7,368	8,135	7,015	6,414	6,016	6,831	6,916	6,479	6,874	9,187	11,694	13,520
MPN	5,302	2,936	3,133	3,127	3,841	4,112	4,404	4,823	4,268	4,667	5,247	5,683	6,575
MPO	1,326	1,166	979	1,479	1,835	1,657	1,768	1,634	1,673	1,411	1,469	1,321	1,654
MPR	4,642	3,325	3,882	4,986	6,317	7,004	8,203	7,993	6,341	5,636	5,151	5,157	5,553
MPS	119	81	75	121	130	108	137	143	132	139	115	118	130
MSG	160	115	129	159	146	47	186	217	188	198	208	240	281
MSY	456	360	329	420	522	537	566	656	616	665	651	711	786
MTO	1,036	764	873	1,083	1,446	1,397	1,560	1,731	1,532	1,608	1,736	1,877	2,293
MTT	171	111	126	154	180	185	207	216	168	133	112	159	190
MUU	790	528	655	661	651	607	628	705	643	724	648	660	753
POD	1,120	932	968	1,335	1,304	1,407	1,665	1,792	1,602	1,365	1,432	1,723	1,739
PSN	458	288	397	241	0	0	0	0	0	0	0	0	0
PSY	7,592	4,260	4,610	4,094	3,899	3,784	4,015	4,263	4,167	4,093	4,723	5,696	8,080

SOURCE: RAND analysis of QME data.
NOTE: Sixty-six panel assignments with invalid specialty codes were removed from analysis. Counts of <10 are censored to preserve confidentiality. The full list of specialty codes is available on QME request Form 105: https://www.dir.ca.gov/dwc/forms/qmeforms/qmeform105.pdf; PSN represents Neuropsychology, a discontinued specialty.

Table D.3. QME Panel Specialty Requested, by Injured Body Part Category

Body Part Category	Requested Panel Specialty	Percentage	Total Panels in Category
Head	Ortho & Musculoskeletal	37%	65,107
Head	Spine & Neurosurgery	3%	65,107
Head	Pain Medicine	5%	65,107
Head	Psych, Behavioral, Neuro	30%	65,107
Head	Chiro, Acupuncture, Occupational	5%	65,107
Head	Internal Medicine & Other	20%	65,107
Neck	Ortho & Musculoskeletal	51%	36,156
Neck	Spine & Neurosurgery	11%	36,156
Neck	Pain Medicine	8%	36,156
Neck	Psych, Behavioral, Neuro	11%	36,156
Neck	Chiro, Acupuncture, Occupational	10%	36,156
Neck	Internal Medicine & Other	9%	36,156
Upper Ext	Ortho & Musculoskeletal	69%	245,788
Upper Ext	Spine & Neurosurgery	3%	245,788
Upper Ext	Pain Medicine	9%	245,788
Upper Ext	Psych, Behavioral, Neuro	5%	245,788
Upper Ext	Chiro, Acupuncture, Occupational	7%	245,788
Upper Ext	Internal Medicine & Other	7%	245,788
Trunk - Back or Spine	Ortho & Musculoskeletal	50%	147,240
Trunk - Back or Spine	Spine & Neurosurgery	19%	147,240
Trunk - Back or Spine	Pain Medicine	8%	147,240
Trunk - Back or Spine	Psych, Behavioral, Neuro	6%	147,240
Trunk - Back or Spine	Chiro, Acupuncture, Occupational	10%	147,240
Trunk - Back or Spine	Internal Medicine & Other	8%	147,240
Trunk - Other	Ortho & Musculoskeletal	34%	52,287
Trunk - Other	Spine & Neurosurgery	4%	52,287
Trunk - Other	Pain Medicine	4%	52,287
Trunk - Other	Psych, Behavioral, Neuro	10%	52,287
Trunk - Other	Chiro, Acupuncture, Occupational	4%	52,287
Trunk - Other	Internal Medicine & Other	44%	52,287
Lower Ext	Ortho & Musculoskeletal	64%	153,664
Lower Ext	Spine & Neurosurgery	3%	153,664
Lower Ext	Pain Medicine	9%	153,664
Lower Ext	Psych, Behavioral, Neuro	5%	153,664

Body Part Category	Requested Panel Specialty	Percentage	Total Panels in Category
Lower Ext	Chiro, Acupuncture, Occupational	7%	153,664
Lower Ext	Internal Medicine & Other	13%	153,664
Multiple, Mental, or Other	Ortho & Musculoskeletal	48%	254,173
Multiple, Mental, or Other	Spine & Neurosurgery	4%	254,173
Multiple, Mental, or Other	Pain Medicine	5%	254,173
Multiple, Mental, or Other	Psych, Behavioral, Neuro	21%	254,173
Multiple, Mental, or Other	Chiro, Acupuncture, Occupational	8%	254,173
Multiple, Mental, or Other	Internal Medicine & Other	12%	254,173
Unlinked Panel	Ortho & Musculoskeletal	53%	370,081
Unlinked Panel	Spine & Neurosurgery	5%	370,081
Unlinked Panel	Pain Medicine	8%	370,081
Unlinked Panel	Psych, Behavioral, Neuro	13%	370,081
Unlinked Panel	Chiro, Acupuncture, Occupational	8%	370,081
Unlinked Panel	Internal Medicine & Other	12%	370,081
Missing	Ortho & Musculoskeletal	43%	1,458
Missing	Spine & Neurosurgery	9%	1,458
Missing	Pain Medicine	7%	1,458
Missing	Psych, Behavioral, Neuro	16%	1,458
Missing	Chiro, Acupuncture, Occupational	5%	1,458
Missing	Internal Medicine & Other	21%	1,458

SOURCE: RAND analysis of linked QME-WCIS data.

Table D.4. Requested Specialty on Panel Assignments, by Requestor Type

Specialty	AA	DA	Claims Administrator	IW
DCH (Chiropractor)	110,957 (14.6%)	3,173 (0.5%)	9,959 (5.1%)	394 (0.2%)
MM* (Internal Med. and Subspecialties)	73,495 (9.7%)	35,148 (5.7%)	9,897 (5.1%)	9,712 (5.3%)
MNB (Spine)	18,055 (2.4%)	41,959 (6.8%)	22,712 (11.6%)	30,135 (16.4%)
MOS (Orthopedic Surgery)	211,042 (27.8%)	395,251 (64.3%)	54,901 (28.1%)	84,122 (45.7%)
MPA (Pain Medicine)	105,073 (13.9%)	8,717 (1.4%)	15,425 (7.9%)	1,489 (0.8%)
MPD (Psychiatry)	47,401 (6.2%)	44,793 (7.3%)	8,659 (4.4%)	7,959 (4.3%)
Other	192,434 (25.4%)	85,672 (13.9%)	73,637 (37.7%)	50,360 (27.3%)
Total	758,457	614,713	195,190	184,171

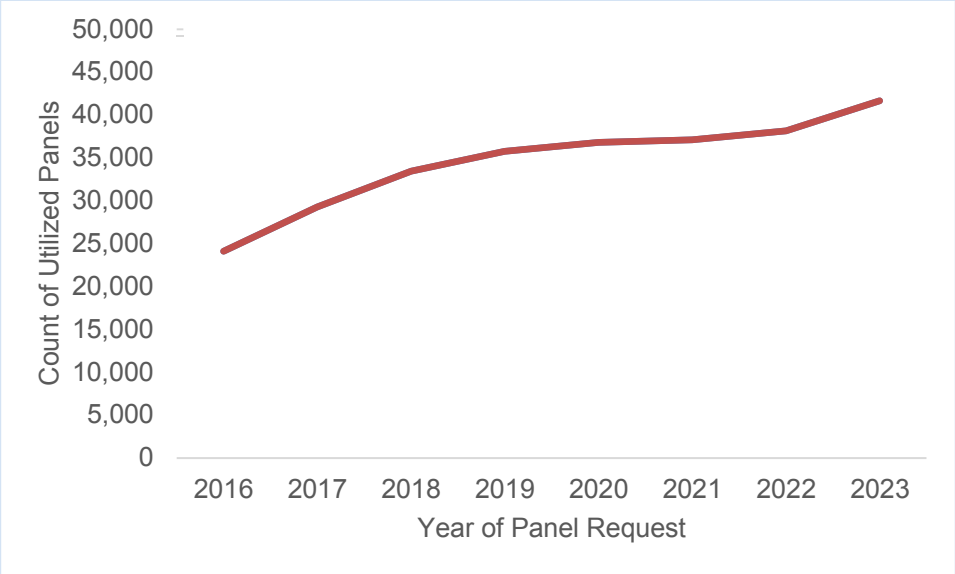
SOURCE: RAND analysis of 2012–2024 QME data.

Table D.5. Counts of Panels Assigned, Linked to Claims, and Utilized

Year	Panel Assignments, N	Panel Assignments Linked to WCIS Claims, N (% of Panel Assignments)	Panels Utilized of Those Linked to WCIS Claims, N (% of Linked Panels)
2016	94,784	52,513 (55.4%)	24,111 (45.9%)
2017	99,950	58,903 (58.9%)	29,259 (49.7%)
2018	107,184	66,021 (61.6%)	33,461 (50.7%)
2019	110,760	70,285 (63.4%)	35,743 (50.9%)
2020	103,339	67,298 (65.1%)	36,824 (54.7%)
2021	96,655	62,814 (65.0%)	37,124 (59.1%)
2022	101,753	64,221 (63.1%)	38,185 (59.5%)
2023	113,962	68,894 (60.5%)	41,666 (60.5%)

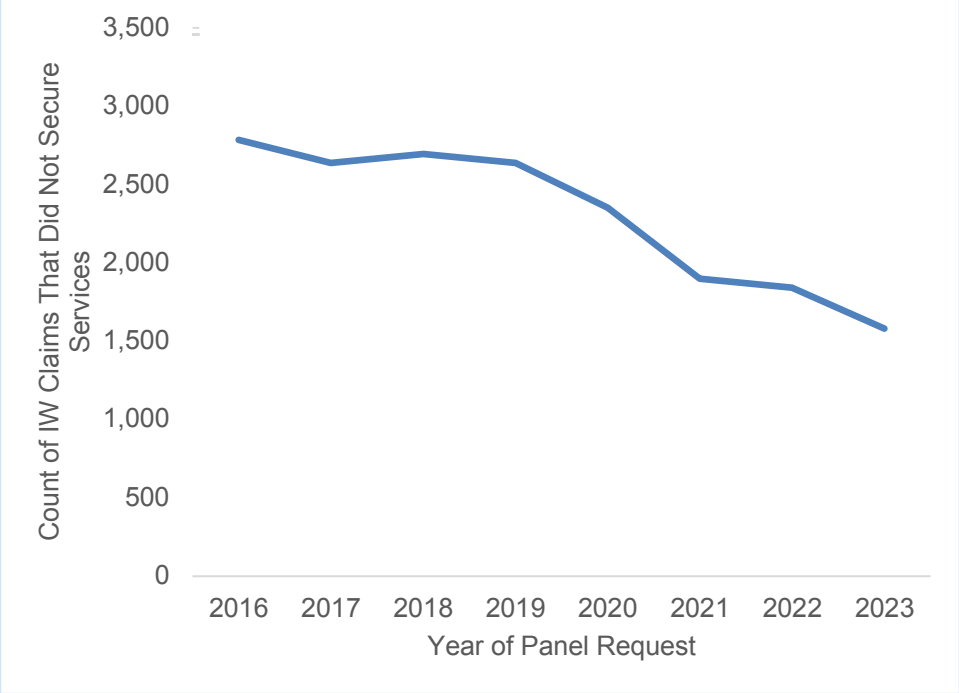
SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: N = 828,387 panel assignments 2016–2023, and N = 444,928 panel assignments linked to WCIS 2016–2024 claims data.

Figure D.1. Count of Panel Assignments That Were Utilized



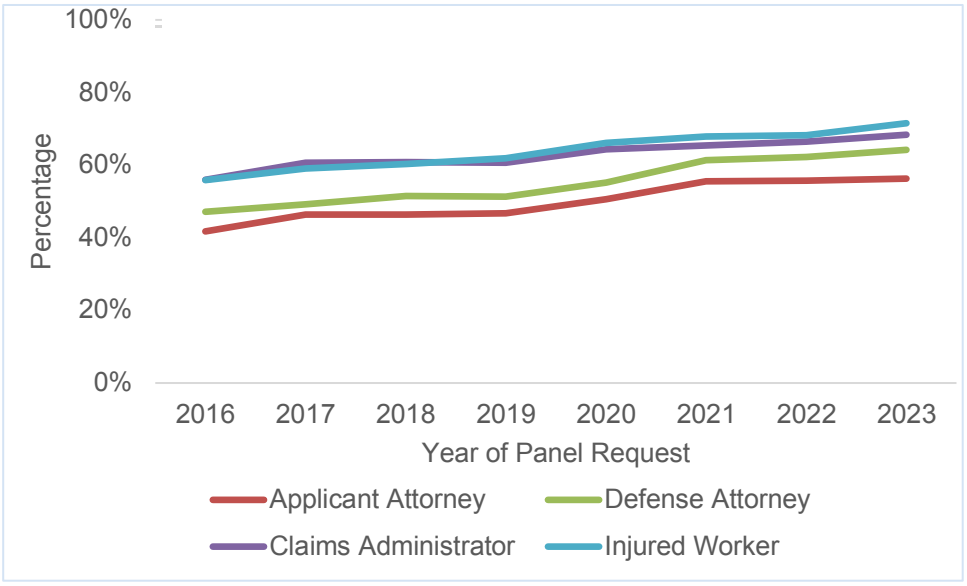
SOURCE: RAND analysis of linked QME-WCIS data.

Figure D.2. Count of Unutilized Panels Requested by Unrepresented Injured Workers (Claim Numbers)



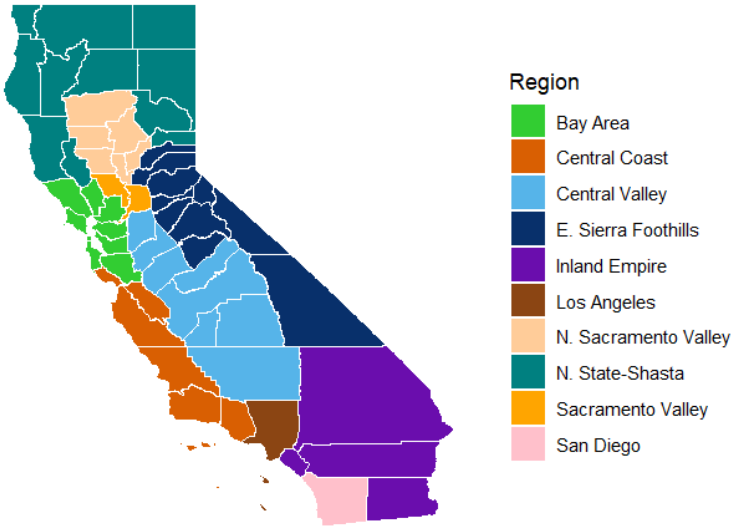
SOURCE: RAND analysis of linked QME-WCIS data.

Figure D.3. Percentage of Panels Utilized, by Requestor



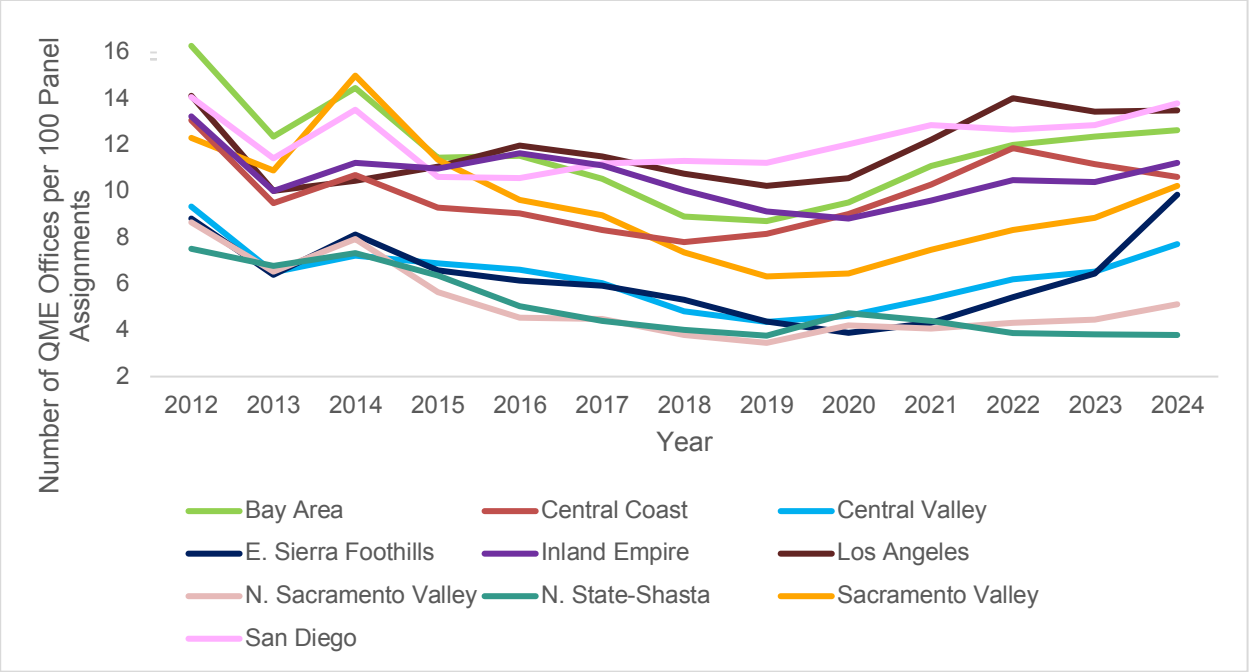
SOURCE: RAND analysis of linked QME-WCIS data.

Figure D.4. California Workers' Compensation Geographic Regions



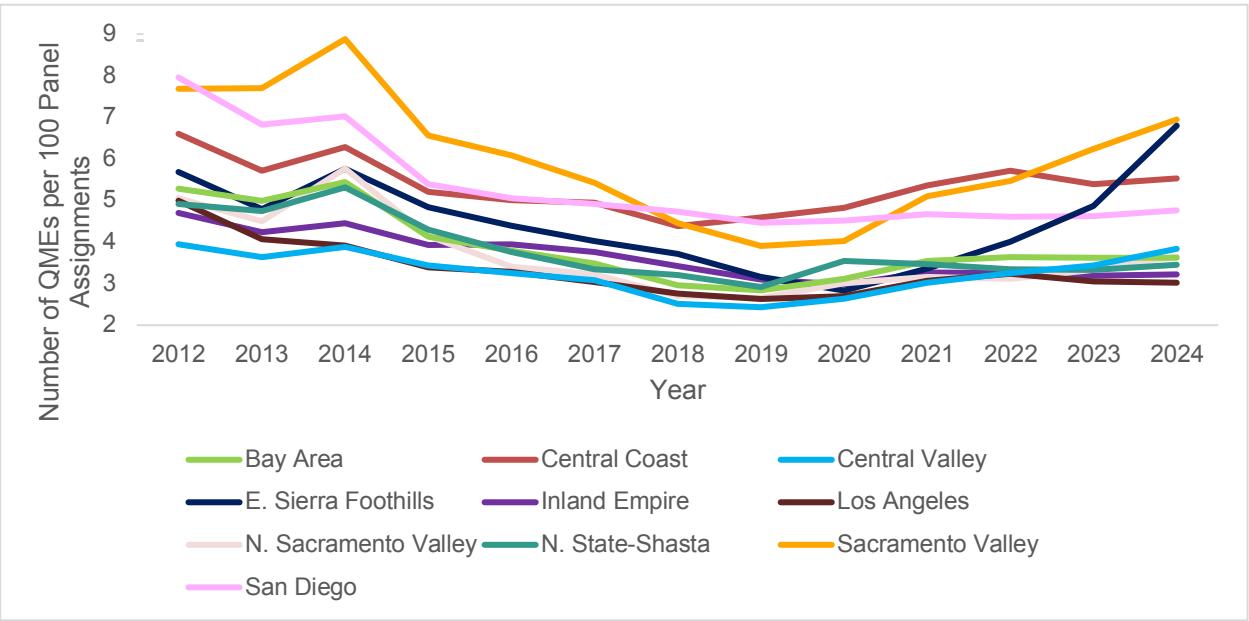
SOURCE: RAND mapping of DIR geographic regions, defined at https://www.dir.ca.gov/dwc/wcis/WCIS_tables/TABLE-7/WCIS_Reports-Table7.html, accessed February 18, 2026.

Figure D.5. QME Offices per 100 Panel Assignments, by Geographic Region and Year



SOURCE: RAND analysis of QME data.

Figure D.6. QMEs per 100 Panel Assignments, by Geographic Region and Year



SOURCE: RAND analysis of QME data.

Table D.6. Number of QMEs, by California Geographic Region and Year

Region	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Bay Area	909	891	875	845	832	784	718	686	658	671	718	776	859
Central Coast	398	390	426	445	457	467	435	429	428	459	497	508	565
Central Valley	407	406	438	477	488	473	435	427	416	448	508	586	717
E. Sierra Foothills	99	84	85	94	93	91	90	87	75	74	94	125	180
Inland Empire	839	855	904	964	979	982	939	910	889	935	1,022	1,133	1,345
Los Angeles	1,236	1,228	1,274	1,303	1,323	1,297	1,261	1,224	1,214	1,285	1,377	1,452	1,655
N. Sacramento Valley	60	53	58	60	56	53	50	50	47	45	51	55	69
N. State-Shasta	81	75	76	75	75	66	67	62	63	56	56	62	67
Sacramento Valley	310	302	309	304	316	298	269	255	250	268	304	377	462
San Diego	406	409	417	416	409	401	388	369	345	347	372	414	481
Total Number of QMEs per Year	3,243	3,139	3,112	3,043	2,948	2,834	2,684	2,564	2,480	2,547	2,644	2,717	2,967

SOURCE: RAND analysis of QME data.
NOTE: QMEs may have offices in more than one region, so the total number of QMEs per year is less than the sum of the column.

Table D.7. Percentage of Replacement Panel Cases with Med-Legal Expenses Paid at Time of Panel Replacement, by Time Interval

Replacement Panel Request Year	Med-Legal Payment Anytime Before Replacement Panel Request Date	Med-Legal Payment Within 1 Year of Replacement Panel Request Date	Med-Legal Payment Between 1–2 Years of Replacement Panel Request Date	Med-Legal Payment 2 Years or More Before Replacement Panel Request Date
2017	1.4%	1.4%	N/A	N/A
2018	5.2%	5.1%	0.2%	N/A
2019	8.2%	7.5%	1.8%	0.0%
2020	12.9%	10.5%	4.8%	1.0%
2021	17.8%	13.6%	7.9%	3.3%
2022	19.6%	14.9%	8.3%	4.7%
2023	21.3%	16.1%	9.0%	6.0%
2024	23.5%	18.0%	11.0%	7.9%

SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: Linked data is not available prior to 2017, so percentages in “Med-Legal Payment Anytime Before Replacement Panel Request Date” and “Med-Legal Payment 2 Years or More Before Replacement Panel Request Date” have different observed look back periods and are not directly comparable.

Table D.8. Distribution of Reasons for QME Replacement on Panel, by Year (All Reasons)

Reason for Replacement	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Struck by DA or AA	44%	44%	45%	46%	46%	45%	46%	46%	47%	46%	46%	46%	46%
Untimely appointment	20%	20%	20%	20%	21%	20%	20%	21%	20%	20%	20%	20%	19%
QME unavailable	7%	8%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%
Other	5%	5%	5%	4%	4%	4%	3%	3%	3%	3%	3%	3%	3%
WCAB judge ordered change	5%	4%	5%	5%	5%	5%	5%	5%	4%	5%	4%	5%	5%
Romero case exception	4%	4%	4%	4%	4%	4%	4%	4%	4%	5%	5%	4%	4%
Former QME inactive	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Wrong or changed specialty	2%	2%	2%	2%	1%	2%	1%	2%	1%	2%	2%	2%	2%
Report time frame infraction	1%	2%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
IW moved	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
QME is PTP	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Panel expired (24 months+)	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Conflict of interest	1%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME doesn’t evaluate body part	1%	1%	1%	1%	0%	0%	0%	0%	0%	1%	1%	0%	0%
Reappointment denied	1%	0%	0%	0%	1%	1%	1%	1%	1%	0%	0%	0%	1%
QME deceased	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Telehealth disagreement	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%
No doctor response	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Reason for Replacement	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Same group practice	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Specialty change approved	0%	0%	0%	0%	0%	0%	1%	1%	0%	1%	0%	0%	1%
QME not at location	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
IW prefers other zip	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Parties agreed new local panel	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Not taking new QME appointments	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME retired	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Appointment cancelled	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME became PTP	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Unknown code	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
No appointment notice form	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME ill	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME moved	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME phone is disconnected	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Missing telemed note	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
QME exceeded max 10 locations	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Total Panel-Reasons	22,819	26,213	28,348	36,431	39,572	41,788	45,500	46,620	43,022	36,661	37,170	36,902	31,937

SOURCE: RAND analysis of EAMS data.
NOTE: The table reports the share of panel-reason combinations in each calendar year, calculated as a percentage of all reported panel replacement reason instances in that year. There may be as many as 3 unique reasons per panel.

Table D.9. Correspondence Between Replacement Reasons and EAMS Case Events

Reason for Replacement	% of Panels Where at Least One EAMS Replacement Event Occurred	% of Panels Where at Least One EAMS Medical Report Rejection Event Occurred	% of Panels Where any EAMS QME Panel-Related Event Occurred	Number of Panels
WCAB judge ordered change	38.70%	0.11%	50.67%	8,262
QME phone number disconnected	5.97%	0.00%	10.45%	67
Parties agreed new local panel	4.93%	0.00%	10.34%	203
Other	4.88%	0.00%	10.28%	3,706
Panel expired (24 months+)	4.79%	0.00%	9.58%	1,086
No appointment notice form	5.62%	0.00%	9.38%	160
Multiple reasons	4.16%	0.02%	9.31%	18,567
Former QME inactive	3.31%	0.00%	9.14%	514
Report time frame infraction	4.33%	0.00%	9.09%	4,203
QME retired	3.48%	0.00%	8.99%	345
IW moved	4.13%	0.00%	8.25%	1,648
QME deceased	4.34%	0.00%	8.09%	1,038
Conflict of interest	4.34%	0.05%	8.04%	2,214
Appointment cancelled	3.70%	0.00%	7.41%	675
QME inactive	3.42%	0.01%	7.27%	20,339
Same group practice	2.76%	0.00%	7.18%	1,267
QME unavailable	3.38%	0.00%	7.16%	4,528
QME moved	5.36%	0.00%	7.14%	56
Telehealth disagreement	2.90%	0.00%	7.13%	1,724
Untimely appointment	3.70%	0.01%	7.10%	94,405
QME is PTP	3.68%	0.00%	7.09%	5,456
IW prefers other zip	3.77%	0.00%	6.92%	159
Reappointment denied	3.52%	0.00%	6.52%	1,734
QME not at location	2.94%	0.00%	6.43%	1,463
No doctor response	2.29%	0.00%	6.16%	1,396
Wrong or changed specialty	3.39%	0.00%	6.15%	2,357
QME doesn’t evaluate body part	2.69%	0.00%	6.00%	2,234
QME ill	1.45%	0.00%	5.80%	69
Specialty change approved	3.26%	0.00%	5.11%	920
Romero case exception	2.47%	0.02%	4.48%	8,176

Reason for Replacement	% of Panels Where at Least One EAMS Replacement Event Occurred	% of Panels Where at Least One EAMS Medical Report Rejection Event Occurred	% of Panels Where any EAMS QME Panel-Related Event Occurred	Number of Panels
QME became PTP	0.00%	0.00%	4.11%	73
Unknown code	0.80%	0.00%	4.00%	125
Not taking new QME appointments	2.12%	0.00%	3.89%	566
Missing telemed note	0.00%	0.00%	0.00%	4

SOURCE: RAND analysis of linked QME-WCIS data.
NOTE: This table examines the correspondence between reported reasons for QME panel replacement and observed EAMS case activity for replacement panels issued between 2012 and 2024. Replacement reason "Struck by DA/AA" was excluded because attorney strikes are a standard part of the QME panel selection process. Romero case exception refers to replacements permitted under *Romero v. Workers' Compensation Appeals Board*, which allows departure from standard QME selection procedures under specific legal circumstances. WCAB denotes the Workers' Compensation Appeals Board. PTP refers to the primary treating physician identified in the claim record. Multiple reasons indicates cases in which more than one replacement reason was reported for the same panel request.

Table D.10. Duration from Date Reported to Claim Administrator to Panel Request Date, Among Cases with Durations Less Than 1 Year

Report Year	Average Duration	% Within 30 Days	% Between 31–90 Days	% Between 91–365 Days	N
2016	150	7.1%	28.5%	64.4%	46,244
2017	148	8.0%	27.9%	64.1%	50,640
2018	146	8.4%	28.2%	63.4%	53,303
2019	144	8.7%	29.2%	62.1%	56,190
2020	139	10.3%	29.4%	60.2%	50,664
2021	136	10.8%	30.8%	58.4%	53,936
2022	132	11.9%	32.2%	55.9%	60,144
2023	122	15.0%	34.2%	50.8%	68,166

SOURCE: RAND analysis of WCIS and QME linked data.

Table D.11. Duration from Date Reported to Claim Administrator to Panel Request Date, Among Cases with Durations Less Than 2 Years

Report Year	Average Duration	% Within 30 Days	% Between 31–90 Days	% Between 91–365 Days	% Between 1–2 Years	N
2016	234	5.5%	21.8%	49.3%	23.4%	60,357
2017	226	6.2%	21.8%	50.1%	21.9%	64,809
2018	223	6.6%	22.2%	49.8%	21.4%	67,782
2019	220	6.9%	23.1%	49.1%	20.9%	71,052
2020	212	8.3%	23.6%	48.4%	19.7%	63,107
2021	217	8.5%	24.2%	46.0%	21.4%	68,585
2022	207	9.6%	25.8%	44.8%	19.8%	74,983

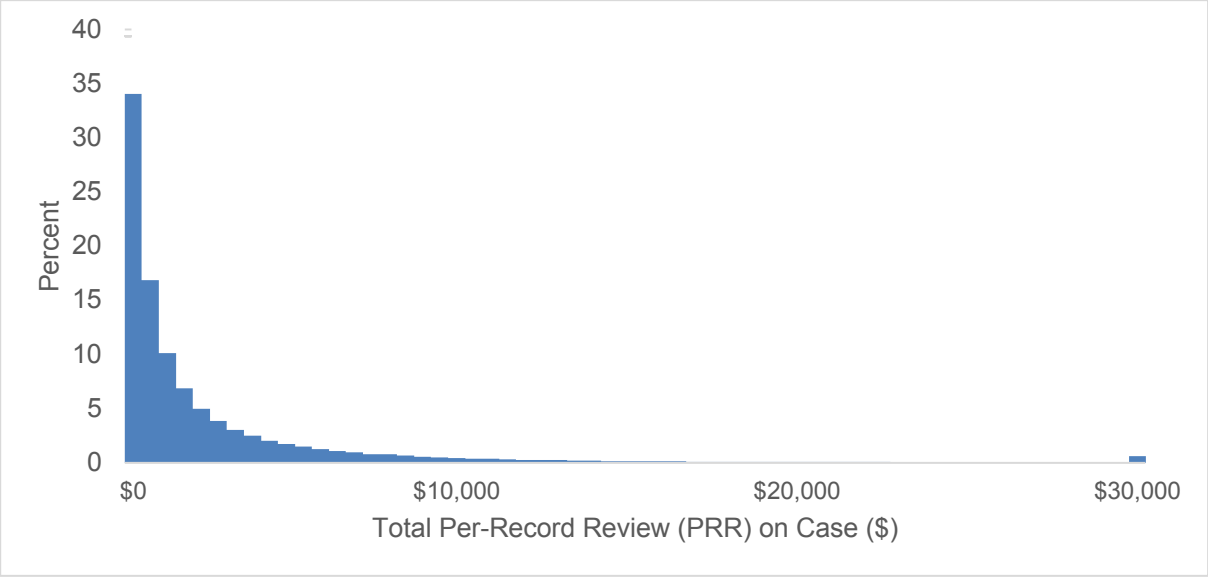
SOURCE: RAND analysis of WCIS and QME linked data.

Table D.12. Duration from Panel Assignment Date to QME Exam Date, by Specialty

Requested Specialty	Average Duration	% Within 90 Days	% Between 91–365 Days	% Over 1 Year	% With No QME Exam from Panel	N
Ortho & Musculoskeletal	132	24.6%	25.5%	2.4%	47.5%	280,242
Spine & Neurosurgery	130	27.7%	24.0%	2.6%	45.6%	34,271
Pain Medicine	138	19.6%	22.4%	2.3%	55.7%	39,125
Psych, Behavioral, Neuro	122	24.7%	21.4%	1.7%	52.2%	57,783
Chiro, Acupuncture, Occupational	138	14.8%	13.8%	1.7%	69.6%	34,127
Internal Medicine & Other	129	23.9%	22.9%	2.1%	51.1%	65,400

SOURCE: RAND analysis of WCIS and QME linked data.
NOTE: Durations reflect time elapsed between panel assignment and completed QME exam for panels issued from 2016 to 2023. N refers to the number of panels in each year. “No QME Exam from Panel” includes records where no matching QME identifier was found or where a match existed, but the exam occurred outside the panel assignment window (i.e., before the exam or after a subsequent panel assignment).

Figure D.7. Distribution of Per-Record Review Payments per Case, 2016–2024 Injury Dates



SOURCE: RAND analysis of WCIS data.
NOTE: N = 198,774 cases with 2016–2024 injury dates and 1 or more paid bills for per-record review. Paid amount per case top-coded at $30,000.

Abbreviations

AA	applicant's attorney
AAMC	Association of American Medical Colleges
AI	artificial intelligence
AMA	American Medical Association
AME	Agreed Medical Evaluator
CME	Continuing Medical Education
COLA	cost-of-living adjustment
COVID-19	coronavirus disease 2019
CWCI	California Workers' Compensation Institute
DA	defense attorney
DIME	Division Independent Medical Examiner or Examination
DIR	Department of Industrial Relations
DWC	Division of Workers' Compensation
EAMS	Electronic Adjudication Management System
EMA	Expert Medical Advisor
FROI	First Report of Injury
ICA	Industrial Commission of Arizona
IME	independent medical examination
IMR	independent medical review
IW	injured worker
JCN	Jurisdiction Claim Number
Med-Legal	Medical-Legal
MEI	Medicare Economic Index
MMC	medical management company
MMI	maximum medical improvement
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OMFS	Official Medical Fee Schedule
PQME	Panel Qualified Medical Evaluator
PTP	Primary Treating Physician
QME	Qualified Medical Evaluator
SB	Senate Bill
WCAB	Workers' Compensation Appeals Board
WCIRB	Workers' Compensation Insurance Rating Bureau
WCIS	Workers' Compensation Information System

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