

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	<p>Commenter is pleased that the division requires QME's to include both pre and post AMA report formats. Commenter also agrees on the specific guidelines on how to request Agreed panel QME's and that if it isn't done correctly the division will respond with specifics as to advise them why they were not in compliance and how to correct it.</p> <p>Commenter recommends that the course outline on report writing for QME's include addressing apportionment per SB-899.</p> <p>Commenter is concerned that a company fails to timely deny a claim a panel QME cannot be requested without a court finding that the presumption is rebuttal. This procedure delays the processing of the claim. Can you recommend a more expeditious process?</p>	J1	Tina Coakley Legislative Analyst The Boeing Company July 10, 2008 Written Comment	<p>Commenter's feedback on AMA report formats and Agreed panel QME's noted.</p> <p>Responses to general comment about apportionment per SB 899 (§ 11.5) and failure to timely deny a claim (§ 30) are provided in those sections below.</p>	None.
General Comment	<p>Commenter suggests a requirement that a QME swear on penalty of perjury that he/she uses any particular office at least 1 hour per month. Commenter contends that this would eliminate the most abusive 5-10% without harming the majority of physicians who are doing things honestly.</p>	G1	George Balfour MD President – CSIMS July 8, 2008 Written Comment	Rejected. For other reasons the Administrative Director withdrew and deleted the proposed section 17(c) on primary practice locations and will consider any change such as commenter suggests at a future time.	None.
General Comment	<p>Commenter requests clarification as to the change from "injured employee" to injured worker. Throughout the proposed regulations, existing paragraphs that contained the word "employee" were being switched to "worker."</p> <p>Commenter recommends being consistent with the Labor Code where "employee" is widely used. Labor Code §3351 defines employee which helps determine eligibility for workers' compensation benefits.</p>	O1	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Rejected. The existing regulation text used both phrases so the wording changes the commenter notes were being changed for consistency. Both phrases are clear enough for the regulated public to understand what is required to comply.	None.

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Forms – General Comment	<p>With the addition of "MPA Psychiatry – Pain Management" there are now five separate "MPA – Pain Management" codes in the list on Form 100. However, the list of specialties on Forms 105 and 106 include only the "macro" MPA classification. Thus, it would appear that when a worker (or the party having the right to name the specialty of the QME) designates "MPA" this list may contain physicians from each of the five categories included on Form 100.</p> <p>Commenter strongly recommends that all of these forms be revised to include separate three letter codes for each of the five separate pain medicine categories. This will allow the worker, or the party having the right to name the specialty, to specify which of these categories is requested. The alternative is that the assigned panel may not include the desired category. Either alternative violates the intent of the statute which is to give the worker, or in certain circumstances the claim adjuster, the right to select the specialty of the evaluating physician.</p>	N9	Susan Borg, President California Applicants’ Attorneys Association July 10, 2008 Written Comment	&&&Rejected. See discussion on this issue below under Forms 105 and 106.	None.
Section 1 (d)	<p>1) For subdivision (d), commenter strongly recommends that the phrase “or if none the Employer” be deleted. If an Employer is self-insured and self-administered it is a Claims Administrator as provided in the definition in subdivision (k). Likewise, if the Employer is self – insured and using a TPA, the TPA is the Claims Administrator. Finally if the Employer is insured, the Insurer is the Claims Administrator as set forth in the definition of Claims Administrator in subdivision (k).</p> <p>2) Additionally, this subdivision (d) allows for a 25 percent increase in the fee, commensurate with that of an AME. Commenter strongly objects to the expansion of this bonus to yet another group as he sees no difference in work responsibilities of a QME, an Agreed Panel QME, or an AME. Further, requiring a 25 percent increase in</p>	II	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	1) Rejected. The phrase, “, if none the employer,” following “claims administrator” clearly distinguishes the two. Mr. Suchil’s comments do not address those instances in which it is the employer who must act because there is no ‘claims administrator’, such as a claim made against an uninsured employer. Until the Uninsured Employers Benefits Trust Fund (UEBTF) has been joined in a case, the employer is	1) None. 2) None. 3) None.

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	<p>the fee may well act as a disincentive to pursuing that agreement.</p> <p>3) The language “Claims Administrator, or if none the employer”, found throughout these regulations and forms could be misinterpreted to imply that an insured employer must comply with the many duties of it Insurer. This provision should be removed in subdivision (d) as well as in the following locations: Section 1(f), Section 10(f), Section 30(d)(1) through (4), Section 31.5(a)(7), Section 34(a) and (d), Section 35(a) and (a)(4) and (c), Section 36(b), Section 36.5(a)(5), Section 41(c)(4) and (8), Section 41.5(f) and (g), Section 43(b), Section 44(b), Section 45(b), Section 46(b), Section 46.1(b) and in Forms 105, 106, 111 and 120.</p>			<p>responsible for providing any benefits claimed. Often joinder of UEBTF does not occur until months after the claim form is filed and sometimes even a month or more after an application for adjudication has been filed. This wording is needed to be consistent with the language in the Labor Code which places the legal obligations to comply with and provide workers’ compensation benefits on the employer.</p> <p>2) Rejected. Labor Code 4062.2(c), as amended by SB 899, requires parties in a represented case to attempt to agree on a QME named on a panel letter to serve as an agreed medical evaluator (AME). Once the parties reach agreement to use an Agreed Medical Evaluator (i.e. one evaluator selected jointly by parties in a represented case), that a physician whether selected from a QME panel list as specified by the Legislature in Labor Code § 4062.2(c) or selected prior to, and without the need to request, a panel as described under Labor Code</p>	

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				<p>§ 4062.2(b), the evaluator is serving in an AME capacity in a disputed case. Based on the agreement, the parties are committing to be bound by the practices associated with AMEs. The physician should be paid accordingly under the medical/legal fee schedule, in section 9795 of Title 8.</p> <p>3) Rejected. Proposed section 1(k) "Claims Administrator" clearly stated: "Claims administrator" means <i>the person or entity responsible for the payment of compensation for any of the following...</i> Therefore, after the words "claims administrator" appear in a regulation, the phrase "if none the employer" is needed to provide the specific direction to the employer by removing any doubt about the employer's liability and responsibility to act when no claims administrator is administering workers' compensation claims.</p>	
Section 1(d)	<p>Commenter recommends the following language:</p> <p>(d) "Agreed Panel QME" means the Qualified Medical Evaluator described in Labor Code section 4062.2(c), that the claims administrator,</p>	L1	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel &	Rejected. An unlawfully, uninsured employer is not included in the definition of a claims administrator in subdivision 1(k), now	<p>Subdivision 1 (d) is being amended to provide:</p> <p><b><u>(d) "Agreed Panel QME" means the Qualified</u></b></p>

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	<p><del>or if none the employer</del>, and a represented employee agree upon and select from a QME panel list issued by the Medical Director. An Agreed Panel QME shall <u>not</u> be entitled to use modifier “-94” as defined in subdivision 9795(d) of Title 8 of the California Code of Regulations for medical/legal evaluation services.</p> <p>If the Division declines to accept this recommendation and decides to permit an increased reimbursement for an agreed panel QME, CWCI recommends reducing the increase to 10% and designating a new Modifier to identify agreed panel QMEs.</p> <p>Also see comment for Section 30(a).</p> <p>As currently written, the definitions of “agreed panel QME” will result in 25% more reimbursement for an agreed panel QME than for a panel QME, even though the work is identical. Claims administrators may be reluctant to further raise costs and may therefore decline to agree on a panel QMEs. CWCI believes it is better to remove such a disincentive that may result in fewer agreed panel QMEs. CWCI urges the Division to revise the language to clarify that an agreed panel QME may not use modifier -94.</p> <p>If the Division decides to permit an increased reimbursement for an agreed panel QME, the increase needs to be lowered to 10% to reduce unnecessary cost increases; and a new modifier will be necessary to distinguish services and their costs by agreed panel QMEs from AMEs. If there is no separate modifier, valuable research data will be lost because agreed panel QME panel data will be intermingled with AME data.</p>		<p>Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments</p>	<p>renumbered 1(j). It is highly unlikely that such an employer would have a claims administrator. However, there is some inconsistency in the way the phrase is punctuated so that is being corrected.</p> <p>In reference to commenter’s concern about data loss unless a separate identifier is used, the Administrative Director has decided to edit the proposed wording to remove the reference to an identifier. A separate identifier will be addressed in a future rulemaking to amend section 9795 of Title 8.</p>	<p><b><u>Medical Evaluator described in Labor Code section 4062.2(c), that the claims administrator, or if none the employer, and a represented employee agree upon and select from a QME panel list issued by the Medical Director without using the striking process. An Agreed Panel QME shall be entitled to be paid at the same rate as an Agreed Medical Evaluator under <del>use modifier “-94” as defined in subdivision 9795(d)</del> section 9795 of Title 8 of the California Code of Regulations for medical/legal evaluation <del>services</del> procedures and medical testimony.</u></b></p>
Section 1(f)	Commenter recommends deleting the extraneous “s” in	O2	Marie W. Wardell	Accepted and done.	Subdivision 1(f) has been

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	the sentence: "...and a represented employees to resolve disputed..."		Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment		amended to correct this as follows: "...employees..."
Section 1(k)	In subdivision (k), commenter recommends deleting "and insured employer". If the Employer is insured, their Insurer is the Claims Administrator. Adding "an insured employer" has the potential for creating confusion as to who is responsible for the duties of the Claims Administrator in this relationship. It could also potentially require an insured employer to be subject to the Department of Insurance's requirements for certification of all Claims Administrators.	I2	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	Proposed section 1(k) clearly states: "Claims administrator" means <i>the person or entity responsible for the payment of compensation for any of the following...</i>	None.
Section 1(bb) and Section 32(a)	<p>As an acupuncturist QME during the last few years, commenter has been selected to address all issues including disability for injured workers. All parties have been satisfied with the reports I he has written. Commenter states that the education background for acupuncturists is getting more solid and AMA guides are strictly followed when evaluating disability. Commenter feels very competent when rating the impairment.</p> <p>Commenter requests that the division consider removing the limitation for acupuncturist QME to evaluate disability. This rule</p> <ol style="list-style-type: none"> <li>1. discourages the profession's growth and development,</li> <li>2. delays the process of QME report writing</li> <li>3. increases the cost of med-legal aspect for the employers.</li> </ol>	K1	Frank He, L.Ac., QME Integrative & Sports Medicine Center July 10, 2008 Written Comment	Rejected. Commenter's suggestion would require a legislative change, since Labor Code section 3209.2(e) provides: "(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of chapter 2 of Part 2 or under Section 2708 of the Unemployment Insurance Code."	None.
Section 10(b)	Commenter appreciates the modification to this section,	I3	Steven Suchil	Rejected. In some cases, the	Subdivision 10(b) has been

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	but it should clearly state that the physician will not be eligible to be placed on a panel until the suspension or probation has been successfully completed. Suspension and probation are punishments placed by the licensing body and he does not believe these punishments should be mitigated by another entity.		Assistant Vice President American Insurance Association July 10, 2008 Written Comment	terms of probation imposed by a licensing body allow the physician to continue practicing and treating patients. The Administrative Director has amended the wording in the section to clarify the process to be used, in compliance with the provisions of Labor Code § 139.2(m).	amended as follows: <u>(b) The Administrative Director may deny appointment or reappointment to any physician who has performed a QME evaluation or examination without valid QME certification at the time of examining the injured employee worker or the time of signing the initial or follow-up evaluation report. An applicant who is currently serving a period of probation imposed by the applicant's professional licensing agency shall be denied appointment as a QME until the applicant's professional license is unrestricted.</u> An applicant serving a period of probation imposed by the applicant's professional licensing <i>board or</i> agency may be allowed to take the QME examination while on probationary license status, <u>as long as the probationary status is scheduled to terminate within twelve (12) months of the date of the QME</u>

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					<p><del>examination and the applicant is otherwise deemed eligible by the Administrative Director. Applications for appointment or reappointment from physicians who are on probationary license status with a California licensing board or agency while the QME application is pending shall be reviewed by the Medical Director on a case-by-case basis consistent with the provisions of Labor Code section 139.2(m).</del></p>
Section 11(f)(8)	<p>Commenter recommends the following language:</p> <p>(8) Any applicant, who upon good cause shown by the test administrator, is suspected of cheating may be disqualified from the examination and, upon a finding that the applicant did cheat in that exam, the applicant will be denied further admittance to any QME examination <del>for a period of at least five years thereafter.</del></p> <p>An applicant, who is found to be cheating, should forfeit his or her opportunity to conduct evaluations in the workers' compensation system.</p>	L2	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Rejected. A five year bar on eligibility to take the competency exam, which a physician must pass prior to being appointed as a QME, is sufficient.	None.
Section 13	<p>Commenter recommends the following language:</p> <p>A physician's specialty(ies) is one for which the</p>	L25	Brenda Ramirez Claims and Medical Director	Rejected. The language the commenter seeks to delete would conflict with wording	None.

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	<p>physician is board certified or, <del>one for which a medical doctor or doctor of osteopathy is board certified has completed a postgraduate specialty training as defined in Section 11(a)(2)(A),</del> or held an appointment as a QME in that specialty on June 30, 2000, pursuant to Labor Code Section 139.2. To be listed as a QME in a particular specialty, the physician's licensing board must recognize the designated specialty board and the applicant for QME status must have provided to the Administrative Director documentation from the relevant board of certification or qualification.</p> <p>To ensure a high professional standard for injured workers in California, commenter recommends the Division require a physician to be board certified in a specialty in order to be listed as a QME in that specialty. Medical legal assessments are now based on a single well qualified medical evaluator assigned by the Division or selected by the parties. Since there is no opportunity for either the employer or the injured worker to rebut that physician's opinion with a stronger, more knowledgeable medical opinion, a competent, well reasoned, and comprehensive medical legal report is essential to the fair administration of the workers' compensation system.</p> <p>If the Division declines to accept this recommendation, commenter recommends identifying those QMEs that are board certified on the panel issued to injured employees. In addition, CWCI recommends that the Division compare the performance of board certified and non-board certified QMEs in future Labor Code section 139.2(i) annual reports so that this issue can be reconsidered based on performance results in the future.</p>		<p>Michael McClain General Counsel &amp; Vice President California Workers' Compensation Institute July 10, 2008 Written Comments</p>	<p>in Labor Code § 139.2(b)(3)(B) wherein the Legislature provided that medical doctors and doctors of osteopathy who completed ACGME accredited residency programs should be appointed as QMEs. Labor Code § 139.2(b)(3)(B) provides in pertinent part:</p> <p>“(b) The administrative director shall appoint...as a qualified medical evaluator a physician...who is licensed in this state and who demonstrates he or she meets...and if the physician is a medical doctor (or) doctor of osteopathy....also meets the applicable requirements in paragraph (3)...:</p> <p>(3) Is a medical doctor or doctor of osteopathy and meets <i>one</i> of the following requirements:</p> <p>(A) Is board certified...</p> <p>(B) Has successfully completed a residency training program accredited by the American College of Graduate Medical Education or the osteopathic equivalent...”</p>	

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				The ACGME (American College of Graduate Medical Education) changed its name to the Accreditation Council for Graduate Medical Education after this subdivision was enacted.	
Sections 12 and 13	<p>It is commenter's position that DWC continues to lack authority to promulgate the regulation as proposed. The addition of Labor Code sections 139.4, 139.43 and 139.45 as legal authorities for the regulation and the Business and Professions Code section 651(i) as Reference is not sufficient to overcome the lack of statutory authority.</p> <p>California Business and Professions Code Section 651(h)(5)(A) pointedly authorizes licensed health care professionals, including doctors of chiropractic, to advertise specialty designations. In fact, the statute imposes no qualifications or restrictions on a doctor of chiropractic's authority to so advertise, unlike the way the statute operates with respect to other health care professionals such as medical doctors, optometrists, dentists, and podiatrists, whose ability to use designations is circumscribed by special statutory restrictions.</p> <p>The Board of Chiropractic Examiners (BCE) does not have authority to limit on a categorical basis which boards the BCE will recognize. The BCE has no authority to restrict the use of specialty designations. Any effort to do so would be inconsistent with the statutory provisions that do not impose any restrictions on the use of designations pertinent to doctors of chiropractic. The BCE has no authority to enlarge or restrict the statutes.</p>	F1	David Benevento President California Chiropractic Association July 8, 2008 Written Comment	<p>Rejected . The authority of the Administrative Director to adopt regulations pertaining the doctors of chiropractic seeking appointment and reappointment as qualified medical evaluators is clear from Labor Code §§ 133, 139.2 and 5307.3.</p> <p>Labor Code § 133 provides, in pertinent part, "The Division of Workers' Compensation, including the administrative director...shall have power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it under this code." Labor Code § 139.2 in various subdivisions directs the Administrative Director to adopt regulations governing aspects of QME</p>	None.

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	<p>Rather, it is the province of the Legislature to govern the use of specialty designations.</p> <p>Moreover, a doctor of chiropractic's right to advertise specialty designations is constitutionally protected commercial speech. Even the Legislature, much less the DWC, could not restrict the use of specialty designations unless it shows a substantial state interest lest it would violate the United States Constitution.</p> <p>To be sure, the BCE itself does not restrict a chiropractor's use of specialty designations by policy in any way. Still, the BCE may pursue an enforcement action to restrict the use of a particular designation that the BCE deems actually misleading as applied in a specific case, but such an action must comport with the constitutional protections and the statutory authority. However, even the BCE itself has no authority to restrict the use of a particular designation unless the BCE provides a strong evidentiary case that the use of the particular designation is misleading to the public.</p> <p>In summary, it is commenter's position that the DWC does not have the authority to impose a condition that the BCE itself cannot impose. More specifically, the DWC does not have the authority to adopt a regulation to preclude a doctor of chiropractic from serving as a QME in a specialty area unless the BCE recognizes the board that conferred the specialty designation. Given the foregoing, CCA respectfully request the DWC keep Sections 12 and 13 intact as they currently exist.</p>			<p>functions in the workers' compensation system. Labor Code § 5307.3 provides, in pertinent part, "The Administrative Director may adopt, amend or repeal any rules and regulations that are reasonably necessary to enforce this division, except where this power is specifically reserved to the appeals board or the court administrator."</p> <p>In reference to advertising by evaluators in the workers' compensation system, the authority of the Administrative Director to adopt regulations is expressly stated in Labor Code §§ 139.4 and 139.45.</p> <p>Business and Professions Code section 651(i) provides in pertinent part, "Each of the healing arts boards <i>and examining committees within Division 2</i> shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code."</p>	

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				<p>(emphasis added). The Board of Chiropractic Examiners in California is such an examining committee. Licensure of doctors of chiropractic stems from the Chiropractic Act, an initiative measure approved by the voters in 1922. (See Bus. &amp; Prof. Code, § 1000; Historical and Statutory Notes, 3A, Pt. 1, West’s Ann. Bus. &amp; Prof. Code (2003 ed.) foll. § 1000-1, p. 424.)(See, also <i>Tain v State Bd. Chiropractic Examiners</i> (2005) 130 Cal. App. 4<sup>th</sup> 609, 618; 30 Cal. Rptr. 3d 330, review denied 2005 Cal. LEXIS 10509 (Sept. 21, 2005).</p> <p>The reference to this Business and Professions Code section was added to comply with that statute, since in the view of the Administrative Director, it applies to the Board of Chiropractic Examiners, which is the “examining committee” in California with the exclusive jurisdiction to license and regulate the treatment practice of doctors of</p>	

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				<p>chiropractic, who are “licensed.... <i>under any initiative act</i>” within the meaning of Business and Profession Code section 651(a). By the express wording of section 651(i) of the Business and Professions Code, quoted above, the authority to adopt regulations governing use of the term ‘board certified’ rests solely with the licensing boards and examining committees under Division 2 of the Business and Profession Code.</p> <p>Accordingly, the Administrative Director disagrees with commenter’s arguments about the authority of the Board of Chiropractic Examiners, in this regard. Until that body which has authority under Business and Professions Code section 651(i) takes action to address which if any post-graduate specialty programs are medically and educationally sufficient to enable its licensees to state and advertise that they are ‘board certified’ in a given subspecialty, the Administrative Director</p>	

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				<p>desires to avoid a conflict in regulations on this issue.</p> <p>Labor Code 139.2(b)(4)(A) provides only that the Administrative Director shall appoint, as QMEs, any doctor of chiropractic who provides evidence of completion of a chiropractic postgraduate specialty program of a minimum of 300 hours. It does not direct or authorize the Administrative Director to perform the functions of a medical licensing board in California under Business and Professions Code 651 to determine which specialty boards for that medical area of practice should be recognized for the purposes of allowing licensees to use the term 'board certified' under that Code. That authority is clearly left to the medical licensing boards and examining committees in California by the provisions of section 651(i).</p> <p>As specified in proposed section 12 in this rulemaking, once the licensing board for California doctors of chiropractic recognizes</p>	

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				specialty boards, the Administrative Director shall recognize those boards for the purposes of being listed in a specialty as a QME.	
Section 12 and 13	<p>On May 22, 2008, during public session, commenter's Board unanimously voted to initiate rulemaking proceedings to formally recognize chiropractic specialties. The Board directed its staff to take the necessary steps to develop proposed regulatory language for the Board's review and approval. It is anticipated that staff will present the proposed regulatory language to the Board at its next public meeting scheduled for July 30 – 31, 2008.</p> <p>The commenter's Board believes that recognizing chiropractic specialties provides additional choices to injured workers and enhances consumer protection. Injured workers should not be deprived of selecting chiropractic specialists as Qualified Medical Evaluators.</p> <p>In light of the above, commenter respectfully requests that the division defer action on eliminating chiropractic specialties pending the outcome of his rulemaking package that will recognize chiropractic specialties.</p>	C1	<p>Frederick N. Lerner, D.C. Board Chair Board of Chiropractic Examiners June 26, 2008 Written Comment</p>	<p>Comment noted. However, the Administrative Director rejects the request to defer the proposed action in this rulemaking. The rules proposed in sections 12 and 13 are necessary and appropriate to be consistent with the Labor Code, the Business and Professions Code and to clearly define the criteria the Administrative Director will use to recognize specialties for a QME once the appropriate California licensing board for the physician has done so.</p>	None.
Sections 12 and 13	<p>In the 15 day revision, the division has offered additional authority and reference under notes in what appears to be an attempt to address the California Chiropractic Association's (CCA) arguments that the division lacks authority to limit advertising. Commenter is confused about why the division listed LC 139.45 as Authority and B&amp;P 651(i) as Reference. 139.45 specifically exempts physicians so it shouldn't apply and 651(i) appears to allow advertising if the licensing board doesn't object within a certain time frame, which would actually allow chiropractic</p>	D1	<p>Kristine Shultz Government Affairs Director California Chiropractic Association July 1, 2008 Written Comment</p>	<p>Rejected. Section 139.45 of the Labor Code does not exempt physicians. Further, for the reasons stated in response to commenter Benevento, above, the Administrative Director interprets Business and Professions Code section 651(i) to place the authority</p>	<p>The reference to Labor Code section 139.43, under Authority, shall be stricken. No other action is necessary.</p>

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	<p>specialties because they probably have been deemed to be approved since the use of specialties is clearly being allowed now. Why were these sections included?</p> <p>Commenter has been informed that the DWC thinks chiropractic specialties are misleading to injured workers. Commenter is trying to determine if there is any evidence of that or how the division came to that conclusion?</p>			<p>for adopting such regulations with the Board of Chiropractic Examiners, not the Administrative Director.</p> <p>The Administrative Director has expressed concern to individual doctors of chiropractic who also are QMEs about proposed letterhead and business card wording using terms such as “Board Certified Chiropractic Orthopedist”, as being confusing or misleading to the public, especially in view of existing legal opinions, the wording of Business and Professions Code 651 and the fact that the Board of Chiropractic Examiners had not recognized any post graduate specialty training programs for the purposes of using the term ‘board certified’.</p>	
Section 17	With respect to the \$100.00 additional fee in this subdivision, commenter suggests that the fee be increased. The Division has found it difficult to curtail the number of locations claimed by a QME, and an increase in the additional office fee could provide a financial disincentive to add extra offices.	I4	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	Rejected. The Administrative Director is not convinced that an increased fee will act as a disincentive. Moreover, a fee cannot be confiscatory and must bear some relationship to the purposes for which it is assessed.	None.

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Section 17(b)	<p>Consider increasing the annual QME fees for listing additional office locations to \$500 for more than 2 locations and to \$1,000 for more than 5 locations.</p> <p>Some QMEs who perform evaluations at only one or two locations say they have left, or will leave, the QME system because QME business is being taken disproportionately by QMEs manipulating the system by listing multiple locations to boost their frequency in the “random” selections. Raising the fees according to the number of office locations may reduce the incentive for such behavior and make it more attractive for single location QMEs to remain in the system.</p>	L3	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	Rejected. The Administrative Director is not convinced that an increased fee will act as a disincentive. Moreover, a fee increased to the level suggested could be found confiscatory.	None.
Section 30(a)	<p><b>Commenter recommends the following language for this section and elsewhere:</b></p> <p>The claims administrator (<del>or if none the employer</del>) shall provide Form 105 along with the Attachment to Form 105 (How to Request a Qualified Medical Evaluator if you do not have an Attorney) to the unrepresented employee by means of personal delivery or by first class or certified mailing...</p> <p>There is no claim without a claims administrator. A self-administered self-insured employer is encompassed in the claims administrator definition. This language will create confusion because it suggests that an employer that is not a claims administrator may have a role to play in this process. This and similar language needs to be revised wherever it occurs in these proposed regulations and forms.</p>	L4	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	Rejected for the reasons stated above in regard to section 1(k), now re-lettered as 1(j). An unlawfully, uninsured employer is not included in the definition of a claims administrator, and it is highly unlikely that such an employer would have a claims administrator.	None.
Section 30(b)	<p>Commenter recommends the following language:</p> <p>(b) Represented cases. Requests for a QME panel in a represented case, for all cases with a</p>	L5	Brenda Ramirez Claims and Medical Director Michael McClain	Rejected. Labor Code § 4062.2 provides, in pertinent part:	None.

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	<p>date of injury on or after January 1, 2005, and for all other cases where represented parties agree to obtain a panel of Qualified Medical Evaluators pursuant to the process in Labor Code section 4062.2, shall be submitted on the form in section 106 (Request for a QME Panel under Labor Code Section 4062.2) (See, 8 Cal. Code Regs. § 106). The party requesting a QME panel shall: 1) identify the disputed issue that requires a comprehensive medical/legal report to be resolved; 2) <del>attach a copy of the written proposal, naming one or more physicians to be an Agreed Medical Evaluator, that was sent to the opposing party once the dispute arose</del> 3) designate a specialty for the QME panel requested; 4) state the specialty preferred by the opposing party, if known; and 5) state the specialty of the treating physician. In represented cases with dates of injury prior to January 1, 2005, and only upon the parties' agreement to obtain a QME panel pursuant to Labor Code section 4062.2, the party requesting a QME panel shall submit QME Form 106 in compliance with this section <del>and provide written evidence of the parties' agreement. Once such a panel request in a represented case with a date of injury prior to January 1, 2005 is issued, the parties shall be bound by the timelines and process as described in Labor Code section 4062.2.</del></p> <p>Labor Code section 4062.2(b) permits ("may"), but does not require a written request naming at least one physician.</p>		<p>General Counsel &amp; Vice President California Workers' Compensation Institute July 10, 2008 Written Comments</p>	<p>"(a) Whenever a comprehensive medical evaluation is required to resolve any dispute arising out of an injury or a claim injury occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation shall be obtained only as provided in this section. (b) If either party requests a medical evaluation pursuant to Labor Code sections 4060, 4061 or 4062, either party <i>may commence</i> the selection process for an agreed medical evaluator by making <i>a written request naming at least one proposed physician to be the evaluator....If no agreement is reached with 10 days of the first written proposal</i> that names a proposed agreed medical evaluator...either party may request the assignment of a three-member panel of qualified medical evaluators..."</p> <p>Use of the words 'may commence' are descriptive of the manner in which the parties must satisfy the precondition to obtaining a</p>	

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				QME panel, i.e. exchanging written proposals for AMEs that name one or more physicians. From the wording of the 3 <sup>rd</sup> sentence of section 4062.2(b), it is clear that the Legislature required written proposals to be made, since the timeline for the 'race' between the parties to submit the first QME panel request is conditioned on the <b>date</b> of the first written proposal.	
Section 30(b)	<p>Commenter recommends removing the comma after "2005" and moving it after the word "issued" as follows:</p> <p>“...prior to January 1, 2005 is issued, the parties shall be bound by the timelines and process as described in Labor Code section 4062.2.”</p>	O3	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Rejected. It is appropriate punctuation after a year stated in numbers.	None.
Section 30(f)	<p>Commenter appreciates that fact that the Division has tried to address the problem of multiple office locations for QMEs. In the proposed regulations released through the DWC Forum there was a proposal to limit physicians to offices within a 30 mile radius, while in the original regulations proposed for adoption there was a proposal to identify and give more weight to "primary practice locations." However, in the current modified proposal there is no mechanism for prohibiting or even limiting this problem. While commenter recognizes that there were problems with both of the proposed solutions, commenter strongly urges the Division not to simply ignore this problem. Waiting to adopt the "perfect" solution will only make the problem worse by further discouraging potential QMEs from applying for the</p>	N1	Susan Borg, President California Applicants' Attorneys Association July 10, 2008 Written Comment	Accepted in part.	The proposed regulatory language in sections 1, 17 and 30(f) pertaining to primary practice locations is being deleted. The Administrative Director is not satisfied the earlier proposal is the proper solution.

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	<p>necessary certification.</p> <p>Commenter believes that the Division has sufficient authority to adopt rules that will ensure that the process of assigning QME panels is a true "random selection method." One possibility is to simply limit the number of locations that an individual physician can list. Any such limitation could be accompanied by an exception allowing additional locations to be listed where it is found necessary to provide access, for example in some rural areas of the state.</p> <p>Another possibility is to adopt a sliding scale of fees for listing additional offices. As proposed in these regulations a physician can list an unlimited number of offices for the fixed additional fee of \$100 each. This fee schedule could be revised to provide that the first 4 additional offices will be charged a fee of \$100 each, the next 5 a fee of \$500 each, the next 5 a fee of \$1,000 each, and so on. Such a graduated fee schedule should have little or no impact on those physicians that legitimately maintain multiple practice locations, but would help discourage the current practice of listing phantom offices merely to increase the odds of being selected.</p> <p>At the very least, commenter recommends that the Division go back to the original proposed language and adopt a weighting process that gives preference to those offices in which the physician actually practices medicine.</p>				
Section 30(d)(4)	<p>Commenter opposes the requirement that the administrator must get a finding and order from a WCALJ before requesting a QME panel on AOE/COE issues. There are situations where because of either oversight, lack of cooperation from the injured worker or</p>	B1	Janet Selby Workers' Compensation Manager Municipal Pooling	Rejected. Since being enacted in 1989, the wording, now in Labor Code section 5402(b), that provides if liability for a claim is not	None. Other minor wording changes have been made to improve syntax and clarity.

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	<p>new evidence not obtainable within the 90 days, an administrator is not in a position to request a QME panel within the 90 days. Despite the showing of reasonable cause, a WCALJ may disagree and deny the request to obtain a QME panel. The administrator/employer would then have to litigate the issue at considerable expense. Ultimately, the ability to get an admissible medical-legal opinion necessary to dispute liability for an injury is in question and this may become a due process issue. And the overall administration of benefits would be delayed during this litigation, which would not serve the interests of anyone. Commenter suggests striking this subdivision entirely.</p>		<p>Authority June 25, 2008 Written Comment</p>	<p>rejected within 90 days of receipt of the claim, the injury is presumed compensable and can be rebutted only by evidence discovered subsequent to the 90 day period, has applied to workers' compensation cases with dates of injury on or after January 1, 1990. (1989 Stats. Ch. 893 § 6.) Once the presumption has attached due to a defendant claims administrator's failure to accept or deny a claim within the 90 day period, any dispute about whether the presumption has been rebutted is one that only a Workers' Compensation Administrative Law Judge may decide.</p> <p>Under Labor Code sections 5402 and 4060, the Legislature provided 90 days for the defendant claims administrator to investigate the claim including the option to obtain a comprehensive medical-legal examination to determine compensability. In practice, either the defendant claims administrator will rely on the treating physician's</p>	

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				<p>determination of work-relatedness, or if defendant disagrees with that determination, defendant has up to 90 days to obtain a QME evaluation on the compensability issue.</p> <p>When an injured worker fails or declines to cooperate with a defendant's request to attend an exam with a QME or AME, the defendant claims administrator may petition a Workers' Compensation Administrative Law Judge for an order to suspend medical and indemnity benefits under Labor Code § 4053.</p> <p>For these reasons, the Administrative Director is satisfied that the wording of subdivision 30(d)(4) protects the rights of both injured workers and defendant claims administrators, or if none of employers, to a fair process for determining compensability as well as avoiding delay in the administration of claims and benefits.</p>	

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Section 31(c)	This subdivision provides that where a primary treating physician or secondary physician appears on a panel, that physician must notify the parties of this reason for disqualifying him or herself. This should be amended because as a practical matter that physician will not know if he or she is on such the QME list. The parties, or their attorneys, will know if one of the listed names is the treating or a secondary physician, and should have the responsibility for notifying the medical director and requesting a replacement.	N2	Susan Borg, President California Applicants' Attorneys Association July 10, 2008 Written Comment	Agree.	<p><del>(d e)</del> Any physician who has served as a primary treating physician or secondary physician and who has provided treatment <u>to the employee</u> in accordance with section <del>9785.5</del> <u>9785</u> <del>this</del> <u>Title 8</u> of the California Code of Regulations for <del>this</del> <u>the</u> <del>disputed</del> injury <del>for an unrepresented employee</del> shall not perform a QME evaluation on that employee. <del>If</del> <u>Whenever</u> that <del>physician</del> <u>QME physician's name</u> appears on a QME panel, he or she shall <del>notify both parties of this reason for disqualifying him or herself, and if contacted by a party to perform the evaluation, the employee the panel requestor either</del> <u>Either party</u> may request a replacement QME <u>for this reason</u> pursuant to section 31.5 of Title 8 of the California Code of Regulations.</p>
Section 31.3	<p>Commenter requests that the Division add the timeframes for the QME appointment process.</p> <p>Delete the prohibition against a claims administrator</p>	L6	Brenda Ramirez Claims and Medical Director Michael McClain	Accepted in part. Agree to add language referring to timeframes as provided in Labor Code § 4062.1(b) and	Subdivisions 31.3(a) and 31.3(c) have been amended to add as follows:

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	<p>discussing the selection of the QME with an unrepresented worker.</p> <p>It will be helpful for the description of the QME appointment process to include the timeframes.</p> <p>There is no statutory authority for prohibiting the claims administrator from discussing or answering questions about the selection of the QME with an injured employee. It is not helpful to the injured worker and creates frustration and unnecessary delay.</p>		<p>General Counsel &amp; Vice President California Workers' Compensation Institute July 10, 2008 Written Comments</p>	<p>(c).” Rejected commenter’s suggestion to delete subdivision 31.3(b) prohibition against a claims administrator discussing the selection of the QME with an unrepresented worker. This prohibition existed prior to this rulemaking and the Administrative Director believes the protection against undue influence should be maintained.</p>	<p>(a) When the employee is not represented by an attorney, the unrepresented employee shall, <u>within ten (10) days of having been furnished with the form</u>, select a QME from the panel list....”</p> <p>“(c) If, <u>within ten (10) days of the issuance of a QME panel</u>, the unrepresented employee fails to select a QME...”</p>
Section 31.3(c)	<p>Commenter recommends providing a time certain when the Claims Administrator can take charge of choosing the QME and setting the appointment.</p>	I6	<p>Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment</p>	Accepted.	<p>See amended language in section 31.3(a) and (c), above.</p>
Section 31.3(a)	<p>Commenter suggests including the time period within which the injured employee has to choose the QME and make the appointment.</p>	I5	<p>Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment</p>	Accepted.	<p>See amended language in section 31.3(a) and (c), above.</p>
Section 31.5(a)(11)	<p>The first sentence in this paragraph refers to a violation of Section 34 (Appointment Notification by the QME). However, the new second sentence refers to failure to object to an evaluator’s report within 15 days of the date the report was served. There appears to be no connection</p>	N3	<p>Susan Borg, President California Applicants’ Attorneys Association July 10, 2008 Written Comment</p>	Accepted in part.	<p>The proposed second sentence of subdivision 31.5(a)(11) has been stricken, and the subdivision reworded for clarity, as</p>

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	between these two sentences.				<p>follows:</p> <p><del>(5 40 11) Any violation of</del> <b><u>The evaluator has violated</u></b> section 34 (Appointment Notification <del>by the QME, and</del> <b><u>Cancellation</u></b>) of Title 8 of the California Code of Regulations <del>Failure by a party to object to an evaluator's report within fifteen (15) days of the date the report was served by the evaluator on the grounds of a violation of section 34 shall be deemed a waiver of the objection, unless otherwise ordered by a Workers' Compensation Administrative Law Judge, except that the evaluator will not be replaced for this reason whenever the request for a replacement by a party is made more than fifteen (15) calendar days from either the date the party became aware of the violation of section 34 of Title 8 of the California Code of Regulations or the date the report was served by the evaluator, whichever is earlier.</del></p>

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Section 31.5(a)(12)	<p>Commenter recommends the following amendment to the first sentence in 31.5(a)(12):</p> <p>... and the party <del>asking</del> <u>requesting</u> for the replacement <del>requested</del> objected to the report on the grounds of lateness prior to the date the evaluator served the report.</p>	O4	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accepted.	The requested changes have been made.
Section 31.5(a)(13)	<p>Commenter recommends adding the word "in" the sentence in 31.5(a)(13):</p> <p>The QME has a disqualifying conflict of interest as defined <u>in</u> section 41.5 of Title 8 of the California Code of Regulations.</p>	O5	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accepted.	The requested change has been made.
Section 31.5(a)(15)	<p>New language in this paragraph allows the parties to request a replacement QME if the evaluator "fails" to provide a complete medical evaluation. Commenter believes this word should be deleted as it is vague and will cause unnecessary litigation resulting in added delay and higher costs. What constitutes "failure?" In many cases one or both parties will ask the evaluator to clarify certain issues or to discuss an issue that may not have been raised in the initial report. Does that constitute "failure" and disqualify that evaluator? Commenter believes this paragraph should allow a request for replacement only where the evaluator <u>refuses</u> to provide a complete medical evaluation.</p>	N4	Susan Borg, President California Applicants' Attorneys Association July 10, 2008 Written Comment	Accepted in part.	<p>The subdivision has been amended for clarity, as follows:</p> <p><del>(14 15) Failure or refusal of the</del> <b><u>The</u></b> selected medical evaluator, who <del>is</del> otherwise <b><u>appears to be</u></b> qualified and competent to address all disputed medical issues <del>from all inquiries reported on one or more claims from prior to the initial evaluation, fails or</del> <b><u>refuses</u></b> to provide, <b><u>when requested by a party or by the Medical Director,</u></b> <b><u>either: A)</u></b> a complete medical evaluation as provided in Labor Code sections 4062.3(i) <b><u>and 4062.3(j), or B) a written</u></b></p>

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					<p><b><u>statement that explains why the evaluator believes he or she is not medically qualified or medically competent to address one or more issues in dispute in the case.</u></b></p> <p>Evaluators are required by Labor Code section 4062.3(i), in pertinent part, to “address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee’s initial appointment with the medical evaluator.” Labor Code section 4062.3(j) provides, in pertinent part, that “If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.”</p> <p>However, from experience of the parties and the Administrative Director, at times disputed medical</p>

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					<p>questions involve issues that go beyond the scope of practice or clinical competence of the initially selected evaluator, in which case either the evaluator needs to obtain a consultation from a physician in the required specialty, as provided under 8 Cal. Code Regs. § 32, or the parties need to obtain a second evaluator in the required specialty, as provided in the proposed section 31.7 of Title 8 of the California Code of Regulations. To harmonize these provisions of the proposed regulations, the Administrative Director revised the proposed wording of subdivision 31.5(a)(15) as stated.</p>
Section 31.7(b)(4)	<p>Commenter likes the idea of conferring with the I&amp;A Officer in unrepresented cases, regarding a dispute over QME specialty. However, the regulations do not state that the Information and Assistance Officer can make final decisions should the parties be unable to agree. I also wonder if the Information and Assistance office is staffed for the volume of dispute resolution on this issue. Commenter suggests that there be regulations specifying how disputes will be resolved, i.e. specialty of the treating physician, then specialist most appropriate for treatment of the injury, something like that.</p>	B2	<p>Janet Selby Workers' Compensation Manager Municipal Pooling Authority June 25, 2008 Written Comment</p>	<p>Rejected. Information and Assistance Officers have been authorized and trained to assist the parties in an unrepresented case to obtain a medical evaluation on disputed clinical questions since 1991. (See, Lab. Code § 5703.5(b) (Stats. 1990, c. 1550 (AB 2910), § 63.) When an Information and Assistance Officer is unable</p>	None.

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				to assist the parties in reaching agreement, the officer may refer the matter to a Workers' Compensation Administrative Law Judge, who may issue an order as provided in other subdivisions of proposed section 31.7.	
Section 32(b)	<p>The title of the guides 'AMA Guides [Fifth]' consistent with the definition listed under '§1 Definitions' should be listed throughout the regulations in order to prevent confusion and the inadvertent use of the Sixth Edition (recently released) by the medical evaluators prior to a statutory change.</p> <p>In order to be consistent with the definition, commenter recommends the following:</p> <p style="text-align: center;">Except as provided...and the AMA <u>g</u>Guides [Fifth Edition].</p>	O6	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accept in part.	The word 'guides' is being capitalized for consistency with subdivision 1(e) which defines AMA Guides. The wording in subdivision 1(e) already specifies the Fifth Edition, so it is unnecessary to do so here.
Section 32(c)	Commenter recommends deleting the words "or upon agreement by a party to pay the cost." This subdivision permits a QME to obtain a consultation "as reasonable or necessary under Labor Code section 4064(a)." Adding the subject clause " <u>or</u> upon agreement by a party to pay the cost" appears to give legal authorization to obtain a consultation even where it is not "reasonable or necessary."	N5	Susan Borg, President California Applicants' Attorneys Association July 10, 2008 Written Comment	Accepted.	The phrase 'or upon agreement by a party to pay the cost has been stricken for clarity.
Section 32(c)	Upon reading this subsection in conjunction with Labor Code section 4064(a), the language is not clear what authority a QME has to schedule a "consultation" and what the scope of such a consultation might be. A liberal reading could argue that since §32(c) allows for a consultation "from any physician" the evaluating QME	E1	Rene Thomas Flose, JD, PhD July 8, 2008 Written Comment	Rejected. The practice of QMEs obtaining a consultation from a physician in a different medical specialty has existed in the California workers' compensation system since	The Administrative Director rejected the commenter's suggestions but made other wording additions to this section for clarity and consistency with other existing regulations and

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	<p>can select any consultant he/she desires in any medical specialty for any purpose including organ system evaluations outside his specialty without going through any panel process, and further that the person he/she selects need not be a QME, but need only be “any physician”.</p> <p>The term “consultation” is not defined in §1 Definitions. Thus, it is not clear if a QME who has imaging studies interpreted by a radiologist has made a “consultation” or if a psychiatrist who has psychometric testing done is also having a “consultation” and at the other extreme, if an Agreed Panel QME in one specialty who determines that the worker has injuries in one, two or three other areas of medicine can schedule one two or three consultations with “any physicians” without going through any process of any kind. Such would seem to be the case if I look only at the language of §32(c) without looking at any other provisions of these proposed regulations.</p> <p>On the other hand §32(b) seems to suggest that no consultation can be scheduled in such cases except for situations discussed §32(a).</p> <p>In other words, I find the language of §32(b) and §32(c) to be conflicting, if not at least confusing as to when a QME can or cannot order a “consultation” and for what purpose.</p>			<p>1990 without the need to define the term consultation.</p> <p>The existing and proposed wording in subdivision 32(a) is needed to enable QME acupuncturists to obtain a consultation on the issues of disability which, by statute, the QME acupuncturist may not address. (See, Lab. Code § 3209.3(e).</p> <p>The wording in proposed subdivision 32(b) is needed to clarify that except for QME acupuncturists, other QMEs may not use the mechanism of obtaining a consultation to address the issue of permanent disability and apportionment. In such cases, the parties will be required to obtain a QME report in a different specialty, if that is the reason another physician’s opinion is needed. Consultations may be needed by a QME on disputed issues pertaining to medical treatment that are outside the scope of practice of the evaluating QME. Such treatment issues may go beyond diagnostic testing, therefore the commenter’s</p>	<p>statutes.</p>

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	<p>It would seem that new §31.7 “Obtaining Additional QME Panel in a Different Specialty” has established a comprehensive scheme for a QME, or any party to obtain a comprehensive medical legal evaluation in a second, third, or additional specialty. This would now under the proposed regulation require use of another random panel. This scheme when read in conjunction with §32(c) would seem to imply that a “consultation” should not go so far as to refer the worker to different specialties for complete medical legal evaluations. However, §32(c) does not clearly say that and is ambiguous in terms of what is and is not a “consultation”. Thus, the language in §32(c) needs to be clarified to remove any doubt about what is intended.</p> <p>Commenter suggests the following possible revisions:</p> <p>1 Defining the term “consultation” in the Definitions §1. The definition should exclude referral for complete comprehensive evaluations in specialties other than the specialty requested by the parties at the time of the QME panel request. It should include minor diagnostic consultations in areas such as radiology, psychometrics, nerve conduction and similar procedures. If the specialty “protocols” are re-written, then the term “consultation” could be defined as what is included in the published “protocols” for each medical specialty.</p> <p>2 Consider deleting the language of §32(c) altogether. It is not clear why this provision is needed.</p> <p>3 Or, modify the language of §32(c) so that it clearly does not conflict with §32(a) and §32(b) and</p>			<p>proposed wording in this regard is too restrictive.</p> <p>The proposed wording in subdivision 32(c) is existing wording, but has been amended, as explained above, to delete the phrase “or upon agreement by a party to pay the cost” in order to remove ambiguity that such a consultation may be obtained even when it is not reasonable or necessary.</p> <p>The Administrative Director has added subdivisions 32(d) through 32(g) to address the other procedural issues that often arise when a QME obtains a consultation. Subdivision 32(d) clarifies the QME’s responsibility for arranging the consultation appointment and advising the parties of the time, date and place of the appointment by use of QME For 110.</p> <p>Subdivision 32(e) is added to clarify that the consulting physician who may not be a QME must send his or her report to the referring evaluator who must review it, incorporate the report by</p>	

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	<p>§31.7 such as the following language:</p> <p>“§32(c) For injuries occurring on or after January 1, 1994, a QME may obtain <b>diagnostic</b> consultations to <b>assist his comprehensive evaluation within his area of specialty</b> from any physician as reasonable and necessary pursuant to Labor Code section 4064(a) <b>provided that such physician provide the parties with ten days written notice of the name of the physician, and the reason for the consultation and that there be no written objection voiced by any party</b>, or upon agreement by a party to pay the cost.” A diagnostic consultation under this section shall not include a referral to another medical specialty for a comprehensive evaluation without complying with the provisions of §31.7</p>			<p>reference, and comment on the consulting physician’s findings and conclusions.</p> <p>Subdivision 32(f) is added to clarify that the referring QME must still be the time requirements for filing a timely QME evaluation report.</p> <p>Subdivision 32(g) is added to clarify the rules on communications and the prohibition against ex parte communications with a consulting physician since the provisions of Labor Code section 4062.3 do not expressly address communications with a consulting physician.</p>	
Section 33(e)	<p>Commenter recommends the following language:</p> <p>(e) If a party with the legal right to schedule an appointment with a QME is unable to obtain an appointment with a selected QME within 60 days of the date of the appointment request, <u>provided both parties agree in writing to waive the sixty (60) day time limit</u>, that party may <del>waive the right to a replacement in order to</del> accept an appointment no more than ninety (90) days after the date of the party’s initial appointment request. <del>When the selected QME is unable to schedule the</del></p>	L7	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	<p>Rejected. Labor Code section 139.2(j)(1)(C) provides in pertinent part:</p> <p>“The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Sections 4061 and 4062. These timeframes shall give the employee the</p>	None. The Administrative Director made one non-substantive change to the proposed section for consistency by inserting the word ‘sixty’ before the number 60.

SECTION	<b>QME REGULATIONS (8 CCR 1-157)</b> <b>RULEMAKING COMMENTS</b> <b>15 DAY COMMENT PERIOD</b>	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><del>evaluation within ninety (90) days of the date of that party's initial appointment request, either party may report the unavailability of the QME and the Medical Director shall issue a replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations upon request, unless both parties agree in writing to waive the ninety (90) day time limit for scheduling the initial evaluation.</del></p> <p>The QME process used to resolve disputes over medical care and other benefits is a lengthy one. Prolonging the process even further is unnecessary and will negatively affect the injured employee by further delaying benefits. The injured employee should never wait more than 90 days from the appointment request for an appointment, and should only wait more than 60 days if both parties agree to the delay. A treatment delay affects the injured employee's recovery and impedes return to work. Delays to other benefits can affect an employee's income.</p>			<p>right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, <i>but shall also permit the employee to waive this right for a specified period of time thereafter.</i>" Accordingly, pursuant to this section, the Administrative Director has proposed that the employee may waive the right to a replacement QME only as long as the QME to be selected can schedule the appointment within a maximum of 90 days of the initial appointment request. In view of the statutory changes enacted in SB 899, which now limit the parties in represented cases to using a panel QME where an AME has not been agreed to, and pursuant to the authority in Labor Code section 139.2(j)(6) which authorizes the administrative director to adopt regulations governing, in pertinent part, "any additional medical or <i>professional standards</i> that a medical evaluator shall meet....", the Administrative</p>	

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				Director has amended the wording of subdivision 33(e) to use the phrase 'a party with the legal right to schedule an appointment' in order that the waiver option for a maximum of 30 days (to a total time of 90 days from the initial call for an appointment) applies in both unrepresented and represented cases. Further, where the parties agree to waive the 90 day time limit for scheduling an initial evaluation, the Administrative Director sees no reason to prevent the parties from using the evaluator each party believes is worth waiting for to perform the evaluation.	
Section 33(e)	The decision to waive the 60 day limit for setting an appointment in this subdivision should not be unilateral. Commenter recommends that waiver only be allowed if the parties agree.	17	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	Rejected. Labor Code section 139.2(j)(1)(C), discussed above, specifies that the decision to waive is at minimum the unrepresented employee's. The wording, as proposed, would change that only when the unrepresented employee fails to select a QME and schedule the appointment, in which case pursuant to Labor Code § 4062.1(b) or (c) the claims administrator, or if	None.

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				<p>none the employer, gains the right to select the QME or schedule the appointment. In a represented case, the party with the legal right to schedule the QME appointment (initially the represented employee pursuant to Labor Code section 4062.2(d)) will have the authority to decide whether to waive the 60 day limit in order to accept an appointment within the 90 day time period. The Administrative Director believes this approach is more consistent with the relevant provisions of the Labor Code than giving the opposing party a veto based on a 30 day time difference.</p>	
Section 34(d)	<p>Commenter recommends the following language:</p> <p>(d) An appointment scheduled with <del>a panel QME</del> <u>an evaluator</u> shall not be cancelled or rescheduled by the <del>QME evaluator</del> or by any party less than three (3) business days before the date scheduled. Whenever the claims administrator, <del>or if none the employer</del>, or the injured worker, or either party's attorney, cancels an appointment scheduled <del>with by a panel QME</del> <u>an evaluator</u>, the cancellation shall be made in writing, <del>and state</del> <u>with the reason for the cancellation, and the other parties copied</u>. Oral cancellations shall be followed with a</p>	L8	<p>Brenda Ramirez Claims and Medical Director Michael McClain General Counsel &amp; Vice President California Workers' Compensation Institute July 10, 2008 Written Comments</p>	<p>Accepted in part. The Administrative Director has extensively revised the subdivisions in section 34 that address appointment cancellations as new proposed subdivisions 34(d) through 34(g). Proposed subdivision 34(f) specifically addresses cancellations by AMEs.</p>	<p><b><u><del>(d)</del> An evaluator, whether an AME, Agreed Panel QME or QME shall not cancel a scheduled appointment less than six (6) business days prior to the appointment date, except for good cause. Whenever an evaluator cancels a scheduled appointment, the evaluator shall advise the parties in writing of the reason for</u></b></p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>written confirming letter that complies with this section.</p> <p>There is no apparent reason such prohibitions should apply only in the case of panel QMEs and not in the case of agreed panel QMEs and AMEs.</p> <p>When an evaluation is cancelled, other parties need to be informed.</p>				<p><b><u>the cancellation. The Appeals Board shall retain jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation pursuant to this subdivision was for good cause. The Administrative Director shall retain jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of this section.</u></b></p> <p><b><u>(e) An Agreed Panel QME or a QME who cancels a scheduled appointment shall reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation. The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.</u></b></p> <p><b><u>(f) An Agreed Medical</u></b></p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
					<p><b><u>Evaluator who cancels a scheduled appointment shall reschedule the appointment within sixty (60) calendar days of the date of the cancellation.</u></b></p> <p><b><u>(g) Failure to receive relevant medical records, as provided in section 35 of Title 8 of the California Code of Regulations and section 4062.3 of the Labor Code, prior to a scheduled appointment shall not constitute good cause under this section for the evaluator to cancel the appointment.</u></b></p>
Section 34(d)	<p>This new subdivision, which prohibits cancelling or rescheduling a QME appointment within 3 business days of the date scheduled, should have a good cause exception. Unfortunately injured workers, by the very nature of their situation, may have to cancel an appointment due to their medical condition or other factors, and this should be recognized in this regulation. Furthermore, where an appointment is cancelled for good cause there should be a bar against charging for the missed appointment. Currently some physicians charge a cancellation fee and in many cases defendants either refuse to pay this fee or will demand a credit against the award. This is unfair and should be prohibited where the cancellation is for good cause.</p>	N6	Susan Borg, President California Applicants' Attorneys Association July 10, 2008 Written Comment	Accepted in part.	<p>As noted above, the Administrative Director re-drafted the subdivisions in section 34 that address appointment cancellations by the evaluator and cancellations by a party. The newly proposed provision regarding cancellations by a party is as follows:</p> <p><b><u>(h) An appointment scheduled with an evaluator, whether</u></b></p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>In addition, it should be noted that under §41(a)(8) a QME is to refrain from cancelling a scheduled evaluation less than 14 days from the date scheduled "without good cause." There are two issues here. First, as noted commenter believes that the "good cause" exception must also be added to §34(c). However, commenter also notes that the language of §34(c) applies to both the worker and the QME. This appears to establish two restrictions on QMEs, one discouraging cancellations within 14 days of the scheduled evaluation and the other barring cancellation within 3 days. If this is the intent, it may be appropriate to reference the three day ban in §41. Finally, commenter recommends that the wording of §41(a)(8) be amended to mandate that the rescheduled appointment following any cancellation or rescheduling of the original appointment cannot be extended beyond the 60 day time frame without the approval of both parties.</p>				<p><b><u>an AME, Agreed Panel QME or a panel QME shall not be cancelled or rescheduled by the QME or by any party or the party's attorney less than three (3) six (6) business days before the appointment date scheduled, except for good cause. Whenever the claims administrator, or if none the employer, or the injured worker, or either party's attorney, cancels an appointment scheduled by a panel QME, an evaluator, the cancellation shall be made in writing, and state the reason for the cancellation and be served on the opposing party. Oral cancellations shall be followed with a written confirming letter that is faxed or mailed by first class U.S. mail within twenty four hours of the verbal cancellation and that complies with this section. An injured worker shall not be liable for any missed appointment fee whenever an appointment is cancelled for good cause.</u></b></p>

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					<p><b><u>The Appeals Board shall retain jurisdiction to resolve disputes regarding whether an appointment cancellation by a party pursuant to this subdivision was for good cause.</u></b></p> <p>In addition, section 41(a)(7) and (a)(8) have been amended as follows:</p> <p>(7) Refrain from <u>unilaterally</u> rescheduling a panel QME examination <del>three (3) or more</del> <b><u>than two</u></b> times in the same case.</p> <p>(8) Refrain from cancelling a <del>panel</del> QME examination less than <del>fourteen (14) calendar</del> <b><u>six (6) business</u></b> days from the date the exam is scheduled <u>without good cause and without providing a new examination date within thirty (30) calendar days of the date of cancellation.</u></p>
Section 34(d)	Cancellation of QME appointments is a frequent drain on the schedules and resources of QMEs. Commenter is pleased to see the Division begin to address this problem. However, the language provides no remedy for the aggrieved party when the appointment is cancelled within	M1	Steven J. Cattolica, Director of Governmental Relations AdvoCal	Accepted in part. The time frame for cancelling an appointment has been changed to less than six business days rather than 3.	See proposed new language above.

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	<p>three business days of the appointment date or the injured worker is a “no show.” Without any remedy, the regulation is severely undermined in its intended effect.</p> <p>In addition, the language of the regulation should stipulate that it is the date of receipt of a written cancellation that governs compliance. For example, a written cancellation, postmarked prior to the third business day before the appointment, but received after that date should not be considered timely notice.</p>		<p>July 11, 2008 Written Comment Late Comment</p>	<p>Language has been added to address the manner of computing the date of cancellation.</p>	
Section 34(d)	The Agreed Panel QME should be added.	I8	<p>Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment</p>	Accepted.	See proposed new language above.
Section 35	<p>Replace in this section and elsewhere in these regulations the term “evaluator” in lieu of “QME” or “AME or QME”, etc.,” wherever the generic term is appropriate.</p> <p>The change is necessary to avoid disputes over which provider types are intended.</p>	L9	<p>Brenda Ramirez Claims and Medical Director Michael McClain General Counsel &amp; Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments</p>	Accepted in part.	This change is made when possible.
Section 35(c)	<p>Commenter strongly opposes the requirement that an itemized log be attached to the front of documents served on the injured worker in advance of an evaluation. This will be very time-consuming for claim examiners, and she question whether the worker will even read it much less find it of value. Commenter suggests as an alternative a requirement to separate the documents by type: medical reports, medical records, statements, etc.</p>	B3	<p>Janet Selby Workers’ Compensation Manager Municipal Pooling Authority June 25, 2008 Written Comment</p>	Rejected. The itemized log is important for all parties, whether represented or not and for the evaluator, in order to determined whether all records and information being provided to the evaluator has been provided.	None.

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				The proposed language does not inhibit claims administrators from grouping the documents as proposed, as long as the itemized log uses a similar organizational presentation.	
Section 35(b)(1) and (m)	Commenter suggests changing “AME or QME” to “evaluator” or adding Agreed Panel QME.	I9	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	Accepted.	This change has been made.
Section 35.5(g)	<p>The AMA Guides (Fifth) is specific in how impairment should be explained and has instructions on how to report the impairment. Reports on injuries occurring on or after 1/1/2005 and those occurring prior to 1/1/2005 that meet certain criteria are required to contain the AMA Guides (Fifth) method(s) in the determination of permanent disability. These reporting standards should be reflected in the medical evaluator’s report.</p> <p>Commenter recommends adding the following new subsection (g):</p> <p><u>§ 35.5 (g) When a Qualified Medical Evaluator provides an opinion in a comprehensive medical/legal report on a disputed permanent disability issue, the evaluator’s opinion shall be consistent with the reporting standards of the AMA Guides [Fifth], where applicable, and the requirements under Division 1, Chapter 4.5, Subchapter 2, section 10606 of Title 8 of the California Code of Regulations (Physicians’ Reports As Evidence).</u></p>	O7	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Rejected. The Administrative Director does not believe the additional proposed language is necessary.	None.

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Section 36	Commenter has become aware that within this proposed regulation, there is no guidance or accommodation for the unrepresented worker that does not cooperate by requesting a physician to receive his/her psychiatric evaluation. This situation can present an ethical and dangerous situation for the evaluator. Commenter states that the division must provide guidance in the form of an expansion of Section 36 to include the situation where the injured worker will not cooperate.	M2	Steven J. Cattolica, Director of Governmental Relations AdvoCal July 10, 2008 Written Comment	<p>Accepted in part. Sections 36 and 36.5 are revised. See the revised language for section 36.5 in response to Brenda Ramirez’s comment below.</p> <p>The subdivisions in section 36 have been amended to instruct the evaluator how to serve the medical-legal report, <i>unless section 36.5 applies</i>. Section 36.5 governs service of medical-legal reports when injury to the psyche is disputed and either the evaluator makes a determination under Health and Safety Code section 123115(b) that the evaluation report is a ‘mental health record’ within the meaning of section 123115(b) that should not be provided directly to the injured employee, or that the report does not need such protection and offers the injured worker the option to designate a physician upon whom the injured workers’ copy of the report may be served, in order that the designated physician may review the report with the worker.</p>	<p>Section 36 is revised to state:</p> <p><b><u>(a) Whenever an injured worker is represented by an attorney, the evaluator shall serve each comprehensive medical-legal evaluation report, follow-up comprehensive medical-legal evaluation report and supplemental evaluation report on the injured worker, his or her attorney and on the claims administrator, or if none the employer, by completing QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report Form)(See, 8 Cal. Code Regs. § 122) and attaching QME Form 122 to the report, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable in a claim involving disputed injury to the psyche, the evaluator shall comply with the requirements of section 36.5 of Title 8 of the California Code of</u></b></p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
				<p>In response to this commenter's concern, language is added as subdivision 36.5(k).</p>	<p><b><u>Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs. §§ 36.5, 120 and 121).</u></b></p> <p><b><u>(b) Whenever an injured worker is not represented by an attorney, the Qualified Medical Evaluator shall serve each comprehensive medical-legal evaluation report, follow-up evaluation report or supplemental report that addresses only disputed issues outside of the scope Labor Code section 4061, by completing the questions and declaration of service on the QME Form 111 (QME Findings Summary Form) (See, 8 Cal. Code Regs. § 111 ), and by serving the report with the QME Form 111 attached, on the injured worker and the claims administrator, or if none on the employer, unless section 36.5 of Title 8 of the California Code of Regulations applies. If</u></b></p>

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					<p><u>applicable in a claim involving disputed injury to the psyche, the evaluator shall comply with the requirements of section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs. §§ 36.5, 120 and 121.)</u></p> <p><u>(c) Whenever the evaluator is serving a medical-legal evaluation report that addresses or describes findings and conclusions pertaining to permanent impairment, permanent disability or apportionment of an unrepresented injured worker, the evaluator shall serve the evaluation report, the completed QME Form 111 (QME Findings Summary Form) (See, 8 Cal. Code Regs. § 111), DWC-AD form 100 (DEU) (Employee's Disability Questionnaire)(See, 8 Cal. Code Regs. §§ 10160 and</u></p>

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					<p><u>10161) and DWC-AD form 101 (DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report)(See, 8 Cal. Code Regs. §§10160 and 10161) on the local DEU office, the claims administrator, or if none the employer, and on the unrepresented employee within the time frames specified in section 38 of Title 8 of the California Code or Regulations, unless section 36.5 of Title 8 of the California Code of Regulations applies. If applicable, in cases involving disputed injury to the psyche, the evaluator shall follow the procedures described in section 36.5 of Title 8 of the California Code of Regulations (Service of Comprehensive Medical-Legal Report in Claims of Injury to the Psyche)(See, 8 Cal. Code Regs. §§ 36.5, 120 and 121).</u></p> <p>(b) (d) If an evaluation report is completed <del>under</del> <del>subdivision (a)</del> for an</p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
					<p>unrepresented employee, in which the QME determines that the employee's condition has not become permanent and stationary as of the date of the evaluation, the parties shall request any further evaluation from the same QME if the QME is currently an active QME and available at the time of the request for the additional evaluation. If the QME is unavailable, a new panel may be issued to resolve any disputed issue(s). If the evaluator is no longer a QME, he/she may issue a supplemental report as long as a face-to-face evaluation (as defined in section 49(b) of <del>these regulations</del> <u>Title 8 of the California Code of Regulations</u> ) with the injured worker is not required. In no event shall a physician who is not a QME or no longer a QME perform a follow up evaluation on an <b><u>unrepresented</u></b> injured worker.</p> <p>(<del>e</del>) <u>A</u> <b>After a Qualified Medical Evaluator who has served a</b></p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
					<p><u>comprehensive medical-legal report on an unrepresented injured worker, the claims administrator, or if none the employer, and the Disability Evaluation Unit, that addresses a disputed issue involving permanent impairment, permanent disability or apportionment, <b>the QME shall not issue any supplemental report on that issue, unless requested to do so by the Disability Evaluation Unit, by the Administrative Director in response to a petition for reconsideration of a disability rating or by a Workers' Compensation Administrative Law Judge.</b></u></p> <p>In addition, subdivision 36.5(k) as now proposed provides:  <b><u>(k) In the event the injured worker declines or refuses to designate any physician in writing to be listed on either QME Form 120 or QME Form 121, the evaluator's report shall be served as appropriate</u></b></p>

SECTION	QME REGULATIONS (8 CCR 1-157) RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
					<p><u>under section 36, and within the time periods under section 38, of Title 8 of the California Code of Regulations. It is recommended that the evaluator serve the medical-legal evaluation report with an authorization for release of medical information signed by the injured worker. A non-mandatory Authorization for Release of Medical Information form is available as QME Form 125 (Authorization for Release of Medical Information). (See, 8 Cal. Code Regs. Section 125.)</u></p>
Section 36(c)	This new subdivision sets forth rules for service of comprehensive medical-legal reports. However, as proposed this subdivision applies only to reports that address disputes under Labor Code §4061. Commenter recommends that the reference to §4061 be deleted to require service of <u>all</u> comprehensive medical-legal reports.	N7	Susan Borg, President California Applicants’ Attorneys Association July 10, 2008 Written Comment	Accepted.	See newly proposed wording for sections 36 and 36.5.
Section 36.5	Require the employee’s copy of a mental health record defined in (a) to go to the primary treating physician, or alternatively, require a copy to go to the primary treating physician in addition to another physician designated by the injured employee.	L10	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel &	Accepted in part. The Administrative Director rejects the suggestion that the report be served only on the primary treating physician.	Section 36.5(b)(6) has been revised as follows:  <u>(§ 6 ) Only serve Serve the completed</u>

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	<p>The proposed regulations offer the employee an additional medical consultation in the case of a qualified psychiatric report. Rather than have the injured employee designate a consulting physician with whom to consult on the report, the primary treating physician (PTP) who has a relationship with the injured employee already should be tasked with this consultation. Since the PTP is more likely to understand both the medical and the legal consequences of the report, he or she is in the best position to explain them to the employee.</p> <p>If the Division decides that the employee can designate an additional physician with whom to consult on a qualified psychiatric report, a copy of the report should also go to the PTP so that the PTP can fulfill his or her responsibilities. As currently written, the PTP may not receive the psychiatric report, without which the PTP may not have all the information necessary to properly fulfill responsibilities that include managing the employee's treatment and completing the permanent and stationary report.</p>		<p>Vice President California Workers' Compensation Institute July 10, 2008 Written Comments</p>	<p>As explained in the last rulemaking period (after the 45 day comment period), this proposal is unreasonable because the injured worker may not have selected the primary treating physician due to the operation of law governing selection of the primary treating physician. Prior to the passage of SB 899, the employer had "medical control" and therefore sent the injured worker to the physician of the employer's choice during the first 30 days after injury, unless the injured worker had "pre-designated", that is advised the employer of the name of a physician prior to the date of injury. Upon passage of SB 899, new provisions were added to the Labor Code that provide, in essence, that an employer that creates an approved Medical Provider Network (MPN) will control medical treatment for the life of the workers' compensation claim, by being allowed to limit the injured worker's choice of physicians to only those physicians within the employer's MPN, unless the</p>	<p><del>medical treatment or medical/legal</del> <b><u>comprehensive medical-legal evaluation report, follow-up medical-legal report or supplemental medical-legal report(s) subject to the provisions of this section, with the completed QME Form 121 (Declaration Regarding Protection of Mental Health Record) attached, on the licensed physician designated by the injured worker on QME Form 121, and on the claims administrator, or if there are no claims administrator, on each party's attorney, if any, as provided in section 36, and within the time periods in section 38, of Title 8 of the California Code of Regulations. In the event the injured worker designates a physician on QME Form 121 other than the current primary treating physician in his or her workers' compensation claim, the evaluator shall also serve a copy of the report on the primary</u></b></p>

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				injured worker pre-designated. The Administrative Director and the Medical Director have received a number of comments from psychiatrists and psychologists regarding their concern, from a medical standpoint, of the impact on an injured worker upon reading a medical-legal report discussing psychological and psychiatric assessments. Accordingly, it has been the Administrative Director's view that especially in the case of disputed injury to the psyche, the injured worker should be given the opportunity to designate a physician of his or her choice with whom to review a medical-legal report about the disputed injury.	<u>treating physician.</u>  In addition, the Administrative Director made other amendments to improve the clarity, cross reference and syntax of the section.
Section 36.5(a)	This set of proposed regulations refers to the Qualified Medical Examiner provisions of the Labor Code. Specifically, §36.5 refers to service of the comprehensive medical/legal report in psyche injury claims. The primary treating physician would not perform or serve a comprehensive medical/legal evaluation and commenter recommends removing the references to the treating physician in this section as illustrated below.  It would be more reasonable for the treating physician to	O8	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accepted in part. Section 36.5 has been amended to limit its coverage to determinations made by an evaluator finding that either the evaluator's report or reports received by the evaluator in the course of the evaluation should be subject to the protections of Health	Subdivision 36.5(b) has been amended, in pertinent part, to delete references to the treating physician as follows:  <del><u>§(b) Whenever injury to the psyche is claimed and either the primary or secondary physician or</u></del> <u>in the course</u>

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	<p>be the designated physician to review the medical/legal psyche report with the injured employee rather than any physician of choice. The treating physician would be more familiar with the issues of the case and would therefore be equipped to facilitate the employee's understanding of the issues.</p> <p>Commenter recommends the following revisions:</p> <p>(a) Whenever injury to the psyche is claimed and either the primary treating physician or the evaluator makes a determination pursuant to Health and Safety Code section 123115(b) that there is a substantial risk of significant adverse or detrimental medical consequences to the injured worker in seeing or receiving a copy of part or all of a mental health record, <del>the treating physician or</del> the evaluator shall do all of the following:</p> <p>(1) Complete QME Form 121 (Declaration Regarding Protection of Mental Health Record);</p> <p>(2) Advise the injured worker that the determination under Health and Safety Code 123115(b) has been made regarding the specified mental health record and that <del>the treating physician or</del> the evaluator may only provide the employee's copy of the mental health record <del>to a person designated in writing by the injured worker who is a licensed physician, as defined in Labor Code section 3209.3, or a health care provider as defined in Health and Safety Code section 123105(a) the employee's primary treating physician (CCR §9785).</del></p>			<p>and Safety Code § 123115(b).</p> <p>For reasons explained in reply to the commenter above, the Administrative Director rejects the suggestion that only the primary treating physician be the designated physician.</p>	<p><u><i>of the evaluation, the evaluator makes a determination pursuant to Health and Safety Code section 123115(b) that there is a substantial risk of significant adverse or detrimental medical consequences to the injured worker <del>in</del> from seeing or receiving a copy of part or all of evaluation report which is a mental health record. <del>the treating physician or the evaluator</del> shall do all of the following:</i></u></p> <p><u><i>(1) Complete QME Form 121 (Declaration Regarding Protection of Mental Health Record);</i></u></p> <p><u><i>(2) Advise the injured worker that the determination under Health and Safety Code 123115(b) has been made regarding the evaluation report as a <del>specified</del> mental health record and that <del>the treating physician or the evaluator may only</del> only may <del>provide</del> serve the employee's injured worker's copy of the <del>mental</del></i></u></p>

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					<del>health record to</del> <b><u>evaluation report on a person,</u></b> <del>designated in writing by the injured worker,</del> <b><u>who is a licensed physician, as defined in Labor Code section 3209.3 and whose name the injured worker designates in writing prior to leaving the evaluator's office.</u></b> <del>or a health care provider as defined in Health and Safety Code section 123105(a).</del>
Section 36.5(g)	This subsection proposes that the physician designated by the injured worker on QME Form 120 or 121 <i>is not limited to the primary treating physician</i> in the disputed workers' compensation claim. For the same reasons discussed in Section 36.5(a), commenter recommends that the primary treating physician be the designated physician in QME Form 120 or 121.	O9	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Rejected, for the reasons stated above on this issue.	None.
Section 36.5(g)	This section provides that as an additional medical expense incurred in the claim, the claims administrator shall reimburse the physician designated by the injured employee on QME Form 120 or 121 for one office visit when used for the purpose of reviewing and discussing the evaluator's report with the injured worker at the OMFS rate.  Commenter recommends the following amendments:  36.5(g) The physician designated by the injured worker on QME Form 120 or QME Form 121 is <del>not</del> limited to the primary <u>or secondary</u> treating physician in the disputed workers' compensation	O10	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accepted in part. The Administrative Director does not believe the addition reference to a secondary treating physician is necessary. The subdivision is being amended to clarify the reimbursement basis.	Subdivision 36.5(g) has been re-lettered to subdivision 36.5(i), and is proposed as follows:  <del>(g)</del> <b><u>(i) The physician designated by the injured worker in writing and listed on QME Form 120 or QME Form 121 is not limited to the primary treating physician in the disputed workers'</u></b>

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	<p>claim.</p> <p>... for one office visit, when used, for the purpose of reviewing and discussing the evaluator's report with injured worker. <u>Reimbursement will be</u> at the OMFS rate for an office visit and may include, as appropriate, record review, any necessary face-to-face time during the visit in excess of that specified in the CPT office visit code, and charges, <del>if necessary,</del> for time required to prepare a treatment report, <u>if necessary.</u></p>				<p><i><u>compensation claim. As an additional medical treatment expense incurred in the claim within the meaning of section 4600 of the Labor Code, the claims administrator, or if none the employer, shall reimburse the physician designated by the injured worker and listed on either the QME Form 121 (Declaration Regarding Protection of Mental Health Record) or the QME Form 120 (Voluntary Directive for Alternate Service of Medical-Legal Evaluation Report on Disputed Injury to the Psyche), for one office visit, when used, for the purpose of reviewing and discussing the evaluator's report with injured worker, at the <del>OMFS</del> applicable rate under section 9789.11 (Physician Services Rendered on or After July 1, 2004) of Title 8 of the California Code of Regulations for an office visit and may include, as appropriate, record review,</u></i></p>

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					<u>any necessary face-to-face time during the visit in excess of that specified in the applicable CPT office visit code, and charges <del>of</del> necessary, for time required to prepare a treatment report pertaining to the office visit, if necessary.</u>
Section 38(a)	“AME or QME” should be changed to “evaluator”, Agreed Panel QME should be added.	I10	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	Accepted in part.	The subdivision is revised to state “...QME, Agreed Panel QME or AME...”
Section 38(h)	<p>Commenter recommends the following language:  <del>An extension of the sixty (60) days may be agreed to by the parties in writing without the need to request an extension from the Medical Director.</del></p> <p>The workers' compensation system abounds with statutes and regulations attempting to deal with untimely reporting. Late treatment reports, medical legal evaluations, and supplemental reports cause delays in medical treatment and other benefits that depend on medical opinions. The proposed language should be eliminated, at least, in absence of a showing of good cause. If not eliminated, then commenter recommends modifying the language to clarify that both parties must agree to the extension and the Medical Director should be advised of the extension so that the additional delays can be tracked by the Division.</p>	L11	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Accepted in part. The Administrative Director has added an additional 30 day extension limit to the time frame for completion of supplemental reports.	<p>The subdivision has been revised, as follows:</p> <p><del>(f h)</del> ...An extension of the <u>sixty (60) days time frame for completing the supplemental report, of no more than thirty (30) days, may be allowed without the need to request an extension from the Medical Director, as long as the evaluator contacts both parties at least fourteen (14) calendar days prior to the end of the sixty (60) day time frame and within seven (7) calendar days of</u></p>

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					<p><i><u>being contacted, both parties agree to the extension in writing which is sent to the evaluator. Each party may send the evaluator their written agreement to the extension separately. However, if either party objects to the extension or if either party fails to respond to the evaluator at least seven (7) calendar days prior to the end of the sixty (60) day time frame, the evaluator must request the extension from the Medical Director by completing and submitting QME Form 112 (See, 8 Cal. Code Regs. § 112). The evaluator shall mail the completed QME Form 112 to the Medical Director no later than five (5) calendar days before the end of the sixty (60) day time frame above. may be agreed to by the parties in writing without the need to request an extension from the Medical Director.</u></i></p>
Section 41(c)	Commenter recommends adding the following language:	L12	Brenda Ramirez Claims and Medical	Rejected. Proposed section 35.5(g) addresses the issue	None.

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	<p><u>(8) Address contested medical issues in a manner consistent with the Medical Treatment Utilization Schedule pursuant to Labor Code §§ 4600(b) and 5307.27 and include the relevant portion(s) of the criteria or guidelines relied upon.</u></p> <p>The revised curriculum contained in the proposed regulations makes it clear that evaluating physicians must understand and apply the medical standard of care as stated in the Medical Treatment Utilization Schedule (MTUS). Many medical legal reports fail to note or are inconsistent with the dictates of the treatment schedule and many more make no reference to the treatment guidelines relied upon by the evaluator. The California Supreme Court in its recent <u>Sandhagen</u> decision has made it abundantly clear that reasonable and necessary medical care constitutes treatment that is consistent with the Medical Treatment Utilization Guidelines or treatment justified by scientific medical evidence that has rebutted the guidelines. The Supreme Court in <u>Sandhagen</u> said, in pertinent part:</p> <p><i>“The Legislature amended section 3202.5 to underscore that all parties, including injured workers, must meet the evidentiary burden of proof on all issues by a preponderance of the evidence. (Stats. 2004, ch. 34, § 9.)</i></p> <p><i>Accordingly, notwithstanding whatever an employer does (or does not do), an injured employee must still prove that the sought treatment is medically reasonable and necessary. That means demonstrating that the treatment request is consistent with the uniform guidelines (§ 4600, subd. (b)) or, alternatively, rebutting the application of the guidelines with a preponderance of scientific medical evidence.(§</i></p>		Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	that opinions be consistent with the MTUS. Additional language, as proposed, in this section is unnecessary.	

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	<p>4604.5.)”</p> <p>Commenter strongly recommends this addition to clarify that evaluators must comply with the philosophy of the MTUS and demonstrate their reliance on the statutes and regulations to support their medical conclusions.</p>				
Section 41(c)(8)	<p>Commenter recommends that this paragraph be amended to read:</p> <p>Serve the report as provided in these regulations at the same time on the employee and the claims administrator, or if none the employer, <u>and</u> on each of their attorneys, respectively, if represented</p>	N8	Susan Borg, President California Applicants’ Attorneys Association July 10, 2008 Written Comment	Accepted.	<p>Section 41(c)(8) has been revised to state:</p> <p><b><u>(8) Serve the report at the same time as provided in these regulations at the same time on the employee and the claims administrator, or if none the employer, and on each of their attorneys, respectively.</u></b></p>
Section 53	<p>Commenter recommends adding the following language:</p> <p><b><u>Reappointment: Failure to Comply with Medical Treatment Utilization Guidelines</u></b>  <u>“As a condition for reappointment, when addressing medical disputes, all QMEs shall evaluate medical treatment reasonably required to cure or relieve the injured worker from the effects of his or her injury pursuant to Labor Code §§ 4600(b) and 5307.27, consistent with the Medical Treatment Utilization Schedule, and must include in the report the relevant portion of the criteria or guidelines relied upon or the scientific medical evidence used to rebut the guidelines. The Administrative Director may deny reappointment to any QME who has failed to comply with this requirement on at least three</u></p>	L13	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	Rejected. The proposed additional section is unnecessary. In order to be reappointed, a QME must be “in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director” (Lab. Code § 139.2(d)(1)). This provision would include compliance with regulation 35.5(g).	None.

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	<p><u>occasions during the calendar year.</u></p> <p>The proposed regulations makes it clear that evaluating physicians must understand and apply the medical standard of care as stated in the Medical Treatment Utilization Schedule (MTUS). As previously noted, many reporting medical legal physicians fail to note or are inconsistent with the dictates of the treatment schedule and many more make no reference to the treatment guidelines or other scientific medical evidence relied upon. The Institute strongly recommends this addition to clarify that evaluators must comply with the philosophy of the MTUS and demonstrate their reliance on the statutes and regulations to support their medical conclusions and that their repeated failure to do so may affect their reappointment.</p>				
Section 54	<p>In addition, deny reappointment to any QME who has had more than five evaluations rejected by the Disability Evaluation Unit, or found deficient to the extent the Disability Evaluation Unit needed to make assumptions in order to rate them.</p> <p>Central to the workers' compensation system is that evaluators produce medical-legal opinions that are comprehensive and ratable. Workers' compensation judges should not be forced to rely on deficient or unratable reports, and often judges finalize cases even when they are unratable and seriously deficient.</p>	L16	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Rejected. The Administrative Director believes that Workers' Compensation Administrative Law Judges already reject medical-legal reports that are deficient or unratable. The issue of the consequences of reports found unratable by the Disability Evaluation Unit will require more study than is feasible during this rulemaking period.	None.
Section 54	<p>Reappointment: Evaluations Rejected by the Appeals Board</p> <p>Commenter is concerned that even if the rater sends the evaluation to the WCJ marked unratable, the parties are told to settle the claim or the judge makes a finding.</p>	I11	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008	Rejected. The parties' remedy for decisions by a Workers' Compensation Administrative Law Judge that a party believes is unfounded or inconsistent	None.

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	Commenter believes that this section should be amended to get a report of unrateable evaluations directly from the DEU, rather than from the WCJ.		Written Comment	with the evidence or the law is to petition for reconsideration.	
Section 65	<p>Commenter requests that the division add the following language on page 102 under (16) Report Deficiencies:</p> <p style="padding-left: 40px;">“- Failing to comply with Medical Treatment Utilization Guidelines</p> <p style="padding-left: 40px;">- Failing to include relevant portion(s) of the criteria or guidelines relied upon"</p> <p>If there are sanctions specifically imposed in these regulations as a consequence for failing to base treatment determinations on the Medical Treatment Utilization Schedule regulations, such behavior is more likely to be corrected and as a result, injured employees will benefit with more effective medical treatment. If there is no consequence to failing to base treatment determinations on the statutory and regulatory standards, we will continue to see many reports that do not comply and injured employees that do not receive effective medical care.</p>	L17	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Rejected. The Administrative Director believes that the existing wording, including "other report deficiencies that affect the substantial rights of a party and are in violation of the regulations governing QMEs", is sufficiently broad to impose discipline when warranted.	None.
Section 65	<p>Violations of Material Statutory/Administrative Duties which May Result in Alternative Sanctions</p> <p>15. Failure to Follow AD Evaluation Guidelines</p> <p>Commenter recommends changing this criterion to 2 or more instances form 3 or more instances.</p>	I12	Steven Suchil Assistant Vice President American Insurance Association July 10, 2008 Written Comment	Rejected. The Administrative Director believes the existing wording is more appropriate.	None.
Section 65	<p>16. Report Deficiencies</p> <p>Commenter recommends adding the following:</p> <p>“Absence of or inadequate discussion re: Medical</p>	I13	Steven Suchil Assistant Vice President American Insurance Association	Rejected. The Administrative Director believes there is sufficient authority under the existing regulatory language to	None.

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	Treatment Utilization Schedule or, when the condition is not included in the Medical Treatment Utilization Schedule, other science based, peer-reviewed, nationally recognized medical literature when treatment is at issue.”		July 10, 2008 Written Comment	address violations that merit discipline.	
DWC Forms 100, 104, 105 and 106	<p>Candidates registering or re-registering as a QME must declare their specialty (ies) on Form 100 or 104, depending on the physician’s QME status at the time.</p> <p>The choices found on these two form create confusion with respect to Pain Medicine by utilizing the same three-character code (MPA) to stand for all five of the following:</p> <ul style="list-style-type: none"> <li>• Pain Medicine (by itself)</li> <li>• Anesthesiology – Pain Medicine</li> <li>• Neurology – Pain Medicine</li> <li>• Physical Medicine &amp; Rehabilitation – Pain Medicine</li> <li>• Psychiatry – Pain Medicine</li> </ul> <p>For example, a QME candidate who is eligible as a Neurologist in Pain Medicine is required to use the same code as the Anesthesiologist and Psychiatrist.</p> <p>Elsewhere within the present rulemaking, CCR section 41, Ethical Requirements, paragraph (c)(4) is proposed to read: (underlining added):</p> <p>“(The QME shall)…Render expert opinions or conclusions only on issues which the evaluator <u>has adequate qualifications, education and training</u>. All conclusions shall be based on the facts and on the evaluator’s <u>training and specialty-based</u> knowledge and shall be without bias either for or against the injured worker or the claims administrator, or if none the employer.”</p>	M3	Steven J. Cattolica, Director of Governmental Relations AdvoCal July 10, 2008 Written Comment	Rejected. The basis for including the specialties to be coded under “MPA” is that each is a certified specialty or certified subspecialty in Pain Medicine recognized by the American Board of Medical Specialties (ABMS). To the extent that a disputed injury requires an evaluation from a physician with a certified specialty in pain medicine, the Administrative Director determined it is more appropriate to group the “pain medicine” specialists under one code and then to distinguish those areas of practice in other specialties who would not have the required ‘pain medicine’ subspecialty certification. The Administrative Director is confident that the physicians holding the subspecialty certification, and those without it, will not be confused and will identify their area of certified specialty appropriately. Accordingly, the list of specialty codes was amended	None.

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	<p>Know that the QME’s declared specialty, indicated only by the three character code, will dictate the types of injuries that he/she will be called upon to evaluate, use of a single specialty code for all five of the distinctly and differently trained individuals listed above, assures that this ethical standard will either be violated or will find QMEs turning down evaluations causing second requests under CCR section 31.5(a)(1).</p> <p>Represented (Form 105) and Unrepresented (Form 106) injured workers, declare their choice of evaluating physician when making their panel requests.</p> <p>These forms allow for only one choice, MPA, if the injured worker seeks an evaluation by a Pain Medicine specialist, even though that designation is shared by five different and distinctly training evaluators. Nowhere is the injured worker made aware that, if fact, he/she can choose from five different and distinctly trained evaluators. In addition, nowhere is the injured worker made aware that, in fact, he/she indicated on either form, that without such a sub-specialist choice, dozens of different combinations of pain medicine specialists may be listed on the subsequent, random panel of three QMEs. This is unfair to the injured worker and evaluator alike.</p> <p>Commenter strongly suggests that the division revise Forms 100, 104, 105 and 106 to contain codes specific to each existing Pain Medicine specialist as follows:</p> <ul style="list-style-type: none"> <li>• PMG – Pain Medicine – the (general) stand-alone currently shown as MPA</li> <li>• PMA – Anesthesiology – Pain Medicine</li> <li>• PMN – Neurology – Pain Medicine</li> <li>• PMR – Physical Medicine and Rehabilitation –</li> </ul>			<p>to include, for example, both MPA Psychiatry-Pain Medicine and MPD Psychiatry (other than Pain Medicine), or MPN Neurology and MPA Neurology-Pain Medicine, or MPR-Physical Medicine &amp; Rehabilitation and MPA-Physical Medicine &amp; Rehabilitation-Pain Medicine, etc.</p> <p>Further, the Administrative Director determined at the time of grouping all of the listed specialties under MPA that all existing QMEs listed under Anesthesiology were also listed under Pain Medicine, as each held the appropriate credentials for Pain Medicine and none were listed solely under Anesthesiology. Accordingly there was no need for a standalone Anesthesiology category for Qualified Medical Evaluators.</p> <p>Because each of these physicians possesses and must be able to provide documentation to the Administrative Director upon</p>	

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	Pain Medicine <ul style="list-style-type: none"> <li>• PMP Psychiatry – Pain Medicine</li> </ul>			seeking appointment or reappointment of the physician’s specialty or subspecialty certification in pain medicine, the Administrative Director does not believe any will face the type of conflict referred to by the commenter. Moreover, as with evaluators in other specialties, whenever an evaluator determines there is a need for a consultation or need for an evaluator in a different certified specialty, the proposed regulations section 32 (Consultations) or section 31.7(b)(2) provide methods for the evaluator to advise the parties and for the parties to obtain an evaluation from a physician in the appropriate specialty.	
QME Form 105	Replace “Claims Administrator/Employer” with “Claims Administrator”.	L18	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	Rejected. The form is clear as proposed.	However, to make the forms compliant with the Division’s Electronic Adjudication Management System (EAMS), which is transitioning the Division’s systems to a paperless system, the formatting of the form has been changed.
QME Form 106	Replace “claims administrator or employer” with “claims administrator”. Remove “(Note YOU MUST ATTACH A	L19	Brenda Ramirez Claims and Medical	Rejected. This note is necessary both because the	However, to make the forms compliant with the

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	<i>COPY OF YOUR WRITTEN PROPOSAL NAMING ONE OR MORE PHYSICIANS TO BE AN AME.)”</i>		Director Michael McClain General Counsel & Vice President California Workers’ Compensation Institute July 10, 2008 Written Comments	Medical Unit needs a copy of the first written proposal naming one or more physicians to serve as an AME in order to determine whether a panel request in a represented case is premature or timely, prior to processing the request. Labor Code section 4062.2(b) provides, in pertinent part, “If no agreement is reached within 10 days of the first <i>written</i> proposal that names a proposed agreed medical evaluator, or any additional time not to exceed 20 days, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation.” Because the party submitting the first valid request is entitled by section 4062.2(b) to select the specialty of the QME panel, the Medical Unit needs to determine whether a request was sent after, or prior to, the 10 day period for attempting to agree to an AME.	Division’s Electronic Adjudication Management System (EAMS), which is transitioning the Division’s systems to a paperless system, the formatting of the form has been changed.
QME Form 107	Replace “Ins./Adj./Agency” with “Claims Administrator”.	L20	Brenda Ramirez Claims and Medical	Accepted.	The requested change has been made.

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			Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments		
QME Form 108	For consistency, replaced the term "claims adjuster" with "claims administrator" since the Division has made this substitution in every other instance on this form.	L21	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Accepted.	The term 'claims administrator' has been inserted throughout the form in place of claims adjuster.
QME Form 110	Replace the heading "INSURER or CLAIMS ADMINISTRATOR INFORMATION" with "CLAIMS ADMINISTRATOR INFORMATION" and replace "CLAIMS ADMINISTRATOR/EMPLOYER (or attorney if known)" with "CLAIMS ADMINISTRATOR".	L22	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Accepted.	The wording changes suggested have been made in the form.
QME Form 111	Delete from the form "if none, enter Employer information" and delete from the instructions "or if none the employer".	L23	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel &	Reject. An unlawfully, uninsured employer is not included in the definition of a claims administrator, and it is highly unlikely that such an	None.

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			Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	employer would have a claims administrator.	
QME Form 120	Delete “, or if none by my employer”.	L24	Brenda Ramirez Claims and Medical Director Michael McClain General Counsel & Vice President California Workers' Compensation Institute July 10, 2008 Written Comments	Rejected. To be consistent with the Labor Code, the section will refer only to the employer.	The words “claims administrator, or if none” have been deleted.
DWC Form 120	Commenter states that he likes the idea of this form and he is a psychiatrist who performs QME exams.	A1	Bob Cooper, MD June 25, 2008 Written Comment	Noted and accepted.	None requested.
QME Form 121 – Item 3	To enhance clarity, commenter recommends deleting the words “consequences including” in the last part of the sentence.  ...will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, <del>consequences including</del> (describe medical basis for conclusion):	O11	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accepted.	The duplicative wording has been deleted.
QME Form 121 – Item 4	Commenter recommends the following amendment:  ... I was asked by the above named employee, or I was required by law to serve a copy of this medical record on the employee.	O12	Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008	Accepted.	The grammar was corrected.

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QME Form 121 – Item 7	To enhance clarity, commenter recommends deleting the extraneous words “I did” in the second sentence. ... However, <del>I did</del> , at the employee’s request, I did provide or serve a copy of the record...	O13	Written Comment Marie W. Wardell Claims Operations Manager State Compensation Insurance Fund July 10, 2008 Written Comment	Accepted.	The requested change is made.
DWC Form 120 and 121	Commenter acknowledges the need for properly addressing the mechanism by which unrepresented workers are to receive reporting that will be entered into evidence in any given case. Commenter assumes that the procedures that the Division contemplates involve only unrepresented workers. He is unaware of any duty to obtain a release for medical information in situations in which a party to an examination is represented by legal counsel. Currently there is a range of procedures used by mental health practitioners and other doctors when issuing reports regarding individuals with psychiatric problems. Some of his colleagues routinely serve reporting directly upon an unrepresented worker irrespective of that individual’s state of mind. Such doctors do so indicating that it is their obligation under the Labor Code. Other mental health practitioners never serve any reports on examinees indicating that it is not their practice no matter what the Labor Code states. Somewhere in between are clinicians who recognize the need for the unrepresented worker to have access to evidence while being mindful of the need to contemplate its potential adverse effects upon the examinee. Commenter has enclosed a copy of a standard form used in his office for releasing psychiatric information in situations where an examinee or patient is unrepresented. Commenter believes that this document conforms to the existing Health and Safety Code protecting mental health	H1	Robert C. Larsen, MD Clinical Professor, Dept. of Psychiatry UCSF School of Medicine July 10, 2008 Written Comment	Accepted in part.	An optional QME form 125 Authorization for Release of Medical Information has been added, as well as a new section 125.

SECTION	<b>QME REGULATIONS (8 CCR 1-157)</b> <b>RULEMAKING COMMENTS</b> <b>15 DAY COMMENT PERIOD</b>	ID No.	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>records.</p> <p>Typically his office sends out reporting to the defendant as well as the unrepresented worker in workers' compensation cases. He makes a clinical decision as to whether the individual involved should have that information served directly or through a treating, designated clinician. (he is unsure that the regulations contemplated would allow for a master's level clinician to be involved, a situation not uncommonly confronted by examining mental health practitioners.) The documents that are currently contemplated, DWC Form 120 and 121, I are unnecessary given his current practice. He questions that they conform to what is required in the Health and Safety Code. Mental health records when released are to have a specific purpose, a date through which the information can be released, etc. Do you contemplate obtaining a release each time a supplemental report is requested or will the initial DWC forms serve an ongoing purpose and function? If the examining doctor follows your recommended procedure and regulations, is the clinician then required to obtain a separate signed release conforming to the Health and Safety Code?</p> <p>Commenter points out that some unrepresented workers choose not to have legal counsel and are dealing with straightforward administrative matters regarding benefit provision. However, some of the more difficult cases involve individuals who are litigious, mistrustful to the point of being paranoid, impulsive and/or malicious. There is a reason that some people do not have attorneys beyond the notion of there being an insufficient supply of skilled workers' compensation lawyers in California. These cases are extremely difficult for employers, insurers, union representatives, treating doctors and QMEs. Do you contemplate there being situations in which a comprehensive report would not be served on the</p>				

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	<p>applicant, based upon a determination by the examining physician? Form 120 allows for service on a treating physician or to the applicant directly. What is the examiner to do if his determination is not in the examinee's best interest to have the information directly yet that person will not cooperate? There are situations that do not necessarily justify a Tarasoff warning yet could certainly lead to disruption on the part of the applicant or employer representatives should information be misinterpreted. Aside from misinterpretation let us not be naïve; there are some individuals that are if not evil, highly volatile and prone toward impulsivity, if not overt aggression and violence. If reports are to be served upon paranoid, delusional individuals then the reports will no doubt become far less specific. This is just one type of bad situation that needs to be contemplated when providing highly charged information to disturbed persons.</p>				