

Thank you in advance for taking the time to review my recommendations and concerns regarding the proposed changes, which could potentially restrict the number of QME office locations to a maximum of five. I trust that careful consideration will be made prior to making any hasty decisions, which may have far-reaching, unintended, negative consequences.

Following a review of the facts supplied by Frank Neuhauser to the CHSWC members during their board meeting on 06/24/10, I was surprised to learn that thirty-one QME's wrote 10% of all reports evaluated by the DEU from 2005-2010. This is according to the information listed under the Newslines No. 49-10. With the number of QME's registered during the 2005-2010 period averaging out to be 4250, the 31 QME's referenced in Mr. Neuhauser's study equates to less than 1% of the registered QME's responsible for 10% of all reports over the 5-year span.

Details not provided in the information were which physician specialties the 31 referenced QME's were composed of as well as the regions of the state where they were located. If the overall "goal of the proposed restriction of QME office locations is to keep providers interested in participating as QME's, rather than leaving the system due to few panel assignments", an examination of both the fields of specialty and geographical location needs to be done.

A QME located in a rural location with a lower population will not receive as many panel selections as a QME located in a metropolitan area with a higher population per-capita. QME's with niche' specialties such as obstetrics, urology or internal medicine will not receive as many panel assignments based upon the unique aspects an industrial injury would require in order for their specialty to be selected. Musculo-skeletal injuries involving the spine as well as upper and lower extremities will receive a higher number of QME requests. Did Mr. Neuhauser take into consideration this information when calculating the 10% report writing figure used in his research?

A QME located in a less densely populated area who lists additional office locations in neighboring cities will have little to no effect on other QME's located in separate geographical locations, thus by limiting the number of additional office locations will negatively affect this type of QME physician using multiple office locations spread over a greater distance.

Many colleagues whom I have spoken with in my geographical area who have obtained their QME certification maintain only their primary practice location. This was described to me as a combination of a lack of available time sometimes necessary to review substantial medical records as well as the inability to be away from a busy practice. Many QME physicians choose to maintain a larger number of sites, while others decide to maintain few. There is nothing preventing a QME from adding additional evaluation sites.

The decision to add alternate QME sites comes with both the potential for additional evaluation selections as well as a very real possibility of not being selected. The argument that – "I never get picked" or – "it's not fair!" sounds like an elementary school child's complaint to their parent about a game at recess or perhaps a person who plays the lottery week after week and never

wins. The same system that selects the names of the QME's that list eleven-plus locations also lists the names of the QME with one.

I currently maintain forty-two QME sites in thirty-three different cities. In all but six cities I have only one exam location per city. For the six cities with more than one exam location, the cities have an average population in excess of 500,000. The argument that a physician who maintains multiple QME location sites will reduce the number of chances for another physician with only a small number of sites is only accurate if the multiple locations are all in the same geographical region. A single QME location in Napa has no affect on a fellow QME in Salinas and vice versa.

I resent the insinuation that a QME who devotes the additional time and resources required to develop a busy medical-legal/QME portion of their practice is -biased against the injured worker" as one forum post read. Many QME's are extremely proficient with their understanding of the ever changing requirements of report writing and as such produce a higher quality report for the parties involved. The decision to expand the number of exam locations and thus increasing the possibility of additional panel selections is no different than accepting and treating additional patients. For example, another post on the forum felt that even five office locations "is excessive" and that "quality, not quantity, of work should be the primary concern of all the parties" Do all chiropractors desire to treat 50-patients per day? No. Is it possible for those that choose to treat 50-patients per day provide each patient with a quality visit? Yes. Do all chiropractors want to treat 50-patients per day? No. The same rationale can be applied to the comfortable number of QME evaluations. Not every QME wants to evaluate the same number of injured workers, and those that do must adhere to the established timeframes for report completion and content.

In conclusion, to restrict all registered QME's to a maximum of 5-evaluation locations will ultimately reduce the quality of submitted reports and increase med-legal fees and time. It is unclear how the described "goal" of this proposed restriction to "keep providers interested in participating as QME's, rather than leaving the system" will in effect force me out of a system that has allowed me to provide high-quality QME services to a diverse variety of injured workers in underserved locations.

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Dadre Traughber, L.Ac., QME, DNBAO, MS

September 30, 2010

This morning, a few hours after the deadline (9/27) I read about the issue of locations for QMEs. So unfortunately my comments are just after the deadline, but I will comment anyway.

I have been a QME since 1993, since the first exam offered in the Bay Area. My specialty for the past 19 years has been occupational medicine. I have done well over a year in post-graduate training to be board-certified to be to take a proper history, an orthopedic / neurologic exam, and to write a solid QME report. I spend a lot of time with the patient, write excellent reports and have never had a report rejected. Writing QMEs has been an excellent way to keep my clinical and report writing skills honed.

Over the years I have seen the number of QMEs in the acupuncture specialty drop to sometimes only two or three QMEs in San Francisco, and two or three QMEs in Oakland, for example. These days, there are QMEs with multiple locations in the same city, and in several cities, but still only a handful of individual QMEs in the acupuncture specialty. Due to this situation, I have gone from writing a few QMEs a year to none in the past four years.

The past year I attended a QME seminar for acupuncturists in my area where the focus was on making a LOT of money for each QME report, with the billing NOT aligned with the Official Medical Fee Schedule. For a report that should be billed at \$750, a practitioner is billing and being paid literally THOUSANDS of dollars for each report. Why is this allowed? This is quite easy to confirm by doing a web search. When an acupuncturist is following this practice and has unlimited locations in unlimited cities in which to do this, how is this going to attract a variety of acupuncture QMEs when one or two acupuncturists in a wide area are dominating the panels? This has become an acupuncture QME mill, as it looks like it is becoming in the other specialties.

Also, since the relative number of acupuncture QMEs are quite small as the demand is significantly less than in other specialties, the limitation of QME locations should be relative to the number of acupuncture QMEs. Please consider this. Increasing the locations is decreasing the pool of acupuncture QMEs available and attracts fewer practitioners. Please look at the high number of acupuncture QMEs in the past two years which dropped drastically, I believe due to this situation of an excess of multiple locations.

It is not feasible business-wise to continue to pay for CEUs and the QME designation each year unless one is writing QME reports to offset the cost. For this reason and the reason above, unless the situation changes shortly, I regret that I can no longer continue as a QME. Now this makes the QME offerings in acupuncture even more slim; and the DWC has lost another well-educated and many years of experience practitioner to the QME mill.

I appreciate your consideration in this matter, particularly for the small field of acupuncture QMEs. I support a limitation of QMEs in any area relative to the proportion in each specialty, which would be considerably less in acupuncture.

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Lesley Anderson, MD, Chair WC Committee  
California Orthopaedic Association

September 27, 2010

We appreciate the Division revisiting the Qualified Medical Evaluator (QME) regulations to address two issues: 1) the number of practice locations of QMEs; and, 2) QME's board certification requirements.

### **Practice Locations of QMEs**

As the recent CHSWC report indicated, panel QME evaluation assignments are being concentrated in the hands of a very few QMEs who list multiple, if not hundreds of practice locations in the DWC database. We have previously indicated to the Division that COA opposes allowing QMEs to be certified at an unlimited number of practice locations.

COA has received many complaints from our members who felt that allowing a QME to be certified at multiple addresses was having a negative impact on the overall QME system. In the selection of a QME panel, those QMEs with many practice locations were selected more often, giving them an unfair advantage in the selection process.

Many well-qualified orthopaedic surgeons with only one or two practice locations who were actively involved in treating injured workers and performing medical-legal evaluations found that they are receiving no panel assignments. It did not make financial sense for them to recertify as a QME and adhere to all of the QME CME requirements. They have been gradually dropping out of the QME system, now leaving a shortage of orthopaedic surgeons willing to perform panel QME evaluations as reported by the CHSWC report.

We believe that the Division's proposal to allow 5 practice locations and an additional 5 locations in zip codes in which there are fewer than 5 QMEs in a particular specialty, strikes a good balance – allowing QMEs to have multiple offices, but reining in the unfair practices of hundreds of practice locations.

We strongly urge the Division to adopt the regulations as proposed.

### **QME Board Certification**

When an unrepresented injured worker is selecting a QME category for their evaluation, they are presented with a list of available QME specialties. There is really no explanation of what each specialty designation meant and what level of postgraduate training needed to be completed in order to claim a subspecialty area of expertise. It is important for the Division to ensure that when a QME is allowed to list a subspecialty area of expertise, it is meaningful and meets nationally recognized standards.

In the last round of changes to the QME regulations, the Division took a major step towards ensuring uniform application of the board certification requirement. We believe that the proposed changes will strengthen and clarify the intent of the Division even more. This will only serve to ensure that those QMEs who are allowed to have a subspecialty area of expertise listed, will be well-qualified to evaluate the injured worker.

We strongly urge the Division to adopt the regulation as proposed, limiting the board certification recognitions to only those recognized by the licensing authorities for physicians and surgeons or doctors of osteopathy.

California Chamber of Commerce

California Manufacturers & Technology Association

The California Coalition on Workers' Compensation (CCWC), the California Manufacturers and Technology Association (CMTA), and the California Chamber of Commerce thank you for providing the opportunity to comment on the proposed changes to the Qualified Medical Evaluator (QME) regulations posted to the DWC Forum. While we are generally supportive of the direction taken by the Division of Workers' Compensation, we would like to offer the following comments and specific modifications to the proposed regulations.

### **§ 10. Appointment of QME's**

Our coalition supports limiting the number of QME locations as proposed in the draft regulations. The current situation in which "traveling QMEs" dominate the panels, often with identical addresses, create the appearance of impropriety and reduces the credibility of these independent examinations.

In addition, the Commission on Health and Safety and Workers' Compensation (CHSWC) reported that the number of registered QMEs has declined by about 45% since 2005, and that a mere 3.9% of QMEs are performing nearly 40% of the current evaluations. While these two trends may not be connected, CCWC is concerned that additional QMEs could leave the system if balance is not restored. A diverse pool of QMEs is vital for maintaining choice and variety in the QME panels.

Our coalition would suggest a modification to the provision allowing QMEs to open five additional offices in ZIP codes in which fewer than five QME's are currently certified in the QME's medical specialty. As practically applied this would create a first-come-first-serve situation in these ZIP codes, and once enough additional QME offices were added to those ZIP codes to reach a total of five offices then no more certifications would be approved for QMEs with more than five locations. CCWC suggests the following modification:

1. The DWC, when allowing additional offices in these ZIP codes, should give priority to those QMEs with the fewest number of locations. This would eliminate the identified problem of having the same QMEs appear on a majority of panels, provide the workers' compensation community with a wider variety of QMEs, and provide a broad range of QMEs with sufficient referrals to incentivize continued involvement in the QME process.

### **§ 30. QME Panel Requests**

Our coalition supports the changes made to the rules governing QME panel requests because requiring parties to clearly outline the specific issues in dispute would reduce the number of instances where a Panel QME is requested in the absence of a real dispute simply to lock in a PQME specialty.

While we support the uniformity of the requests as proposed in this rule, we would caution the DWC against holding form over substance. The DWC should avoid rejecting panel requests

over minor missing details – a problem that has existed in the past. The unnecessary rejection of panel requests results in the delayed resolution of important issues and does not serve the interests of either party.

### **§31.1 Exchange of Information and Ex Parte Communications**

Our coalition has no specific objection to the proposed changes to §31.1; however, the meaning of the final modification to §31.1(d) is unclear. This portion of the regulations pertains to situations in which a panel has been requested, but the Medical Director has been unable to issue a panel. The specific change in question pertains to the specifics of an order to issue the panel by an Administrative Law Judge. It states that the order must include “the timeframe for requesting the QME Panel”. In this scenario the QME panel has already been requested and needs to be issued. We would suggest replacing this language with a requirement to include the timeframe for *issuing* the panel.

### **§41. Ethical Requirements and §41.5 Conflicts of Interest by Medical Evaluators**

Our coalition is supportive of the changes made to §41(c)(1) and §41.5(a), which prohibit the QME from requesting or accepting payment in excess of the amount allowable pursuant to the official medical fee schedule. However, CCWC would request that these provisions be expanded to include Agreed Medical Examiners (AMEs).

In addition, we recommend that these sections be expanded to specifically address the scheduling of QME and AME depositions. While the fee schedule currently allows a QME to request the advance payment of two hours of their fee, many QMEs and AMEs demand substantially more before agreeing to set a deposition. According to our membership there has been an increased instance of this type of demand, and CCWC believes that it should be directly addressed in the regulations.

The proposed regulations also add new language to §41(c)(3) that would result in a requirement that QMEs render their opinions or conclusions without regard to “age or disability”. CCWC is concerned with this addition because these may be relevant issues when evaluating a claimed industrial injury. We do not see how a QME could issue an opinion on the complex medical issues associated with many workers’ compensation claims without regard to age or disability. Moreover, in some instances, such as evaluating apportionment, a QME will be required to comment on an injured worker’s non-industrial disability.

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Brenda Ramirez, Claims and Medical Director  
California Workers’ Compensation Institute

September 29, 2010

This 1<sup>st</sup> Forum comment on modifications to proposed changes to draft revisions to QME regulations is presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 84% of California’s workers’ compensation premium, and self-insured employers with \$36B of annual payroll (20% of the state’s total annual self-insured payroll).

## **Recommendation**

The Institute recommends revising Section 30 to reflect the en banc opinion of the Appeals Board in Mendoza v Huntington Hospital (75 CCC 634 (2010), as soon as it becomes final.

In Mendoza v Huntington Hospital 75 CCC 634 (2010), (ADJ6820138 and ADJ6820197, June 3, 2010), the Board (en banc) invalidated administrative director Rule 30(d)(3) holding that the rule:

“... conflicts with sections 4060(c) and 4062.2 and exceeds the scope of section 5402(b). Neither section 4060 nor section 4062.2 provides that “only the employee may request” a QME panel after an employer has denied the compensability of a claimed injury. To the contrary, those sections when read together specifically provide that “either party” may make a QME panel request “at any time” after the filing of a claim form. Furthermore, nothing in section 5402(b) provides that a defendant must request a QME panel before it denies liability for an injury, even if that denial is based on medical causation grounds.”

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Staci J. Talan, DC, QME

September 29, 2010

Five office in my opinion is EXTREMELY LIMITED.

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Robert W. Adams, DC, DACBN

September 29, 2010

As a DC of 23 years and a QME of 17 years I would appreciate a fair consideration of the Specialty Designation for Chiropractic Neurologists. I have been practicing this Specialty since 1993. The patient assessments and Clinical applications are different than those implemented by general DC providers.

I recommend reestablishing the Specialty designation.

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Bill Howe, Executive Director  
California Chiropractic Association

September 29, 2010

The California Chiropractic Association opposes the elimination of chiropractic QMEs from being listed by their specialty as recognized by the state Board of Chiropractic Examiners (BCE). This proposal contradicts the DWC’s regulatory change implemented in February 2009 which limited specialty listings to those recognized by the physician’s licensing board. In its Initial Statement of Reasons for that regulatory change, the DWC maintained that the change was necessary to clarify that only California physician licensing boards have jurisdiction to recognize

specialty areas of practice. The DWC further stated that this change would make the criteria for being listed as a QME in a particular specialty transparent and consistent with the jurisdiction exercised by the respective California physician licensing boards.

The BCE now recognizes certain chiropractic specialty boards. For unknown reasons, the DWC has singled out and moved the goalposts for the chiropractic profession.

Specialty recognition allows patients to make an informed choice as to the chiropractic QME selected. The specialty listing is transparent as it discloses chiropractic doctors with advanced education and training. Withholding such information is unfair to all parties. Furthermore, the practice of sending panel letters containing additional post-graduate information *after* the chiropractic QME has been selected undermines the transparency sought by DWC and denies all parties relevant information necessary to make an informed QME selection.

Nearly two decades after the DWC permitted the listing of chiropractic QME specialties, CCA is unaware of issues that have arisen that threaten the safety of injured workers or integrity of the medical-legal evaluation that would warrant consideration of this unilateral restriction.

Finally, intended or not, the proposed regulation reads as blatant discrimination toward the doctors of chiropractic who earned a QME designation and a BCE-recognized board specialty(ies). This is an inconceivable position for any level of government to take.

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Lisa E. Ivancich, Chair, Executive Committee Workers' Compensation      September 29, 2010  
California State Bar Association

The Executive Committee of the Workers' Compensation Section of the State Bar has reviewed the proposed changes to the qualified medical evaluator (QME) regulations. The committee believes that data should be collected for each panel QME to track the number of panel evaluations performed, in what geographic location(s) the panel evaluations are performed, and the number of hours associated with each panel evaluation. Further, consideration should be given to allowing public access to the collected data.

The position stated is that of the Workers' Compensation Section of the State Bar of California. The position has not been adopted by either the State Bar's Board of Governors or the overall membership, and is not to be construed as representing the position of the State Bar of California.

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Mark Gerlach  
California Applicants' Attorneys Association

September 29, 2010

The following comments regarding the draft qualified medical evaluator regulations currently on the DWC Forum are submitted on behalf of the California Applicants' Attorneys Association.

Section 10. We support the proposal to limit a physician to a maximum of five QME office listings and up to five additional office listings in zip codes in which fewer than five QME's are currently certified in the QME's medical specialty. The QME panels have become dominated by physicians who list dozens of different office locations at which they do not actively practice. As demonstrated in the recent study of this issue by the Commission on Health and Safety and Workers' Compensation, the end result is that the assignment process is anything but random, with some QMEs receiving as many as 1,400 assignments in a six month period.

The consequences of these nonrandom assignment of QMEs are both significant and detrimental. One fundamental problem is that this unbalanced assignment process perverts the underlying rationale for assigning QME panels to resolve disputed medical and medical-legal issues. Instead of providing an evaluation by an independent specialist randomly selected from the injured worker's local area, the reality is that two and often all three names on a panel will represent out-of-area providers. In fact, it is a not infrequent occurrence that a QME panel will name three different physicians who have the same address and the same 800-prefix telephone number. Creating this group of self-selected traveling evaluators was never the intent of the Legislature.

The disproportionate share of QME panel assignments that is going to these mega-office providers creates another problem because the fact that some providers receive more panel assignments necessarily means that other physicians receive fewer assignments. Providers are required to devote both time and money in maintaining their QME designation, and it is understandable that physicians who are infrequently named to panels may decide that this expense is no longer justified. As more panel assignments have shifted to the mega-office providers, fewer of the remaining QMEs see the advantage of retaining their QME status.

Consequently, we support the adoption of the proposed language. However, we also urge the Division to continue to evaluate the QME panel selection process to assure that assignments are being made in a random manner. Fundamentally, we believe the intent of the "random selection process" language in statute is that each QME of the selected specialty within a specified area should have an equal chance at being named to a panel. Obviously, where a small number of QMEs are receiving a disproportionate share of panel assignments, this is not happening. One simple method to assure all QMEs have an equal chance to be named is to disallow duplicate names within the selection process. A QME can maintain as many locations as he or she deems appropriate, but allowing every QME to be listed only once in the selection protocol would produce a truly random 3 member panel.

A number of QMEs have submitted comments to the Forum asserting that the maintenance of multiple offices is a service to injured workers. Less travel for the worker may present an advantage to some workers, but is not cause to ignore the statutory requirement for random selection of QME panels. Furthermore, where the satellite location is only a rented space with no medical equipment, not only has the random selection goal been thwarted, but an injured worker who is seen in a back room of a massage parlor will lose all confidence in the integrity of the system and the process. For this reason, we also support the additional proposed language that

requires each listed location to "contain the usual and customary equipment for the evaluation and treatment appropriate to the physician's medical specialty or practice . . . ."

Sections 12 and 13. We do not understand the intent of the proposed change to add the words "and surgeon" after the word "physicians." As amended, section 12 would regulate the recognition of specialty boards for "physicians and surgeons as defined in Labor Code section 3209.3." The problem is that Labor Code section 3209.3 does not define "physicians and surgeons." Subdivision (a) defines "physician" to include "physicians and surgeons" but does not limit the definition to only those two categories. The statutory definition of "physician" also includes "psychologists, acupuncturists, optometrists, dentist, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law." Consequently, the proposed amendment appears to misstate the statute.

In addition, it was noted in the Newsline announcing this proposal that the proposed changes to these sections were necessitated by new regulations adopted by the California Board of Chiropractic Examiners. The Board recently adopted a regulation to recognize chiropractic specialties. That regulation was adopted in response to the amendments of these two sections by your Division in 2009 which allow recognition of only those specialties that are recognized by the respective California licensing boards. Consequently, we are unclear as to why the proposed amendment is required.

Section 30. A proposed amendment to Subdivision (b) would require attachment of "the requesting party's written request prescribed by Labor Code section 4062.2, subsection (b) . . . ." This new language appears to be a revision of the current requirement in paragraph (2) which specifies that a copy of the written proposal naming one or more physicians to be an AME must be attached to a QME panel request. We believe there are several problems with this proposed language.

First, the phrase "the requesting party's written request" is awkward. As we understand the proposed language, the "request" referred to in the phrase "requesting party" is a request for a QME panel, while the "written request" is a proposal to the opposing party naming one or more physicians to be an AME. We suggest that this language be rewritten to clearly state that a copy of the letter to the opposing party naming one or more physicians to be an AME must be attached to the QME panel request, as is required in the current language.

In addition, if the "written request" is a proposal for an AME sent to the opposing party, subdivision (b) is confusing. This subdivision requires that the "written request" include each of the delineated items in paragraphs 1) through 7). We do not believe this is the intent of the change, as it is not necessary to include these items in the letter to the opposing party proposing an AME. Instead, these items should be included in the QME panel request, and the language should be rewritten to make that clear.

We also question the need for the proposed addition to paragraph 2) to require identification of "the relevant Labor Code section for each disputed issue identified." What is the purpose of requiring identification of the applicable Labor Code section? Who will screen it? What if the

section number is wrong? Because QMEs must address all issues in a comprehensive report, we don't see the need for this requirement.

Finally, although paragraph 6) has not been amended, we suggest that the Division reconsider whether this is an appropriate item to be included in the QME panel request. We do not believe this information is relevant to the Division's responsibilities in the issuance of QME panels. If there is a dispute over the requested specialty of the QME, the WCAB is the proper body to resolve that issue. Consequently, we suggest that if the Division moves forward with a revision to the QME regulations, paragraph 6) be deleted.

Section 31.1. The numbering in this section should be corrected as the proposed language skips from subdivision (a) to subdivision (d).

In addition, we continue to believe that the "remedy" set forth in subdivision (d) is meaningless. Allowing either party to seek an order from a WCJ to issue the panel adds unnecessary cost and delay. Furthermore, as there is no penalty to the Division if it also fails to issue the panel within the timeframe set by the WCJ, we do not believe this process provides any more assurance that the panel will be issued. And ironically, even if the panel is ultimately issued within the WCJ's timeframe (but obviously still late), the special handling given to these cases may simply cause further delay on all other cases, generating even more late panels, more litigation, more delays, and more costs. Consequently, we urge the Division to consider adopting a rule that allows the parties in a represented case to select their own QME when the Medical Director is unable to issue a panel within 30 days. This will assure that the represented worker has the same right as the unrepresented worker to get a needed medical or medical-legal evaluation in a timely manner.

With respect to the specific language in this proposal, the wording in subdivision (d) is awkward. The new phrase requiring identification of the zip code, the date of injury, and the parties' addresses is misplaced, because the phrase "or the party to be designated to select the specialty" should immediately follow "the specialty of the QME . . ." We suggest that instead of adding the new requirements to the existing sentence, a new sentence be added, for example: "In addition, the order shall specify the zip code from which to search for QMEs in that specialty, the date of injury, the addresses of all parties, and the date by which the QME panel must be issued."

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James G. Fischer, MD

September 29, 2010

I am an orthopedic QME and have been since the inception of QME's

I am writing to express my disagreement with limiting QME locations to 5. While I understand the concerns related to the QME "Mills" with excessive locations, I think a limitation to 10-15 locations would take care of that problem.

I would have great concerns that a 5 location limit may have many patients waiting for long periods of time to obtain their QME evaluations.

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Carlyle R. Brakensiek and Stephen J. Cattolica, Legislative Advocates      September 29, 2010  
AdvoCal

On behalf of the California Society of Industrial Medicine and Surgery (CSIMS) and California Society of Physical Medicine and Rehabilitation (CSPM&R), thank you for addressing a number of recurrent issues found in the QME regulations.

Below are our constituents regarding the regulatory proposals described within the current *Forum*. In addition, we observed that the previous revision of the QME regulations uncovered a number of ambiguities and added questions which we would like to suggest the Division add to this regulatory package.

#### Current *Forum* Proposal

#### **§ 10. Appointment of QMEs.**

The Division proposes to add a new subdivision (b) to Regulation 10, to read:

(b) A physician may concurrently hold separate QME certifications at up to five physician's office locations chosen by the QME, and up to five additional physician's office locations in ZIP codes in which fewer than five QMEs are currently certified in the QME's medical specialty. Each office location must be located in California, identified by a street address and any other more specific designation such as a suite or room number, must contain the usual and customary equipment for the evaluation and treatment appropriate to the physician's medical specialty or practice, and must comply with the protections and prohibitions contained in Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), section 11135 of the California Government Code, section 51 *et.seq.* of the California Civil Code and other applicable state and federal disability laws. The QME must have a reasonable basis to believe that each office location will be available for the QME's use during the QME's current period of appointment.

As you know, CSIMS and CSPM&R have discussed the issue of multiple QME offices with you and your staff on a number of occasions. In a sense, the process is no longer as random as originally contemplated by the Legislature and Division because of the proliferation of offices by QMEs who "ride a circuit." The CHSWC study cited by the Division clearly shows a "tilted playing field" and strongly suggests that there are significant consequences when only a few QMEs provide a disproportionate number of reports. There have been a number of approaches discussed and considered, each of which have brought new issues to the discussion. While we

appreciate and support the Division's efforts to address this issue, we feel the proffered solution has several shortcomings and oversights.

For example, assume three QMEs each have five registered offices and each would like to open another office in an underserved ZIP code that presently has four QMEs registered in the specialty. Simultaneously, they file their requests to register a new office in the underserved ZIP code. Do they all "win"? If not, who does?

Second, assume a QME has six registered offices, one of which is in an underserved ZIP code. Subsequently, three brand new QMEs register in the underserved ZIP code such that it is no longer considered "underserved" under your regulations. Would the QME who registered his/her sixth office in the formerly underserved ZIP code now have to close his/her office?

Third, assume a QME is recognized in two specialties (e.g., psychology and neuropsychology) and has five registered primary offices. If the physician would like to open additional offices, must he/she register each new location in both specialties, or could he/she register one specialty in five new offices and the other specialty in five other offices? This question is important because the distribution of specialties may differ between locations so there could be an oversupply of psychologists and an undersupply of neuropsychologists in one ZIP code and the opposite distribution in another ZIP code.

Basing the registration of QME offices on ZIP codes does not seem appropriate. Some ZIP codes encompass a few square blocks in metropolitan areas while in rural communities a ZIP code could cover scores of square miles. Not all ZIP codes have the same population densities.

Accordingly, we would like to suggest an alternative to the complex administration, cost, and loss of revenue that the Division's current proposal would cause. We propose that no language be added to Section 10, thereby retaining the present breadth of geographic coverage and fee revenue. Instead, we suggest implementing the following change in Medical Unit's internal procedures that we believe would retain randomness, but blunt the effect of multiple offices.

The basic concept is that in choosing the three QME panelists, the Medical Unit should consider QMEs' names only, not registered office locations.

As we understand the current panel creation process, based on the injured worker's home address, concentric geographic "circles" of increasing distance are drawn until approximately six QMEs are found. From that pool of choices, three names are randomly chosen. Using this model, the more addresses a QME maintains within the radius, the greater the chance he/she will be chosen as one of the final three. Our suggestion would be to count only the names, regardless of the number of addresses that anyone of the QMEs may maintain within the given radius.

When the prescribed number of names is reached, a random group of three is chosen with no QME being represented in that pool more than once, regardless of the number of addresses he/she maintains within the radius. Therefore, each name has an equal chance of being chosen in the final panel of three.

For example: The following 11 physicians are found within a certain radius from the injured workers' residence. Assume the threshold number of physicians needed to properly draw the QME panel is six.

Following are the results of the search to find the pool of QMEs:

Dr. A - has four addresses

Dr. B - has one

Dr. C - has three

Dr. D - one

Dr. E - one

Dr. F - one

Dr. G - one

Dr. H - one

Dr. I - eight

Dr. J - two

Dr. K - two

For the purpose of choosing the panel of three, each name is counted only once, even though one doctor has four offices within the radius, another doctor has three and the rest have only one or two. Taking the six closest names, each name has an equal chance of being chosen (a one-in-six chance). From the pool of six names, three are chosen. If more than one address is available for one of the chosen QMEs, the Division would assign the address closest to the injured worker's residence.

Again, this suggestion blunts the effect of multiple addresses that gives an advantage to physicians who maintain multiple addresses in urban areas while still allowing representation in more rural areas where multiple offices are less likely.

If the DWC chooses to retain even a modified version of the regulatory solution currently proposed we would continue to suggest the above internal process be implemented. This procedure will work to "level the playing field" in urban areas where the effect of multiple offices is most likely to skew panel assignments adversely.

We request a clarification on two points with respect to the phrase, "hold separate QME certifications at up to five physician's office locations ....."

First many QMEs hold more than one specialty designation. Although it is customary to register all specialty designations at all of the addresses, there is no mandate to do so. It is up to the QME. That being the case, we seek some clarification regarding the five locations chosen by the QME. What does the DWC contemplate when the QME can be registered in multiple specialty designations? It could be interpreted to mean that each specialty designation can have five addresses chosen by the QME. Is this correct?

Second there is likely already good coverage statewide in the orthopedic and other "mainstream" specialty designations, meaning at least five per zip code. However, in some mental health disciplines and others (podiatry, ophthalmology, urology, infectious disease, radiation oncology etc.), there may not be adequate coverage and the Division should certainly encourage QMEs to enter into those geographic areas.

Third, will current QMEs be "grandfathered" into their existing offices located in what might otherwise be considered an underserved area? If so, where today, for example, there are ten orthos in one ZIP code and seven of those ten orthopedists are "circuit riders," how does this open or affect that market? If not "grandfathered," then all QMEs must re-apply to each of their current addresses. If a QME sends in his/her application for renewal in May for next July's renewal date, does he/she beat the rest with respect to the underserved ZIP codes? How will the DWC prevent this process from causing a "land rush" mentality wherein QMEs attempt to beat one another by mailing earlier and earlier? Conversely, if this regulation is implemented over a span of time - as QMEs renew - will this process not possibly give the early renewals an unfair advantage over the later ones with respect to "underserved" ZIP codes? Again, if a "land rush" begins, there is a real risk that the local QMEs may be inadvertently displaced by better organized "circuit riders."

Finally, with regard to QMEs who have already registered and paid for locations they may have to drop on January 1, 2011, will they receive a pro-rata refund of their registration fees? Alternatively, will they be permitted to retain those office locations at least until the renewal date of their QME appointment?

## **§ 12. Recognition of Specialty Boards and § 13. Physicians' Specialty.**

We are very disappointed by the Division's proposed amendment to Regulations 12 and 13. The chiropractic profession and the Board of Chiropractic Examiners worked diligently to comply with the current regulation to enable the recognition of chiropractic specialties. It is disingenuous for the Division to thwart those efforts with its proposed amendments.

There is no apparent reason for the Division to omit the Chiropractic Board's members from specialty designation and certainly no medical or academic reason that chiropractic sub-specialties should not be recognized.

We suggest that the phrase, "and surgeons" be stricken in both Section 12 and Section 13. The effect would be to include specialty boards recognized by the California Board of Chiropractic Examiners as has been historically the case.

### **Additional Topics for Consideration**

Since the Division is proposing to make various changes to the QME Regulations, we have several other suggested revisions that should be incorporated into the next rulemaking. Following are our suggestions:

#### **Conflict Between §11(d) and §41(a)(4)**

Current Regulation 11 (d) provides that a QME "[S]hall agree that during a QME evaluation exam he or she will not treat or offer or solicit to provide medical treatment for that injury for which he or she has done a QME evaluation for an injured worker unless a medical emergency arises.... A QME may also provide treatment if requested by the employee pursuant to section 4600 of the Labor Code, but he or she shall not offer or solicit to provide it."

Although Regulation 11 (d) authorizes treatment by a QME in certain circumstances, Regulation 41 (a)(4) seems to prohibit it in all situations, including medical emergencies. Regulation 41 (a)(4) provides that all QMEs, whether or not the worker is represented by an attorney, shall "[r]efrain from treating or soliciting to provide medical treatment, medical supplies or medical devices to the injured worker."

We urge the Division to resolve the inconsistencies between these two regulations.

### **§34. Appointment Notification and Cancellation**

Regulation 34(b) generally provides that a QME may only provide a comprehensive medical-legal evaluation at the location on the panel selection form or, solely for the convenience of the injured worker, at another listed QME office location.

There may be circumstances where compliance with this regulation would be difficult or impossible. First, a patient may be agoraphobic and unwilling to travel to the QME's registered office. Second, the injured worker may be bed-ridden or confined to a hospital or rehab center location. Third, a patient may have moved out-of-state and is unwilling to return to California for the evaluation. Fourth, the patient may reside in a rural part of the state and not have access to convenient public or private transportation to the QME's office.

Recently, we learned of yet another situation where literal compliance with Regulation 34(b) would be difficult or unreasonably expensive. An injured worker selected Dr. R, a psychologist as her panel QME. Dr. R's office is on the second floor of a building that does not have an elevator. The injured worker claims that because of her medical condition, she is unable to climb the stairs to Dr. R's office for her panel exam. Dr. R is willing to travel to her home and perform the evaluation there, but this is not presently permitted by Regulation 34(b).

Although we certainly recognize the former abuses that led to Regulation 34(b), we feel the resulting language was unnecessarily restrictive. Furthermore, with the Division's proposed amendment to Regulation 10(b) to require that all QME offices be ADA-compliant, it is even more imperative that Regulation 34(b) be revised. Accordingly, we urge the AD to consider revising Regulation 34(b) to read:

(b) ~~The~~ Except as provided in this paragraph, the QME shall schedule an appointment for a comprehensive medical-legal examination which shall be conducted only at the medical office listed on the panel selection form. However, upon written request by the injured worker and only for his or her convenience, the evaluation appointment may be moved: (1) to another medical office of the selected QME if it is listed with the Medical Director as an additional office

location, or, (2) to another location approved in writing by either the Medical Director or by both parties.

We feel that such a revision will avoid hardships to injured workers while preventing any opportunities for the abuses at which Regulation 34(b) was originally aimed.

#### **§ 34(h). Appointment Notification and Cancellation**

This section prohibits cancellation of a QME or AME appointment by a party less than six (6) business days prior to the appointment date, except for good cause, but provides no penalty for so doing. Since the Medical-Legal Fee Schedule prescribes the use of the service code ML-I00 for missed appointments, it is within the Administrative Director's authority to assign a reimbursement rate to an occurrence that violates this Section. Since this Section already provides that the Appeals Board retains jurisdiction with respect to a violation of this Section, such a rate would not only be appropriate, but would provide the Board with an action to take if such a violation is established by the Court.

#### **§ 32(c). Consultations**

This section clearly states that the QME may obtain a consultation from any physician as reasonably necessary. We are aware of numerous occasions, however, where an adjuster has refused either to authorize or to pay for a medical-legal consultation because the consulting physician was not a member of the defendant's treating medical provider network (MPN). We recommend that Regulation 32 be amended to clarify explicitly that a consultant in a medical legal situation is not required to belong to an MPN.

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Chris M. Cake, D.C.

September 29, 2010

It is my professional opinion that your goal of attracting more doctors to become QMEs with this proposal will have the opposite outcome. Why would a doctor want to become a QME if he or she is limited to only 5 sites? They will receive hardly any examinations if at all. I have 22 sites, and some months I receive 3-4 evaluations a month, while none other months. The exams I receive is random each month. You don't want to sacrifice the whole QME profession because of a few doctors. I would regulate the few who have brought this forum into the spotlight. Thank you.

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Tony L. Smith, D.C.

September 29, 2010

It has come to my attention that the Division of Worker's Compensation's proposes regulation that will limit the QME specialty listings to medical doctors and doctors of osteopathy. I strongly oppose this action.

I have been a licensed practicing chiropractor with a QME background for well over a decade. Besides believing it is the consumer's right to choose a specialty doctor I also see a strong contradiction between a regulatory change made last year by the DWC.

The elimination of chiropractic QME specialty listings directly contradicts DWC's reasoning for the regulatory change last year requiring specialty listings to be limited to those that are recognized by the physicians licensing board. "This amendment is necessary to clarify that only the CA physician licensing boards have jurisdiction to recognize specialty areas of practice. This change will reduce confusion regarding certified specialty designation for both QMEs and the public who must choose among QMEs to do forensic evaluations." The state Board of Chiropractic Examiners adopted a regulation to recognize "those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractic Association" that complies with the DWC QME specialty listing requirement. I am unaware of any necessity that has developed since the DWC's original regulation on this subject for this further listing prohibition.

Thank you for our consideration. I am sure the DWC will see the conflicts with its prior positions on this matter and consequently drop the proposal. Ultimately, I know that the DWC wants to ensure fairness as well as quality care.

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Perry J. Carpenter, D.C.

September 29, 2010

I'm writing to oppose the new proposed QME Regulations that eliminate Chiropractic listings according to Chiropractic Specialties. The proposed regulation allows Medical Doctors and Doctors of Osteopathy to be listed by Specialty but the new proposed regulation discriminates against Doctors of Chiropractic who have completed extensive post-graduate training in Chiropractic Specialties. I am a Doctor of Chiropractic with post graduate training in Chiropractic Orthopedics (Diplomate, Academy of Chiropractic Orthopedics) and Chiropractic Neurology (Board Eligible). These are Chiropractic Specialties that are recognized by the California State Board of Chiropractic Examiners as well as the American Chiropractic Association. Each of these Specialty designations requires completion of more than 300 hours of lecture and testing along with a significant commitment in personal time and personal finances. 300 hundred classroom hours roughly translates into 20 full weekends of additional study! While I have heard argument that the Chiropractic Specialty programs do not compare in rigor to a Medical Internship – which may involve as much as a 2 year, full time program on site – this is not relevant as relates to the Chiropractic Specialties. The Chiropractic profession does not yet have full time internship programs however, what we do have for those committed doctors who want to advance their expertise in the field of CHIROPRACTIC are our Chiropractic Specialty programs. And, in my opinion, those that complete these voluntary programs deserve special commendation. And, these programs are open to all licensed Chiropractors.

The Division of Worker's Compensation – Medical Unit's decision to eliminate the Chiropractic Specialties raises eyebrows. In February of 2009 when the DWC eliminated Specialty listings for Chiropractors, they (DWC) required that only those specialties recognized by their respective

licensing Boards would be adopted as Specialists for the purpose of QME Panels. At that time, the Board of Chiropractic Examiners did not have in place the process for determining which Chiropractic Specialties would be considered to be “recognized.” After almost 15 months, the Board of Chiropractic Examiners adopted Section 311.1 of Title 16 CCR which stated “For purposes of the Department of Industrial Relations’ Qualified Medical Evaluator Eligibility regulations (Division of Workers’ Compensation, Title 8, California Code of Regulations, **Section 12**), the board recognizes only those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractors Association.” This established the system by which 1) our Board of Chiropractic Examiners would qualify those programs describing themselves as “Specialists” or “Diplomates” and 2) complied with the Division of Worker’s Compensation’s requirement. Unfortunately and for no apparent or written reason, once this was adopted by the Board of Chiropractic Examiners, the Division of Worker’s Compensation – Medical Unit failed to timely adopt this regulation. Rather, the Medical Unit acted to further block the Chiropractic Specialists by changing the language of **Section 12** from its former “physician’s licensing board” to “physician’s and surgeon’s licensing board.” This is clearly discriminatory against Chiropractic Specialists specifically, and against the Chiropractic profession in general. There is no explanation for this but the intention is clear and, as a practicing Chiropractor for over 24 years and an earnest Qualified Medical Evaluator for 15 years, I rely on my advanced training in Chiropractic, Orthopedics, and Neurology in every patient I treat and with every injured worker that I evaluate. In my opinion and in my experience, in all of the Health Care fields – in this case whether that be as a Medical Doctor, a Doctor of Osteopathy, or a Doctor of Chiropractor, those with added training represent the “best of the best” and are the finest evaluators by virtue of their added training. Isn’t that the point? Isn’t that what the public demands? If so, and if Medical Doctors and Doctors of Osteopathy are allowed to be listed by their appropriate Specialty designations, why would Chiropractic Specialties be excluded? Why? What’s the reason?

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Jose Ruiz, Claims Operations and Systems Manager  
State Compensation Insurance Fund

September 29, 2010

State Fund appreciates the time and effort the Division of Worker’s Compensation (DWC) has put into the draft regulations to revise the Qualified Medical Evaluator (QME) regulations. We offer the following comments on the draft regulations.

### **Section 1. Definitions**

#### **§ 1(y) – Discussion**

The draft revision to this section makes a non-substantive change to the definition of “Physician’s office”. Under § 10(b) draft revisions define “office location”. It appears that “office location” and “physician’s office” may be synonymous as used in the regulations in Chapter 1.

### **Recommendation**

If it is the Division's intention to clarify and refine the definition of a "Physician's office" as used in the regulations in Chapter 1, the clarification might be more appropriately placed under §1 – Definitions rather than under § 10(b). If an "office location" is intended to be defined differently than a "physician's office", the definition of "office location" might be better placed under § 1(y) - Definitions.

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David M. Broderick, MD

September 29, 2010

This is in response to the recent proposal to limit the number of offices a Qualified Medical Evaluator could use to perform medical evaluations. As you will recall the prior system entailed having the injured worker referred to the examiner's office for examination. To make the process more convenient for the injured worker, the DWC recommended that that program be changed. The zip code where the injured worker lived, or as close as possible to that locale was to be used in assigning the examination. For that reason many examiners, including myself, would service multiple zip codes. That practice was endorsed by the then DWC director, Ann Searcy.

The present system does provide coverage for the injured worker in multiple zip codes. The proposed program would limit the number of offices an examiner could use to five, with an additional five in under covered areas, which is not going to be adequate in servicing many underserved areas of the state.

There is an additional problem in that many of the younger physicians are not becoming Qualified Medical Examiners or are not permitted to perform examinations due to their contractual obligations with multi-specialty organizations. There will, therefore, be fewer physicians available to perform Qualified Medical Examinations in the future. By limiting the number of available localities, it will be much harder for the injured worker to obtain medical evaluations and it will be unfeasible for evaluators to perform that service.

If it is the intent of the Department of Workers' Compensation to do away with the Qualified Medical Evaluation system, then the above proposal would achieve that goal. It is the opinion of this examiner that limiting the number of offices available to perform examinations would not be in the best interest of the DWC or in the best interest of the injured worker.

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Nicholas B. Houston, D.C., QME

September 29, 2010

I have been a practicing California Doctor of Chiropractic and QME for over 25 years. I am writing to express my ***strong opposition to the Division of Workers' Compensation's (DWC) proposed regulation that would limit the QME specialty listings to medical doctors and doctors of osteopathy.*** I am shocked to hear of the proposal to prohibit chiropractic QME listings. What is the advantage to permitting only medical and osteopathic doctors QMEs to be listed by specialty?

I am a doctor of chiropractic with post-graduate education (Chiropractic orthopedics) that is recognized by the state Board of Chiropractic Examiners. The elimination of chiropractic QME specialty listings is in direct contradiction of the DWC's stated reason for the regulatory change last year requiring specialty listings to be limited to those that are recognized by the physician's licensing board: *"This amendment is necessary to clarify that only the California physician licensing boards have jurisdiction to recognize specialty areas of practice. This change will reduce confusion regarding certified specialty designation for both QMEs and the public who must choose among QMEs to do forensic evaluations."*

Our state Board of Chiropractic Examiners (BCE) adopted a regulation to recognize "those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractors Association" that complies with the DWC QME specialty listing requirement. I am unaware of any concerns that have arisen since the DWC's original regulation on this subject for this further listing prohibition.

**The State Board of Chiropractic Examiners has recognized chiropractic specialties in a manner that complies with the DWC QME specialty listing requirement.** This proposal to prohibit the listing of chiropractic QME specialties is in direct defiance of the authority of provider licensing boards the DWC recognized in its original regulation on this subject that stated: "This change will make the criteria for being listed as a QME in a particular specialty transparent and consistent with the jurisdiction exercised by the respective California physician licensing boards."

Nearly twenty years after the DWC permitted the listing of chiropractic QME specialties; I am not familiar of any issues that have arisen that would threaten the safety of injured workers or warrant consideration of this unilateral restriction. The DWC did not cite any reason other than to reduce potential confusion and bring consistency relative to licensing board jurisdiction over specialties when it limited these listings last year.

The California Business and Professions Code section 651 authorizes the advertisement of chiropractic specialties. Neither the state chiropractic board nor the DWC can limit the use of specialties unless the use of a specialty misleading to the public. In its revision to this section last year, the DWC ensured a QME's specialty designation was not misleading or confusing. A doctor of chiropractic's right to advertise a specialty designation is constitutionally protected commercial speech. Only the Legislature can limit the use of specialty designations - and even then the Legislature could only restrict the use of specialty.

**If this regulation is enacted, it would have the effect of preventing injured workers from selecting a "chiropractic neurologist," "chiropractic orthopedist" or any other state Board of Chiropractic Examiners-recognized specialty as a QME.** As specified in the existing regulation approved only last year, an injured worker should to be able to choose a QME with additional training because that injured worker will get a QME report from a doctor is more highly trained and better informed on treatment protocols for that type of injury.

As the holder of an advance *chiropractic orthopedist* designation, I urge the DWC to withdraw this ill-conceived prohibition on chiropractic QME specialty listings. I ask the DWC to maintain its existing position relative to the listing of chiropractic QME specialty listing as there has been no demonstrable necessity demonstrated for this illogical listing elimination. As this change infringes on the DWC's own recognition of the physician licensing boards' jurisdiction in recognizing specialties for QME listing purposes, I urge your strong consideration for its immediate retraction.

Thank you in advance for your anticipated consideration of my comments. It is my hope and prayer that the DWC will see the conflicts from previous positions on this issue and retract this proposal.

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Deborah J. Beach, DC, DACNB, QME

September 29, 2010

I am writing to oppose the QME chiropractic specialty change. I am a doctor of chiropractic with a post-graduate neurology specialty that is recognized by the state Board of Chiropractic Examiners. We as neurology diplomates, in order to maintain our certificate do extensive reading, writing, and are required to do continuing education that is approximately three times the required general chiropractic license. We are generally called upon for our expertise in specialized cases. If this regulation is enacted, it would prevent the injured worker from selecting a chiropractic neurologist that the State Board of Chiropractic Examiners recognizes as a QME specialty. We provide a valuable service that would be lost should this change take place.

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Mark E. Webb, Vice President & General Counsel  
Pacific Compensation Insurance Company

September 29, 2010

Proposed Section 41(c)(3) would prohibit a QME from rendering an opinion without regard to the injured worker's age or disability. The current regulation uses the same criteria as set forth in Labor Code Sec. 4062.1(d) for allowing an injured worker not to proceed with an evaluation for "good cause", which includes evidence that the evaluator is biased against the employee, "because of his or her race, sex, national origin, religion, or sexual preference...". Both age and disability are criteria of disability in Labor Code Sec. 4660. These are also potential areas of appropriate examination when determining apportionment under Labor Code Sec. 4663. Taken literally, the proposed changes would in essence prohibit a QME from rendering any opinion.

Proposed Section 41.5(c)(2) raises a potential conflict as it relates to utilization review conducted by a "Medical Provider Network" as defined in 8 CCR Sec. 9767.1(a)(12). While current regulations state that the 5% income threshold for creating a "disqualifying conflict of interest" does not include contracts for participation in a Medical Provider Network, [Sec. 41.5(d)(2)(C)], the proposed specific language potentially creates a conflict if an "other entity contracted to

provide utilization review services” can be an MPN where the MPN also provides utilization review services. Is this intended to be an exception to the general rule that participation in an MPN does not create a disqualifying conflict of interest or does the current exemption still apply? The ambiguity is created by the more expansive definition of who is conducting utilization review which, in the current regulation is limited to a “utilization review organization”.

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Judith A. Thurber, DC, QME

September 29, 2010

I am writing to express astonished and strong opposition to the Division of Workers' Compensation's (DWC) proposed regulation that would limit the QME specialty listings to medical doctors and doctors of osteopathy. I am deeply opposed to permitting only medical and osteopathic doctors QMEs to be listed by specialty. I am a doctor of chiropractic that has attended two post-graduate diplomate programs that are recognized by the state Board of Chiropractic Examiners.

I have been in practice for over 28 years and been in the worker's compensation arena for 26 years. I worked very hard to attend an orthopedic and a separate rehabilitation 3 year post-graduate course/s in addition to many work comp seminars to be able to completely understand all treatment options available to injured workers. The elimination of chiropractic QME specialty listings is in direct contradiction of the DWC's stated reason for last year's regulatory change requiring specialty listings to be limited to those that are recognized by the physician's licensing board: "This amendment is necessary to clarify that only the California physician licensing boards have jurisdiction to recognize specialty areas of practice." The change will reduce confusion. The state Board of Chiropractic Examiners (BCE) adopted a regulation to recognize "those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractors Association" that complies with the DWC QME specialty-listing requirement. I am unaware of any necessity that has arisen since the DWC's original regulation for this further listing prohibition. California Business and Professions Code section 651 authorizes the advertisement of chiropractic specialties. Neither the state chiropractic board nor the DWC can limit the use of specialties unless the use of a specialty is misleading to the public. In its revision to this section last year, the DWC ensured a QME's specialty designation was not misleading or confusing. A doctor of chiropractic's right to advertise a specialty designation is constitutionally protected commercial speech. Only the Legislature can limit the use of specialty designations - and even then the Legislature could only restrict the use of specialty designations if it shows a substantial state interest, lest it violate the US Constitution. If this regulation were enacted, it would have the effect of preventing injured workers from selecting a state Board of Chiropractic Examiners-recognized specialty as a QME. An injured worker should be able to choose a QME with additional training because that injured worker will get a QME report from a doctor that is more informed on protocols for that type of injury.

I ask the DWC maintain its existing position relative to the listing of chiropractic QME specialty listing as there has been no supportable necessity demonstrated for this Draconian listing elimination. As this change infringes on the DWC's own recognition of the physician licensing

boards' jurisdiction in recognizing specialties for QME listing purposes, I urge its retraction. Thank you in advance for consideration of my comments. I trust the DWC will see the conflicts with its prior positions on this issue and consequently drop the proposal.

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Jeffrey M. Steinhardt, DC, QME

September 29, 2010

It is my understanding that the DWC wishes to exclude chiropractic QMEs from listing their specialties. I strongly disagree with this exclusion and urge you to allow chiropractor QMEs to list their specialty for a number of reasons. First, the training a DC needs to attain their specialty is extensive and beyond the scope of continuing education, which mandates only levels of minimum competency. Besides taking the advanced coursework, which I believe is more than 300 hours per specialty, the doctor must then pass a rigorous exam. This is not some weekend course that anyone can take or get. Second, the Board of Chiropractic Examiners which licenses all chiropractors to practice in the state, has recognized these specialty boards. This recognition goes through extensive scrutiny and public opinion. It is then passed on the Office of Administrative Law of the State of CA government to approve as a REGULATION. This has been accomplished and recognized by the chiropractic governing board as well as the state of California. If the DWC were to exclude chiropractic specialty recognition, it would be unjust and unfair, show bias by the DWC, and would not be in the public's best interest. After all, the people of the State of CA should be protected and have the best available medicine and QMEs available. Your exclusion would be harmful to the public, as well as to the QME. Thank you for your time and consideration.

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Ronald M. Cappi, D.C., QME, FACO

September 28, 2010

I am writing to express strong opposition to the Division of Workers' Compensation's (DWC) proposed regulation that would limit the QME specialty listings to medical doctors and doctors of osteopathy. I am astonished at the proposal to prohibit chiropractic QME listings. I am a doctor of chiropractic with post-graduate Diplomate of the American Board of Chiropractic Orthopedics, (D.A.B.C.O.) and a Fellow of the Academy of Chiropractic Orthopedics, (F.A.C.O.) which are recognized by the state Board of Chiropractic Examiners. I have been in practice for 20 years and also a Fellow of the Association of Forensic Industrial Chiropractic Consultants, (A.F.I.C.C.), further training in industrial medicine, specifically related to QME work.

The elimination of chiropractic QME specialty listings is in direct contradiction of the DWC's stated reason for the regulatory change last year requiring specialty listings to be limited to those that are recognized by the physician's licensing board: "This amendment is necessary to clarify

that only the California physician licensing boards have jurisdiction to recognize specialty areas of practice. This change will reduce confusion regarding certified specialty designation for both QMEs and the public who must choose among QMEs to do forensic evaluations." The state Board of Chiropractic Examiners (BCE) adopted a regulation to recognize "those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractors Association" that complies with the DWC QME specialty listing requirement. I am unaware of any necessity that has arisen since the DWC's original regulation on this subject for this further listing prohibition.

The state Board of Chiropractic Examiners has recognized chiropractic specialties in a manner that complies with the DWC QME specialty listing requirement. This proposal to prohibit the listing of chiropractic QME specialties is in direct defiance of the authority of provider licensing boards the DWC recognized in its original regulation on this subject that stated: "This change will make the criteria for being listed as a QME in a particular specialty transparent and consistent with the jurisdiction exercised by the respective California physician licensing boards."

Nearly two decades after the DWC permitted the listing of chiropractic QME specialties, I am unaware of issues that have arisen that threaten the safety of injured workers that would warrant consideration of this unilateral restriction, nor did the DWC cite any reason other than to reduce potential confusion and bring consistency relative to licensing board jurisdiction over specialties when it limited these listings last year.

California Business and Professions Code section 651 authorizes the advertisement of chiropractic specialties. Neither the state chiropractic board nor the DWC can limit the use of specialties unless the use of a specialty misleading to the public. In its revision to this section last year, the DWC ensured a QME's specialty designation was not misleading or confusing. A doctor of chiropractic's right to advertise a specialty designation is constitutionally protected commercial speech. Only the Legislature can limit the use of specialty designations - and even then the Legislature could only restrict the use of specialty designations if it shows a substantial state interest, lest it violate the US Constitution.

If this regulation is enacted, it would have the effect of preventing injured workers from selecting a "chiropractic neurologist," "chiropractic orthopedist" or any other state Board of Chiropractic Examiners-recognized specialty as a QME. As specified in the existing regulation approved only last year, an injured worker should be able to choose a QME with additional training because that injured worker will get a QME report from a doctor is more informed on treatment protocols for that type of injury. In my experience doing QME's and reviewing the records and reports of various physicians and specialties, one thing does stand out, Chiropractors with advanced degrees in orthopedics and neurology do a more comprehensive report and evaluation than any other specialty.

I ask the DWC maintain its existing position relative to the listing of chiropractic QME specialty listing as there has been no demonstrable necessity demonstrated for this Draconian listing elimination. As this change infringes on the DWC's own recognition of the physician licensing boards' jurisdiction in recognizing specialties for QME listing purposes, I urge its retraction.

Thank you in advance for consideration of my comments. I trust the DWC will see the conflicts with its prior positions on this issue and consequently drop the proposal.

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Richard Fink, D.C., D.A.B.C.O.

September 28, 2010

Re: changes to § 12 and §13.

The Administrative Director removed chiropractic subspecialties from the QME panel request form over one year ago. The reason given was that the BCE-Board of Chiropractic Examiners did not formally recognize board-certified chiropractic subspecialties. In early 2010 the BCE submitted a regulation acknowledging board-certified subspecialties.

The AD then submitted changes to §12 and 13 stating: "**In response** to a regulation adopted by the Board of Chiropractic Examiners, the Administrative Director is clarifying sections 12 and 13 to state that the administrative director shall recognize only those specialty boards recognized by the California licensing boards for physicians and surgeons."

The changes to §12 and §13 are arbitrary and capricious. The best interest of the public is not served by altering these regulations to favor the lobbying efforts of special interest groups from the medical profession. The medical professional already has 34 specialties listed, whereas the chiropractic profession only has one.

The purpose of listing subspecialties on the QME request form has always been **to provide the public with the ability to choose the most qualified doctors within their respective professions.**

The Diplomat of the American Board of Chiropractic Orthopedists certification requires 2.5 years of postgraduate continuing education. Oral and practical examinations must be passed in order to obtain diplomat status. This substantial education sets apart the board-certified practitioners from their peers. This recognition should be followed on the QME panel request form as well, providing injured worker with the ability to choose the most qualified practitioners within the chiropractic profession.

Therefore, the Administrative Director should not make any changes to the sections and allow chiropractic doctors to list their board-certified sub-specialties , in favor of the general public interest.

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Randall March, D.C., D.A.C.N.B., QME

September 28, 2010

I am writing to express my strong opposition to the Division of Workers' Compensation's (DWC) proposed regulation that would limit the QME specialty listings to medical doctors and doctors of osteopathy.

I am a chiropractor with 15 years of practice experience. I am also a chiropractic neurologist and enjoy active Diplomate status with the American Chiropractic Neurology Board (ACNB). The Diplomate Program in Neurology Certification awarded by the American Chiropractic Neurology Board is fully accredited by the National Commission for Certification Agencies (NCCA), the accreditation body of the National Organization for Competency Assurance (NOCA). The American Chiropractic Neurology Board is the only specialty certification agency for the Chiropractic Profession that is fully accredited by NCCA. NCCA's standards exceed the requirements set forth by the American Psychological Association and the U.S. Equal Employment Opportunity Commission. As you can imagine, the continuing education requirements are also stringent, including 30 hours per year of classroom work and many more in research. ([acnb.org](http://acnb.org) for more detailed information)

As you know, the state Board of Chiropractic Examiners has now recognized chiropractic specialties in a manner that complies with the DWC QME specialty listing requirement. This proposal to prohibit the listing of chiropractic QME specialties is in direct defiance of the authority of provider licensing boards the DWC recognized in its original regulation on this subject that stated: "This change will make the criteria for being listed as a QME in a particular specialty transparent and consistent with the jurisdiction exercised by the respective California physician licensing boards."

If this regulation is enacted, it would have the effect of preventing injured workers from selecting a "chiropractic neurologist," "chiropractic orthopedist" or any other state Board of Chiropractic Examiners-recognized specialty as a QME. As specified in the existing regulation approved only last year, an injured worker should to be able to choose a QME with additional training because that injured worker will get a QME report from a doctor is more informed on treatment protocols for that type of injury.

As a board certified chiropractic neurologist, I would suggest that if you propose any changes, they would be that to be listed as a chiropractic specialty; one must have passed the board examination of that specialty. I do feel that simply completing 300 hours of post-doctoral education is not enough to be a specialist. If chiropractic specialties are to be comparable to those of other physicians listing as specialists, they should have a diploma indicating the passing of the board's examination just as would a medical doctor. Just sitting in the classroom does not make one a specialist, passing a board examination does. I also feel that maintaining an active status with the board is important because it insures the public that the specialist is up to date and continuing her/his education in the specialty.

Thank you in advance for your consideration in this matter. I am putting my trust the DWC to see the conflicts with its prior positions on this issue and consequently either drop the proposal of change it to include only physicians who are board certified in their specialty. Please feel free to contact me at any time for further information or clarification of my opinions.

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M. Hollie Rutkowski, RN, JD, MBA, Esq.

September 28, 2010

"The study said 31 very high-volume QMEs who accounted for 10% of the reports rated by the DWC's Disability Evaluation Unit resulted in disability ratings that were 7% to 21% lower than the ratings assigned to the reports of all other QMEs."

Each one of the 31 very high-volume QMEs makes her or her living writing reports. They are orthopedic surgeons. I was a nurse for eight years before I became an attorney and it is a stereotype, a true one, that doctors become surgeons so they do not have to treat patients like people. They prefer little patient contact. They will never admit it but these very high-volume QMEs do not want to treat patients, it is their goal to never have to treat another person and seeing several injured workers a day is as much patient contact as they can handle. In addition, prior to the Panel process, they established all these offices so that their preferred clientele, the insurance companies, could always get appointments with their favorites doctors, anywhere in California, from Susanville to San Diego. This is why high-volume QME reports are so conservative. These QMEs have not seen how chronic pain devastates a person's life, how that person can't walk from the parking lot to the grocery store, can't sleep without pills, has no stamina to go to picnics or church, can't even pick up their children and hold them, slip into depression. What's worse, they don't care to. I believe that, at the very least, a QME ought to treat patients for a living and that as part of their continuing QME education, they be required to take courses in sensitivity to patient needs and the effects of chronic pain.

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Lisa E. Ivancich, Esq.

September 28, 2010

Pegnim & Ivancich, LLP

We recently deposed a PQME who testified he completed 200 hours of work on our file alone. He testified he completed over 1000 examinations in the past year and was available at 23 locations. How can he possibly and legitimately completed the work noted above? Perhaps a reporting requirement of the total number of cases seen and the hours for each case would stop the perceived abuse.

The proposed limit to 5 locations is a good one. What about requiring the Panel to have physicians from three different offices? We often see the same office location for all three doctors on the panel.

If ex-parte communication is found, why not allow the party seeking relief to select any QME, and not require selection from a new panel?

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The idea that the DWC would bend to conform to the wishes of the self interested groups who have as their ONLY interest in higher or lower disability ratings is completely laughable and a sorry state of affairs!!!

**The DWC ALONE should be in control of the quality of the reports-----not biased self interested groups** who only want to unfairly influence the outcome of the cases.

We as QMEs and as self-respecting Physicians and Chiropractors should not allow ourselves to be manipulated by these self interested groups who do not care one iota about the report quality **ONLY THAT THE DISABILITY RATINGS ARE IN THEIR FAVOR AS MUCH AS POSSIBLE.**

I say that the DWC should not be controlled by unscrupulous self-interested groups but they and they alone should monitor the report quality and take whatever measures are needed to keep the quality high!!!

**If the money collected by the DWC for multiple QME locations is reduced by the projected 1.2 million dollars if we are limited to 5 locations, the resultant personnel cuts at the DWC will be dramatic and will make it even MORE DIFFICULT TO PERFORM ANY MEANINGFUL QUALITY CONTROL-----**by the entity who should be in control as opposed to ceding more and more control to the self-interested groups.

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Mike V. Durich, Jr., Esq.

September 28, 2010

I have experience as counsel for defense, lien claimant and applicant - last 7 years, in all almost 10 years. I have read the comments on regarding the restrictions of the number of locations for panel QMEs. I understand that there may be a problem with the same doctors appearing on multiple panels. However, I practice in Southern California and I do not see this issue in the panels I receive. I generally see quite a range of providers. The issue of a provider appearing multiple times in panels can be resolved without limiting their office locations. Simply limit the number of panels that one provider can be placed on in a month, regardless of their number of locations. This would require some geographical tweaking due to the rural nature of most of California. Despite this, the basic problem I perceive would not be addressed, that is, how to address the issue of quality reports. I understand the DIR requires QMEs to write reports of certain characteristics. The DIR needs to enforce those characteristics more vigorously. Perhaps the DIR should adopt regulations that a certain percentage of medical reports be randomly "picked" and reviewed for compliance. Also, if a medical provider is picked for some chosen percentage of QME's, more of their reports would be subject to greater scrutiny. This would not be discriminatory as the effect of the QME would be greater on the system as they are

introducing more reports into the system than a provider who is picked less. The issue of bias will remain despite the above. Both applicant and defense counsel need to defend their client's interest and learn to avoid those providers who write biased reports.

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Gerard Dericks, MD, QME

September 28, 2010

I strongly disagree with the proposed change in the number of allowed QME locations from unlimited down to 5.

This is a totally unnecessary and DRACONIAN response to the alleged problem that some physicians have 60 or even 90 locations.

I say if the quality of their reports is high, more power to them, and they serve only to increase the available physician pool to service the injured workers.

By decreasing the available physician pool this only DECREASES the available choices of physicians available to service the injured workers. This is not good.

The maintenance of QUALITY REPORTS is paramount above all and needs to be the MOST important consideration.

If the number of locations HAS to be reduced for reasons that remain unclear to me, reduce the number to 15 or 16, but not 5.

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Dennis Sosine, D.C., QME

September 28, 2010

I understand the intent of the QME office limitation. However, I believe that 5 locations is too restrictive.

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Brian J. Reis, D.C., QME  
Diplomate, Board of Chiropractic Orthopedists

September 28, 2010

I am writing to express DWC's decision to limit chiropractic subspecialties to medical doctors and doctors of osteopathy.

I am a chiropractor with an additional three years of post-graduate training, specializing in chiropractic orthopedics on top of 25 years of clinical experience.

Our state Board recognizes these chiropractic subspecialties, compliant with the DWC QME specialty listing requirement. This proposal is in direct contradiction of the authority of provider licensing boards (i.e. State Board of Chiropractic Examiners) that the DWC recognizes. To deny injured workers the opportunity to choose a chiropractor specializing in a particular aspect of the I.W.'s condition is a disservice to him/her. In that this subspecialty listing has continued for a number of years, to my knowledge there is no particular need now to change it.

Please. Restore the chiropractic sub-listings for the sake of fairness and for the sake of the injured worker.

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Daniel Buch, BS, DC, QME

September 28, 2010

The issue of multiple locations was raised a couple years ago. At that time there was some level of agreement that a location cap would be an arbitrary one at best. Are 5 locations too many, or 20? Perhaps a "cap" should be put in place to contain the obvious over indulgent QME's with 20+ locations? This would be a far easier cap to enforce, saving the Medical Unit time and resources needed elsewhere.

On a tangential issue, many DC / QME's, including myself have added additional locations to try to maintain QME assignments, this due to the fewer panel selections of DC's as a specialty. As we have seen, DC panel selections dropped from approximately 15% in 2005 to 5% in 2010. I would hope the Regs will attempt to address this problem. (the proposal to increase the ML fee schedule for MD's was one such proposed solution)

As Dr. Sorensen noted in his comment, quality, not quantity should indeed be the primary concern. But, how does a QME learn and maintain the skills necessary to write a quality report if he/she receives little or no work? The cap on locations and the disparity in panel selections are separate issues, however there is some overlap as the panel selection disparity has forced many QME's to find avenues of attracting work, including additional QME locations.

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Gerard Dericks, MD QME

September 28, 2010

A colleague of mine has calculated that the DWC would lose over 1.2 Million dollars if the proposed limit of 5 QME locations were enacted!!!

This would most certainly result in the firing of a large number of DWC workers, and staff. California is teetering on bankruptcy, and there would be no funds to prevent this widespread firing.

*This is certainly the exact opposite of what we need to be doing.*

If the quality of QME reports is suffering because some doctors are visiting a large number of locations, we **NEED MORE DWC WORKERS TO MONITOR THE REPORT QUALITY \_\_\_\_\_ NOT LESS!!!!**

I would suggest the fee for additional locations be doubled or tripled for all locations after 10, but that **NO LIMITATIONS BE FORCED ON THE REST OF US!!!**

Let the doctors sign up for all the locations they want, but let them pay to have their reports monitored for quality control, and to hire **MORE DWC workers & staff** as needed to do the work.

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Bruce P. Hector, MD  
Medical Director – Parthenia Medical Group

September 28, 2010

Re: Comments On the California Commission on Health and Safety and Workers' Compensation Draft Evaluating the QME Process Is it Equitable and Efficient?

I have had the opportunity to review this draft and wish to provide comment. By way of background, I am a physician and medical director of a group that has been performing medical-legal examinations predominantly in So. Ca. for over 25 years. I have personally treated injured workers throughout this period. I have represented CMA and testified before the DWC and Ca. Legislature. I am intimately familiar and been affected by all the various legal changes particularly as they affect the evaluating and treating physicians. First, I would like to briefly reiterate the study's findings and recommendations. Then, I will discuss and comment on several aspects of it.

The study emphatically states that 31 QME physicians having multiple offices numbering more than 5 to 1 provide a disproportionate number of QME evaluations and that the ratings these physician render are conservative when compared to physicians with 1 to 5 offices. Overall claim frequency has been reduced by 45% and there has been a comparable reduction in QME evaluators. It noted increased QME panel requests from 2007 to 2009 but indicates this was due to concerns over needed medical treatment and not ratings. This resulted in delays in report completion and claims processing. The study notes that while orthopedists represent only 25% of QMEs, they get 45-65% of evaluations, a ratio which has remained stable for several years. It notes hand and pain sub-specialists are under-represented while chiropractors and acupuncturists are over-represented. Lastly, the executive summary notes that while psychologists and

psychiatrists may seem to be over-represented, the nature of their evaluations and a recent trend in increased evaluations make this conclusion speculative.

After reviewing in detail the basis for these observations the study offers 3 potential changes. These include initiating an unspecified “outreach” program to enlist more orthopedic, pain and psychiatric evaluators, increasing the OMFS reimbursement for under-represented specialties and restricting the number of offices a QME may have “if stakeholders perceive the concentration of QME assignments ... as inconsistent with legislative intent and/or public policy”.

From the perspective of a physician who has used the AMA Guides for 16 years and been tested on its use by the American Board of Independent Medical Evaluators for certification 3 times in 10 years, I must respectfully question the study’s implication that simply because the ratings provided by the evaluators with numerous locations represents an inappropriate “under-rating” or overly conservative rating methodology.

What is absent in this analysis is a comparison with ratings provided by physicians in other states that use the AMA Guides. This lack of comparison stands out because it is entirely possible that when those high volume physician’s ratings are compared to ratings from physicians in other states they are entirely in line with appropriate AMA Guides ratings and it is just as likely that the more liberal ratings provided by QME physicians performing evaluations in a small number of locations are not consistent with the philosophy and rule of the AMA Guides. Additionally, the ratings provided by treating QME physicians are commonly exaggerated consequent to intentional or unintentionally patient sympathetic bias. This is recognized in other states and is the philosophic basis for establishing “Independent Medical Evaluations”. The real issue is the consistency of ratings with the criteria established in the “AMA Guides to the Evaluation of Permanent Impairment, 5<sup>th</sup> edition” not a simplistic comment that ratings were less implying that because of this they were inaccurate and/or the evaluators lacked the ability to provide an independent, unbiased rating.

The study goes on to imply that QME physicians with a larger number of office locations have an inherent bias and therefore provide more conservative ratings. The study appears to ignore the same potential bias in QME physicians that provide more liberal ratings. The study implies that the more conservative rating QME physicians are attempting to court a specific audience while ignoring the same and more likely reality for the more liberal rating QME physicians. The study’s conclusion harkens back to the pre SB899 reform when the state wished to eliminate “dueling doctors” who were characterized as writing to one side or the other. SB 899 was charged with the responsibility of eliminating this process and its supposed inherent bias by creating the Panel QME process. However, when one looks at the current state of the QME process it is reasonable to conclude that QME physicians who provide a more liberal rating hold on to the remnants of the “dueling doctor” bias; this is especially true in light of the Almaraz/Guzman II decision which allows for rating by analogy and the overt manipulation of the AMA Guides. In light of this perspective one must look at QME physicians who provide more conservative ratings as a balance to the system. Further these evaluators recognize that the preferred position for them is to be designated as an Agreed Medical Examiner, which provides greater reimbursement and avoids Panel selection altogether. To do so these physicians must

seek to offer opinions that are acceptable to both sides, not just oriented to please the referring party, a bias that was often alleged in the pre SB 899 days.

While the study tangentially touches upon QME physician knowledge of and implementation of the AMA Guides, absent is a discussion of the question of whether the QME physicians with multiple offices, more than 10, and even the 31 physicians providing 10% of the QME evaluations are more competent in the use and application of the AMA Guides than their more liberal rating brethren. This again illustrates the absence in the study of comparing California QME ratings to ratings provided by physicians in other AMA Guides states. This commentator has read other National studies and publications which would draw the conclusion that the conservative California QME ratings are more in accordance with the AMA Guides and that the more liberal QME ratings are not in accordance with AMA Guides, they are higher. Indeed, in sections of the AMA Guides 6<sup>th</sup> edition, the Guides authors specifically address perceived abuses specifically initiated in California wherein additional ratings are provided for the impact of sleep, pain and sex, all activities of daily living which the AMA Guides authors felt were normally included in the provided ratings. If this is in fact the case then the more conservative QME physicians strike an important balance in achieving the goals of the 2004-5 reforms and SB899.

From the perspective of the injured worker, lower ratings reflect reduced payment that may not accurately reflect the degree of income lost as a result of injury. Studies by CHSWC and others have noted this. This is a consequence of legislature presuming that 100% Whole Person Impairment according to the AMA Guides is equivalent to a 100% work related disability. This clearly was not the intent of the AMA Guides and one would hope the legislature had realized this but apparently it did not. This problem could easily be overcome by increasing the cash value of each percentage point of disability. Similarly, applicant attorneys whose fees are in part based upon the impairment ratings are now engaging in physician depositions on a more regular basis usually in an effort to convince the deposed evaluator to consider alternate ratings from inappropriate AMA Guides chapters (under Almaraz-Guzman) that provide greater impairment values. Previously, physician depositions were quite infrequent. It should be noted that the AMA Guides specifically notes that ratings are designed to address the impact of an injury or illness on performance of activities of daily living and are not intended to specifically address work related disability. This is clearly stated in Chapters 1 and 2 of the AMA Guides. The conversion of an impairment rating to a disability rating is the specific charge of the DEU not the physician. Amending that process would be a much more reasonable way to overcome this problem rather than seeking to encourage more evaluators to distort the Guides and provide higher ratings.

The study tangentially touches upon physician education/knowledge of the AMA Guides. In virtually all other fields of medicine it is recognized that physicians who perform more evaluations, treatment or surgeries for a particular condition have more knowledge/understanding and usually demonstrably better outcomes. Logic would suggest that in a like manner, those performing more QME panel examinations gain experience and knowledge that renders them more capable. To suggest a negative bias is contradictory to all other fields of medicine and implies that the high volume evaluators have less professional integrity. There is certainly no proof offered by the study to support this conclusion.

The study notes that claims are down approximately 45% and that physician QME participation as well by about the same percentage. The study goes on to imply that the reason for the reduction/exodus of QME physicians from the system is lack of sufficient QME referrals. This is highly questionable and other causes are not addressed. The expansion of MPN's could be another cause for the reduction of QME physicians and concurrent reduction in QME claim related evaluations. Another potential, equally reasonable but unstated element that may contribute to the reduction of the QME physicians is the bureaucratic quagmire created by the legislature as well as the rules and regulations instituted by the DWC. First, is the evolution from the pre 2004 QME system to the current system implementing the AMA Guides followed by and another set of rules and regulations. Having worked with and trained numerous physicians in these evaluations I know doctors are often reticent to change their behavior and obtain additional rating education especially if it does not afford a complimentary increase in income or imposes excessive demands. Heap on this a new learning curve, report writing requirements prior to being certified as QME, registrations fees, report and evaluation timelines, continuing education requirements, QME testing time limitations and restrictions and one can see a shopping list of other reasons for the diminished QME physician rolls. For example, the QME testing requirement as well as the report writing course requirement for QME certification examinations used to be held twice a year now it is down to once a year. Why can't this testing process be offered online allowing physicians to test throughout the year? Previously, once a physician passed the QME certification examination he had two years to take a writing class, now they must accomplish this prior to the issuing of the QME certification and opportunity to be placed on the QME panels in the specialty of their choice. These are seemingly unnecessary obstacles which along with the others enumerated above should not be taken lightly and must be considered as another reason for the reduction of the QME physician rolls. Possibly these bureaucratic issues may have been developed solely to offset system costs while inadvertently obstructing the QME process. However, the study does not even consider these elements as direct causes.

The study also makes the claim that physicians with multiple offices are affiliated with administrative organizations. What or who these specific organizations comprise is not identified. The study does lightly touch upon the fact that running a medical office is costly. This too must be considered a valid reason for the reduction of the QME physician rolls. Medicine is an expensive profession and the overhead in medicine is enormous ranging as high as 70%. How many physicians can afford to take on the responsibility of renting multiple offices, staffing them, paying the various state, QME, business fees, taxes etc. with no assurance of referrals and a system that depends upon agreement between 2 parties with different vested interests? How many can afford the time away from their primary practices especially when the DWC requires that physicians have a minimum of 20% to 30% of their practice treating patients? One can also argue that genuine medical groups/administrative resources provide a benefit to the State and the QME process by relieving the QME physician of these added responsibilities and burdens. They could be viewed in the same light as our hospital systems such as Stanford, UCSF, UCLA, etc. who take a facility fee for providing a location and association.

The study also discusses the issue of sub-specialties as a source of funneling more QME evaluations to a select group of QME physicians who list themselves in more than one medical specialty category. However this is a medical training reality. For example all Cardiologists,

Nephrologists, Rheumatologists, etc are first Internists and then have specialty training. The specialty training does not diminish from their original training but compliments it. Limiting physicians with adequate training in multiple specialties will only further reduce the available pool of evaluators. On the positive side, competent evaluators in multiple sub-specialty categories also insures that these relatively limited cases will be evaluated by physicians experienced in impairment ratings, something not usually included in virtually any sub-specialty training.

The study addresses over-represented and over-served medical specialties providing recommendations which suggest limiting the number of physician locations while providing incentives for the under-represented specialties. It notes limited evaluators in hand, pain and psychiatry. Proper training in the AMA Guides should allow any orthopedic specialist, indeed any primary care provider to use the AMA Guides to provide an accurate rating for most medical conditions. The AMA Guides references examination and testing procedures for rating that are familiar to almost all providers except in some select fields like ophthalmology, pulmonology and otolaryngology. It should be noted that the AMA Guides does not specify the need for a physician to be specialty ABSM Board certified to perform ratings but rather presumes that any competent physician is qualified to perform ratings using the Guides. While this may not be true for issues of certain types of future medical care especially in highly complex conditions, the rating procedures as outlined in the AMA Guides do not require any ABSM Board certification. If the state is interested in bringing new evaluators onto the panels, removal of this legislatively imposed restriction would be helpful. Of note, this evaluator has performed Independent Medical Evaluations in several other states, provided all the necessary reporting, had his expertise accepted and testified at appeals boards in other states without being ABSM Board certified. Removal of this prejudicial Legislatively imposed restriction and instead requiring training in impairment rating as offered by the American Board of Independent Medical Evaluators would provide the opportunity for many more evaluators to be added to the QME rolls offering the diversification seemingly desired by the study's authors. Frankly, I have never met a specialist, especially one in a surgical field who would rather perform these evaluations than be in the surgical suite where he makes more money per hour of work and does the work for which he was trained. The likelihood of enticing new specialist and sub-specialist physicians with financial incentives may only attract evaluators with threatened incomes as a result of rejection by other income sources including from malpractice. Perhaps the limited use of some specialties is a function of the lay and legal community ignorance regarding certain medical specialties and the public needs better education. The basis by which the claimant or his attorney selects a QME appears to neither have been researched nor even considered. This adds to the speculative nature of the researchers conclusions.

While not opposed to raising fees, to do so in only certain specialties would seem discriminatory to others and not guarantee increased participation especially in those fields where clinical demand is still great and more rewarding. Perhaps DWC needs to sincerely consider increasing overall medical legal fees to something like the pre 1993 reform where billing was presumed correct if it was at 80% of the Usual and Customary fee. Perhaps restoring the level of reimbursement combined and relaxing or eliminating certain regulations, testing, re-visiting report submission timelines etc. would induce more physicians to become QMEs but again there is no certainty.

In summary, this experienced physician must respectfully question numerous elements of the study's conclusions. It is for the reasons noted above but certainly not limited to those reasons alone that I feel the committee recommendations should be tabled or delayed until further study is conducted, study which may lead to the conclusion that the physicians in question, i.e. those providing conservative ratings versus the liberal ratings, and those with a larger number of offices where they perform QME evaluations are a benefit to the system and will prevent an even great flight of physicians from the system. While the efforts of the researchers are appreciated, the above narrative I believe provides sufficient alternate explanation for the findings to suggest that all potential considerations causing the problem were not elaborated and consequently the conclusions cannot be considered objective or the basis for system change.

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Tommy Boggess

September 28, 2010

Having dealt with the QME panel process, receiving lists for my zip code, the doctors all have the same address and phone number. All of the doctors come from the same pool at Alluvial in Fresno, Ca. Going online using Doctor search, I found a lot of their residences on the east coast and some foreign countries. I believe that the 90 minute rule should be implemented, the radius that one can drive, not fly, in 90 minutes. I have four zip codes in my immediate area, I am 45 minutes north of Sacramento and Roseville, 50 minutes south of Chico. None of these doctors are allowed on my list due to zip requirements. This would allow the process to be more open and fair, making a more level field, if implemented.

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Edward D. Jennings DC, DABCN, DAAPM, QME

September 27, 2010

I am writing to express my strong opposition to the Division of Workers Compensation's (DWC) proposed regulations that would permit only medical and osteopathic doctors QME's to be listed by specialty. I am a Doctor of Chiropractic with a post graduate certification as a Diplomate of the American Board of Chiropractic Neurology, DABCN and Diplomate of the American Academy of Pain Management, DAAPM. The DABCN, chiropractic neurologist degree, is recognized by the California Board of Chiropractic Examiners. I've been a licensed chiropractor for 26 years and board certified as a chiropractic neurologist for 19 years. I've been certified as a QME since 2005.

The elimination of chiropractic QME specialty listings is in direct contradiction of the DWC's stated reason for the regulatory change last year requiring specialty listings to be limited to those that are recognized by the physician's licensing board: "This amendment is necessary to clarify that only the California physician licensing boards have jurisdiction to recognize specialty areas of practice. This change will reduce confusion regarding certified specialty designation for both QME's and the public who must choose among QME's to do forensic evaluations." The state board of Chiropractic Examiners (BCE) adopted a regulation to recognize "those specialty

boards that are recognized by the American Chiropractic Association or the International Chiropractic Association that complies with the DWC QME specialty listing requirement. I am unaware of any circumstance that has arisen since the DWC's original regulation on the subject for this further listing prohibition.

The DWC has not cited any other reason to reduce potential confusion relative to a licensing board jurisdiction. The California Business and Professions Code section 651 authorizes the advertisement chiropractic specialties. Neither the state chiropractic board nor the DWC can restrict the use of specialties unless the use of the specialty misleads the public. A Doctor of Chiropractic's right to advertise the specialty designation is constitutionally protected.

If this regulation is an enacted, it would have the effect of preventing injured workers from selecting a Chiropractic Neurologist, Chiropractic Orthopedist or any other specialty recognized by the California Board of Chiropractic Examiners as a QME. It was specified in existing regulations last year that an injured worker should choose a QME with additional training because that injured worker will get a QME report from doctor that is more informed on treatment protocols for that type of injury. Very frequently I encounter individuals who had been looking for a forensic evaluation that would incorporate chiropractic, neurology, orthopedic, and rehabilitation. That is exactly what the chiropractic neurology certification encompasses. Many times these individuals have gone the standard medical route for their injuries which included pharmaceutical intervention, physical therapy and sometimes surgical recommendations, only to be no better off than when they started.

As a Chiropractic Neurologist I urge the DWC to withdrawal this prohibition on the chiropractic QME specialty listings. I think it would be an injustice to the citizens of California to not have available to them the expert opinion of a different specialty. This proposed change infringes on the DWC's own recognition of the physician licensing board's jurisdiction in recognizing specialties. I would also add that the specialty recognition should only be extended to those individuals that have passed examinations by their specialty board and not merely someone that has sat through 300 course hours. This would be an injustice to the public safety of the citizens of California if an individual has only attended 300 hours of classroom work and not proven their expertise by way of the examination process.

Thank you in advance for consideration of my comments. I trust that the Department of Workers Compensation will see the conflicts with its prior position on this issue and consequently drop the proposal.

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Kenneth Winer, D.C.

September 27, 2010

I have taken time out of my busy practice schedule to bring to your attention my strong objection and opposition to the Division of Workers' Compensation's (DWC) proposed regulation that would place limitation to QME specialty listings to medical doctors and doctors of osteopathy.

The California state Board of Chiropractic Examiners (BCE) adopted a regulation to recognize "those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractors Association" that complies with the DWC QME specialty listing requirement. I cannot understand why the DWC has now considered a prohibition of chiropractic specialty listing. This seems inconsistent with our state licensing and regulatory board as well the fact that chiropractic specialty listings have been used in the workers' compensation system successfully for the past 18 years that I am aware.

If this regulation is enacted, it would have the effect of preventing injured workers from selecting a "chiropractic neurologist," "chiropractic orthopedist" or any other state Board of Chiropractic Examiners-recognized specialty as a QME.

I would like to thank you in advance for considering these comments on the proposed regulation. I hope that the DWC will recognize the mistake being made and restore chiropractic specialty listing and drop this current proposal.

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Russell Rottacker DC, DACNB, QME

September 27, 2010

I have been informed of the DWC proposal to eliminate the specialty certifications for the Chiropractic profession.

I am a neurology diplomate and also a QME. My clinical skill level and the ability to effectively evaluate and make recommendations has been substantially enhanced by the additional training and clinical competence achieved in the specialty program.

Why would the DWC wish to eliminate these designations which are instrumental in finding the most competent persons available to evaluate an injured worker?

The specialty certifications distinction is still available to other medical providers and should be available to all providers duly licensed and distinguished by their respective licensing board.

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Michael S. Blott, D.C.

September 27, 2010

I am opposed to permitting only medical and osteopathic doctors QMEs to be listed by specialty. I am a doctor of chiropractic with post-graduate Orthopedic training that is recognized by the state Board of Chiropractic Examiners.

The elimination of chiropractic QME specialty listings is in direct contradiction of the DWC's stated reason for the regulatory change last year requiring specialty listings to be limited to those that are recognized by the physician's licensing board: "This amendment is necessary to clarify

that only the California physician licensing boards have jurisdiction to recognize specialty areas of practice. This change will reduce confusion regarding certified specialty designation for both QMEs and the public who must choose among QMEs to do forensic evaluations." The state Board of Chiropractic Examiners (BCE) adopted a regulation to recognize "those specialty boards that are recognized by the American Chiropractic Association or the International Chiropractors Association" that complies with the DWC QME specialty listing requirement. I am unaware of any necessity that has arisen since the DWC's original regulation on this subject for this further listing prohibition.

Nearly two decades after the DWC permitted the listing of chiropractic QME specialties, I am unaware of issues that have arisen that threaten the safety of injured workers that would warrant consideration of this unilateral restriction, nor did the DWC cite any reason other than to reduce potential confusion and bring consistency relative to licensing board jurisdiction over specialties when it limited these listings last year.

Thank you in advance for consideration of my comments. I trust the DWC will see the conflicts with its prior positions on this issue and consequently drop the proposal.

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Debby Ortega

September 27, 2010

The stated goal of the revision is to keep QME's interested in continuing in the system. Therefore, I am in opposition to the limit of 5 locations for QME's, which would limit their availability of getting onto panels in a sufficient number to remain interested and financially worthwhile for the evaluator. 5 locations is too restrictive, you will lose quality QME's who cannot afford to continue in the system and thus limit the availability even further. There are excessive listings for some QME's which are causing dissatisfaction to some parties, and therefore, if a limit must be set, possibly a limit of 12-15 would be more reasonable, which would correct some of the abuse that is being reported by Physicians who list 30 or more locations.

There is already a delay for injured workers in obtaining evaluation's, reducing the number of QME's so severely will further restrict the accessibility of QME appointments and delay the process.

Reducing the number of locations will severely reduce the revenue the State gets from listing a location. A sliding scale for the fees would limit those who are not willing to pay the fees but would continue to generate revenue, charge more per location after the first 10 locations?

If there are problems with the quality or timeliness of the reports, or the selection of QME's on the panel, the DWC should evaluate and deal with those individuals or groups. CCR 30 (f) is supposed to control QME's selection. The placement on the panel is supposed to be random, the choice to select a Physician off the panel list is not under anyone's control but the party selecting. If the system is truly random, then all physicians should appear on panels an equal amount of times, **(this should be evaluated, not the number of completed reports)** if this is

not occurring, it is a fault of the electronic selection system. The selection off the panel, ie. who gets selected is the right of the injured worker, or party to the case. The evaluation of completed reports is less of an issue than the number of times each physician is on the panel and has the opportunity of being selected.

There are Labor codes that are supposed to limit multiple QME's from the same group appearing on the Panel listing, if this is not happening, the system needs to be fixed.

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Gabor Vari, MD

September 26, 2010

I am a psychiatrist performing QME evaluations throughout Southern California. I have 6 offices listed and do not belong to one of the "mills." I disagree with the proposed change. I pride myself on providing quality, well thought out, individualized reports for each applicant I see. I believe that it is possible to write good timely reports with over 5 locations listed. I am able to do this with my current number of locations.

I do agree with most who have responded in that some form of regulation is needed to prevent the QME panels from being dominated by defense oriented mill docs. I wonder why some of this isn't self regulating; if a QME's reports lack in quality or timeliness then I would think that those QMEs will be struck more often once they establish this negative reputation.

If the problem lies with a few key offenders who belong to report writing mills then perhaps the DWC's efforts would best be aimed at the offenders or the mills directly rather than implementing a generalized solution to a specific problem.

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Tommy Boggess  
Injured Worker

September 26, 2010

I was injured in February of 2005, fell off of a scaffold, due to a faulty safety rail, while inspecting CMU. Medical assistance minimal from the insurance company, I hired an attorney. The attorney and Insurer [Name Removed] agreed on an AME, Dr \_\_\_\_\_ [Name Removed] - orthopedic surgeon, whom I met with in Oakland, CA. where I was examined in a spare room for a masseuse. I had received injuries to my neck, upper and lower back, and both legs.

Dr \_\_\_\_\_ [Name Removed] , had me walk on my heels, then my toes, then had me touch my toes. stated that I had major sprains, do stretching exercises, with a towel, and return to work. Dr \_\_\_\_\_ [Name Removed] did not examine me, nor have the proper setting for his

profession, but rated me at 6%, this was for thoracic, and left shoulder only, all other areas ignored, **face time fifteen minutes.**

Eight months went by, I proceeded to get worse, I fired my attorney, reopened my case to include the missing body parts. Insurer [Name Removed] agreed for me to be seen at \_\_\_\_\_[Name Removed] , in February on 2007, where the doctors requested MRI's. These MRI's show torn muscles, ligaments and torn cartilage, disk issues in my neck, upper, central and lower back, legs and knees still have not been addressed. I had shoulder surgery in March of 2008, this was for the joint area only, Insurer [Name Removed] does not the scapula as being part of the shoulder. I have had EMG's that show nerve damage, in all areas mentioned and surgery was recommended for my cervical and lumbar regions of my back.

Insurer [Name Removed] protested these as in dispute, and demanded a QME panel, Fired my Doctor and put my medical on hold. A Dr \_\_\_\_\_[Name Removed] was selected, he stated that he flies all over the state doing QME Evuals, has a beech aircraft. **Face time, fifteen minutes,** billed for one hour, it was requested that he contact the treating physicians for their complete reports, this never happened. Evual took place in a Chiropractors office, without the customary equipment associated with an orthopedic surgeon. The only measuring device was a non calibrated tape measure that was an advertisement freebee. The office furniture consisted of two chairs, a small writing table and an adjustment bed approximately eighteen inches high by twenty inches wide by five feet long.

This address is like a puppy mill, they rent to more QME's that are out of the area, **some are from the east coast**, this is according to WCAB's QME lists, than they do chiropractic. This evual read as if he copied (plagiarized) Dr \_\_\_\_\_ [Name Removed] and signed his name. The claims adjustors appear to know these QME's on a first name basis due to a few doing the majority of the evaluations. The walk three steps on your heels, three steps on your toes, and touch your toes, is not an evaluation of physically demanding work, to determine disability. I seriously doubt if they belong to the Cal. AMA board, I have not seen a license to practice on any of the walls of the offices that I have been to.

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Justin Frieders, DC, QME

September 24, 2010

Thank you in advance for taking the time to review my recommendations and concerns regarding the proposed changes, which could potentially restrict the number of QME office locations to a

maximum of five. I trust that careful consideration will be made prior to making any hasty decisions, which may have far-reaching, unintended, negative consequences.

Following a review of the facts supplied by Frank Neuhauser to the CHSWC members during their board meeting on 06/24/10, I was surprised to learn that thirty-one QME's wrote 10% of all reports evaluated by the DEU from 2005-2010. This is according to the information listed under the Newline No. 49-10. With the number of QME's registered during the 2005-2010 period averaging out to be 4250, the 31 QME's referenced in Mr. Neuhauser's study equates to less than 1% of the registered QME's responsible for 10% of all reports over the 5-year span.

Details not provided in the information were which physician specialties the 31 referenced QME's were composed of as well as the regions of the state where they were located. If the overall "goal of the proposed restriction of QME office locations is to keep providers interested in participating as QME's, rather than leaving the system due to few panel assignments", an examination of both the fields of specialty and geographical location needs to be done.

A QME located in a rural location with a lower population will not receive as many panel selections as a QME located in a metropolitan area with a higher population per-capita. QME's with niche specialties such as obstetrics, urology or internal medicine will not receive as many panel assignments based upon the unique aspects an industrial injury would require in order for their specialty to be selected. Musculo-skeletal injuries involving the spine as well as upper and lower extremities will receive a higher number of QME requests. Did Mr. Neuhauser take into consideration this information when calculating the 10% report writing figure used in his research?

A QME located in a less densely populated area who lists additional office locations in neighboring cities will have little to no effect on other QME's located in separate geographical locations, thus by limiting the number of additional office locations will negatively affect this type of QME physician using multiple office locations spread over a greater distance.

Many colleagues whom I have spoken with in my geographical area who have obtained their QME certification maintain only their primary practice location. This was described to me as a combination of a lack of available time sometimes necessary to review substantial medical records as well as the inability to be away from a busy practice. Many QME physicians choose to maintain a larger number of sites, while others decide to maintain few. There is nothing preventing a QME from adding additional evaluation sites.

The decision to add alternate QME sites comes with both the potential for additional evaluation selections as well as a very real possibility of not being selected. The argument that "I never get picked" or "it's not fair!" sounds like an elementary school child's complaint to their parent about a game at recess or perhaps a person who plays the lottery week after week and never wins. The same system that selects the names of the QME's that list eleven-plus locations also lists the names of the QME with one.

I currently maintain forty-two QME sites in thirty-three different cities. In all but six cities I have only one exam location per city. For the six cities with more than one exam location, the cities have an average population in excess of 500,000. The argument that a physician who maintains multiple QME location sites will reduce the number of chances for another physician

with only a small number of sites is only accurate if the multiple locations are all in the same geographical region. A single QME location in Napa has no affect on a fellow QME in Salinas and vice versa.

I resent the insinuation that a QME who devotes the additional time and resources required to develop a busy medical-legal/QME portion of their practice is “biased against the injured worker” as one forum post read. Many QME’s are extremely proficient with their understanding of the ever changing requirements of report writing and as such produce a higher quality report for the parties involved. The decision to expand the number of exam locations and thus increasing the possibility of additional panel selections is no different than accepting and treating additional patients. For example, another post on the forum felt that even five office locations “is excessive” and that “quality, not quantity, of work should be the primary concern of all the parties.” Do all chiropractors desire to treat 50-patients per day? No. Is it possible for those that choose to treat 50-patients per day provide each patient with a quality visit? Yes. Do all chiropractors want to treat 50-patients per day? No. The same rationale can be applied to the comfortable number of QME evaluations. Not every QME wants to evaluate the same number of injured workers, and those that do must adhere to the established time-frames for report completion and content.

In conclusion, to restrict all registered QME’s to a maximum of 5-evaluation locations will ultimately reduce the quality of submitted reports and increase med-legal fees and time. It is unclear how the described “goal” of this proposed restriction to “keep providers interested in participating as QME’s, rather than leaving the system” will in effect force me out of a system that has allowed me to provide high-quality QME services to a diverse variety of injured workers in underserved locations.

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Terry L. Burke, DC DABCO

September 24, 2010

I am a diplomate in orthopedics of the American Chiropractic Association. I would like the Ca Board of Chiropractic to recognize board certification as the medical boards do their physicians. We are well trained to provide excellent ortho exams and med-legal reports. I can support having the number of bonafied offices limited to 5-10.

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Rene Thomas Folsie, JD, Ph.D., Esq., Licensed Psychologist

September 24, 2010

I have read and reviewed the proposed changes to the QME regulations. I have comments with respect to §30.

On June 3, 2010 the WCAB held in the en banc decision of Amelia Mendoza v Huntington Hospital (case ADJ 6820138 ADJ 6820197) held that: (1) California Code of Regulations, title 8, section 30(d)(3) (Administrative Director Rule 30(d)(3)), which states that when a claim has been entirely denied by the defendant only the employee may request a panel of Qualified Medical Evaluators, is invalid because it conflicts with Labor Code sections 4060(c) and 4062.2 and exceeds the scope of section 5402(b); (2) the time limits of section 4062(a) for objecting to a treating physician's medical determination do not apply when the injury has been entirely denied by the defendant; and (3) section 4062.2 does not establish timelines for initiating or completing the process for obtaining a medical-legal report on compensability.

Despite this decision, your proposed changes to the QME regulations have not modified the language in §30 to comply with this decision. I suggest that since you are in the process of amending all of these regulations, that you modify §30 to comply with the opinion in Mendoza. It does not make sense to continue to have regulatory language that has been judicially determined to be invalid.

With respect to the proposed language that seeks to limit the number of QME branch offices, the proposed regulation does not go far enough. If a QME has legitimate offices for treatment in more than one location, then including an additional address for QME panel purposes would make sense. On the other hand, offices or pseudo offices maintained just to maximize profits from QME work is an abuse that should be corrected. I suggest language that directly achieves this purpose.

The regulations as proposed relies on the definition of a "Physician's office" to limit illegitimate QME offices as follows:

§ 1(y) "Physician's office" means a bona fide office facility which is identified by a street address and any other more specific designation such as a suite or room number , and which contains the usual and customary equipment for the evaluation and treatment appropriate to the physician's medical specialty or practice.

The language of this definition is too vague to achieve the intended purpose. The term "bona fide" is debatable, and what is or is not bona fide cannot be ascertained.

I suggest that the definition of an acceptable "Physicians office" be more clearly defined to exclude offices such as those used solely for purposes of creation of a cottage industry of marketed QMEs who travel the state. Language of the definition could consider attributes such as the QME must actually treat patients at a branch office a certain amount of time, and must have staff at this office, and must not share this office with more than a small number of QME's who also treat patients at the location, and that the QME must not use the office as part of a marketing scheme managed by a non QME organization. A better definition of what is and what is not an acceptable "physicians office" with clearer terms would stop abusive practices.

Please consider better language for the definition contained in §1(y)to preclude QMEs from having an office in name only.

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Brett Johnson

September 22, 2010

I am an applicant attorney since 1997. During my practice there has been many changes to the discovery rules. Some that did not work, and some that worked. I support the QME regulations limiting the number of offices that they have (except in rural areas). In addition to the studies which reveals the disparity between these traveling doctors and local doctors, there is also another issue to consider: Many unrepresented applicants go through the panel QME process. They then end up with a panel list with at least one (usually two or three) of these traveling doctors on it. They then call the respective offices to see who schedules soonest or who is the closest. Most of the time the traveling doctors are scheduling soonest and have the closest offices so that is who they choose. Of course, these doctors have many offices so it is likely they are closer injured workers than other non-traveling QMEs. Also, they can see applicants soon because they only do very cursory evaluations which take at most 20 minutes. Thus, in an 8 hour work day, the QME could see 24 applicants for QME evaluations.

Finally, I recently started representing a client who was evaluated by Dr. \_\_\_\_\_ [Name removed.]. He has 96 (yes, ninety six) QME offices. I asked him what the office was like. He advised that the QME appointment was held in the back room of a massage parlor. This is at \_\_\_\_\_ [ Address removed]. There are at leave five traveling doctors from the same group who use this "QME office". Unrepresented workers who request an orthopaedist QME lose a great deal of respect for the system when they end up seeing the doctor for about 5 minutes in a back office of a massage parlor. Once the applicant receives the report, the applicant then becomes more angry after reading the report. Unrepresented applicants should at least be given the chance to see a neutral doctor who spends time analyzing the issues. Generally, these traveling doctors do not do this.

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Jeffrey Dittrich, Esq.  
Work Comp and PI

September 22, 2010

There are other matters that need to be dealt with in the new rules. One is the persistent effort to prevent issuing QME panels unless we define the issue with great particularity. The latest effort requires the requestor to point out a particular medical report of the PTP and the particular thing

in the report we disagree with. That is ridiculous. In many cases, the PTP does not wish to comment or clarify what we need to move the case forward. To get a timely QME panel, it is necessary to do so as early as possible. What purpose is served in delaying the issuance of a panel when it is going to happen sooner or later. We need to streamline the process, not put in more road blocks.

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Marjory Harris, Esq.

September 21, 2010

I support the DWC's proposal to limit QMEs to 5 locations. We get the same doctors repeatedly dominating panels, and often they are not board-certified, work out of report-writing mills, do cursory evaluations and defective reports. The worst offender is Dr. \_\_\_\_\_. [Name removed.]

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Lawrence I. Stern, Esq.  
Mallery & Stern, A Professional Corporation

September 21, 2010

As you know, there is a company in Fresno that lists hundreds of doctors at multiple addresses. I can get a panel with the names of three doctors and they all have the same address and same 800 or 888 numbers....What is also interesting is they have NO business license at the "place" where they are doing business which is a violation of the City Codes. Therefore the DWC is allowing a misdemeanor to take place by allowing these doctors to "practice" at these offices. Dr. \_\_\_\_\_[Name Removed] is listed on over 90 offices in the State of California.

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Daniel Saban, Esq.  
The Carlo Law Group

September 21, 2010

I have been an attorney representing injured workers and insurance companies for over 10 years. I believe one of the worst problems right now is the ability for certain orthopedic doctors to get listed too many times on the PQME list. I frequently find PQME lists with all 3 doctors from the same location, with the same or similar report writing. That in turn causes defendants to always

request ortho panels and for Applicant attorneys to always want alternative specialties to avoid the risk of getting that type of ortho panel. Consequently, both sides are not necessarily using the process correctly and as intended. To reiterate, having certain orthopedic doctors overly listed/represented in the PQME process is causing unfair results to injured workers and continued “gaming” of the system by both sides.

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Robert A. Levin

September 21, 2010

I am an applicants' attorney in Berkeley and have appeared before the WCAB since 1970. I was a certified specialist for 30 years.

I wish to support the proposal to limit the number of offices QMEs can claim to have. I have seen too many panels with doctors' claiming to have an office in the East Bay when, in fact, this "office" exists only as an address to qualify them for QME panels.

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Dr. Kai Tiltmann, DC, CAE  
Qualified Medical Examiner, Graston Technique  
Financial District Chiropractic

September 20, 2010

I am unfamiliar with the rules for this Forum so please excuse me if they I have made a mistake in protocol.

I would like to voice my support for the changes noted below. I am a QME with 3 locations. I have seen very few Panel QMEs in the past year and I am sure that is partly due to the large number of chiropractors who have upwards of 30 sites. It appears, when checking various locations for QME that the same names appear in various geographical areas. I think that it is in the best interest of all parties involved that QMEs are done by a large variety of doctors vs. a small concentration. The random selection process of the panel is not longer random with a small number of doctors have 30 sites vs. everyone else who has one or 2.

Thank you.

(b) A physician may concurrently hold separate QME certifications at up to five physician's office locations chosen by the QME, and up to five additional physician's office locations in ZIP codes in which fewer than five QMEs are currently certified in the QME's medical specialty. Each office location must be located in California, identified by a street address and any other

more specific designation such as a suite or room number, must contain the usual and customary equipment for the evaluation and treatment appropriate to the physician's medical specialty or practice, and must comply with the protections and prohibitions contained in Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), section 11135 of the California Government Code, section 51 *et.seq.* of the California Civil Code and other applicable state and federal disability laws. The QME must have a reasonable basis to believe that each office location will be available for the QME's use during the QME's current period of appointment.

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Kathryn Randmaa, Esq.  
Law Office of Randmaa & Buie

September 17, 2010

Defendants have become less inclined to utilize agreed medical evaluators in their cases because they know they have a high probability of receiving a panel with 2 or more of the "traveling" doctors who are well known for providing defense oriented, low disability reports. In fact, a defense attorney at a deposition the other day told us his clients never use AMEs anymore because the QME panels almost always include the conservative "traveling" doctors. This leads to increased litigation, especially since these "traveling" doctors usually do not provide reports that would be considered substantial evidence, and a delay in resolution of the cases. If parties were encouraged to utilize AMEs, or received fair panels with AME quality doctors, there would be less litigation and more expeditious resolution of claims.

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Michael Blott, D.C.

September 17, 2010

The Administrative Director shall recognize only those specialty boards recognized by the respective California licensing boards for physicians and surgeons as defined in [Labor Code section 3209.3](#)

Why are the words "and Surgeons" entered into the regulation.

It is redundant and using prevalent legal interpretation the word "or" is more appropriate.

As is stands only surgeons qualify.

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Market Street Chiropractic

September 17, 2010

With the understanding "the goal of the proposed revision is to keep providers interested in participating as QME's, rather than leaving the system due to few panel assignments."... does this imply the allowance of AMEs also disinterest QMEs in participating in the system as well?

The QMEs with multiple sites may specialize in Med Legal Evaluations allowing a higher quality evaluating system.

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D. Lachlan Taylor, Workers' Compensation Judge  
Commission on Health and Safety and Workers' Compensation

September 16, 2010

1. The language for Rule 10(b) should probably use a different way of identifying underserved locations where a QME may exceed the 5-location cap.

In urban areas where zip codes are geographically small, a resident of a zip code with zero QME offices may nevertheless be within five miles of a dozen or more QME locations.

The algorithm for assigning QME panels uses an expanding radius from the worker's zip code until it can generate a sufficient pool for the random draw of a panel. This might provide a very direct measure of underserved areas.

For example, if orthopedic QME requests originating from 95646 needed to go to a 50 mile radius to generate a sufficient pool, you could identify 95646 as an underserved area. By running dummy panel requests through the algorithm, you could identify every zip code which is underserved for each specialty. You could publish the list so that physicians or their facilitation services would know in advance where the extra locations would be permitted.

With that in mind, Rule 10(b) might simply allow the extra locations to be in zip codes the Administrative Director has listed as underserved in the relevant specialty. Then you could give physicians some predictability in knowing where they can site additional exam locations, but you would not need a new rulemaking to account for changes in the number of exam locations that might shift any one zip code into or out of the underserved category.

2. Perhaps the intent of Rules 12 and 13 would be better expressed with something along the following lines. This suggested alternative is incomplete because it does not incorporate Section 13's grandfather clause or reference to Section 11(a)(2)(A), but I think it expresses the concept of the proposed amendments to 12 and 13:

“The QME specialty of a physician and surgeon holding an M.D. or D.O degree shall be one for which the physician is board certified by a specialty board recognized by the Medical Board of California pursuant to Chapter 5 of Division 2 (beginning with Section 2000) of the Business and Professions Code. The QME specialty of any other type of physician as defined by Section 3209.3 of the Labor Code shall correspond to the type of licensure under Division 2 of the Business and Professions Code. “

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Craig A. Paul, Esq.  
Law Office of Frieze & Paul

September 16, 2010

Due to the fact that the geographical regions of California, such as North vs. South, Central vs. North/South, realistically being quite diverse, a consideration might be made for Panel QME's being limited within 100 (or 150) miles from the Panel QME's main office or address.

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Jody Buie

September 16, 2010

I support these proposed regulations. The panels seem to be dominated by the same physicians, all of which have numerous offices and seem to make a living off of their profession as a QME. Further, the majority of these "travelling QMEs" seem to be biased against the injured worker. This claim is substantiated by a comment by a defense attorney yesterday who said that 3 out of 4 of his clients won't agree to an AME because they get the best results by using the panel QME process. It appears that these QMEs with multiple zip codes are not objective. This results in more litigation which is what the whole system was suppose to prevent.

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Raul Marco, DC

September 16, 2010

With regards to not recognizing that I went to 2 years of orthopedics is not fair in the community. I believe that all education should be recognized and knowledge is at stake of why doing something if it is not recognized. Therefore I recommend that you take into consideration all the time and effort that is placed on education. Recognition is the reward of knowledge.

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Thomas Payne

September 16, 2010

Does the current assignment system favor multiple locations? Apparently. Do carriers prefer that arrangement?

Lets clean up MPN's. SCIFF has listed on their website a guy who doesn't even do panels, in fact may not even be a QME, as one of their MPN provider guys.

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Gregg S. Sorensen, MD, MPH, QME

September 16, 2010

As a QME since the inception of the process, I support the concept of limiting the number of "office locations" to 5. In truth, I believe that number is excessive.

Quality, not quantity, of work should be the primary concern of all parties, including us who serve as evaluators.

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Gina M. Garcia, Claims Consultant  
Aon Accelerated Claim Closure

September 16, 2010

Reading this would make one wonder if this is the reason that QME reports take several months to obtain and in some cases to the point of having to take physician depositions.

In my professional position at this point in time it is imperative that these reports be received in a timely manner as it is only moved to when there is discrepancies by both sides and could be the deciding factor to lost wages to the claimant, accommodation of employment by the employer, surgical decisions and/or settlement of the case.