July 5, 2019
Charles R. Rondeau, Esq.
The Rondeau Law Firm

By way of this letter, I would like to offer the within comments regarding the Proposed Updated Rules of Practice and Procedure ("Proposed Updated Rules"). It is my hope that these comments, along with those submitted by all other parties, will be given due consideration by the Workers' Compensation Appeals Board ("WCAB" or "Appeals Board") and will be utilized by the WCAB to formulate a final version of the Proposed Updated Rules which will facilitate the most expeditious and equitable resolution of disputes properly within the Appeals Board's statutorily-conferred jurisdiction.

Introduction

In the main, I believe that the Proposed Updated Rules represent a timely, well-conceived and much-needed effort to bring greater clarity and currency to the procedural rules applicable to proceedings before the Workers' Compensation Appeals Board ("WCAB"). For that reason, my comments are relatively brief. In particular, I believe that proposed Regulations 10555, 10600, 10629, 10752, 10872, and 10832 would be very beneficial to all interested parties

On the other hand, in certain instances, particularly with respect to the proposed changes to the rules governing the resolution of medical-legal expense disputes, the Proposed Updated Rules would actually "set the clock backward" to the state of affairs which preceded the most recent prior revisions to the Rules of Practice and Procedure in 2013 and would run contrary to the public policy objectives sought to be advanced by those prior revisions. Indeed, as discussed herein, the Proposed Update Rules would, without legal justification, have the effect of transforming parties sseking reimbursement for litigation-related costs, including medical-legal service providers, into lien claimants.

The comments set forth herein will be organized in numerical order in relation to the Proposed Updated Rules.

Proposed Regulation 10305

Proposed Regulation 10305 would delete the term "Costs" as a defined term because, according to the included comments, this term is defined in Labor Code sections 4600, 4620, 4903, 5710, and 5811. I respectfully submit that this statement is inaccurate in that only two (2) of the cited code sections (i.e., Sections 4620 and 5811) even include the words "cost" or "costs" within the language of the statutes. More importantly, the definition of the term "costs" which appears in current Regulation 10301, subsection (h), serves an important purpose, namely, of defining expenses which are primarily litigation-related and thus are reimbursable without the necessity of filing a lien against compensation pursuant to Labor Code section 4903 and complying with all of attendant procedural requirements and lien filing fees. I respectfully submit that retaining the current definition of the term "costs", or some other substantially similar version of it, is vital so that these types of expenses are not conflated with other types of expenses, primarily medical treatment-related expenses, which are only reimbursable upon the filing of a lien and compliance with the attendant procedural requirements and payment of the required fees. For that reason, I submit that the proposed deletion of the term "costs" would introduce ambiguity

(where, on the other hand, the current definition creates clarity) into the entire realm of expenses incurred in connection with claims for workers' compensation benefits and into the process of resolving disputes concerning such expenses. This deletion would create unnecessary confusion on the part of litigants and workers' compensation judges and would cause certain parties claiming the right to reimbursement for litigation-related expenses to "act defensively" and proceed with the filing of a lien even though such is not required, thereby inaccurately placing them within the category of "lien claimant". Therefore, I respectfully submit that Proposed Regulation 10305 should retain the current definition of the term "costs".

Expanding upon the above comments, and for the same reasons, I also submit that Proposed Regulation 10305 include an additional subsection to follow the current definition of the term "costs" which would define the term "Cost claimant". The additional subsection would define the term "Cost claimant" as a party claiming a right to reimbursement of "Costs" in the current definition of that term. This new definition would serve to further differentiate the role of a "cost claimant" as a party claiming the right to reimbursement for a litigation-related expense which does not necessitate the filing of a lien from "lien claimants" who are required to file a lien. I note that Proposed Regulation 10305 retains the current definition of the term "Lien claimant" as subsection (m). The proposed retention of "lien claimant" as a defined term only further serves to underscore the need for inclusion of a definition of the term "cost claimant". Therefore, I respectfully submit that Proposed Regulation 10305 should include a definition of the term "Cost claimant".

Similarly, I further respectfully submit Proposed Regulation 10305 include the term "cost claimant" within the definition of the term "Party" as set forth in subsection (o).

Proposed Regulation 10305 would delete the term "Rating mandatory settlement conference" as a defined term because, according to the included comments, "we no longer have these proceedings". I do not understand this statement or am not aware of any public policy reason supporting the proposed deletion of rating mandatory settlement conferences as a recognized proceeding. To the contrary, I can state without hesitation that there are, to this day, many instances where the applicant and the defendant are unable to agree on the ratings of the medical-legal evaluator reports in a particular case and that obtaining a Consultative Rating Determination by the Disability Evaluation Unit is essential to reaching a resolution of the case. Therefore, I respectfully submit that Proposed Regulation 10305 should include a definition of the term "Rating mandatory settlement conference" and that the WCAB continue to recognize the validity of these proceedings.

Proposed Regulation 10547

Proposed Regulation 10457 is a proposed new rule which sets forth the procedures for resolution of disputes concerning claims for attorneys' fees payable pursuant to Labor Code section 5710. While I believe that the proposed rule would provide much-needed structure to the process of resolving such disputes, I question the requirement, pursuant to subsection (d)(3), that the "Petition for Attorney's Fees Pursuant to Labor Code Section 5710" be served on the injured worker. Transparency in all matters which directly affect the right and interests of injured workers is, without a doubt, a categorical imperative. However, since it is the defendant, rather than the injured worker, who will be solely liable for payment of a claim for attorneys' fees

pursuant to Section 5710, disputes concerning such claims do not implicate those rights and interests. Moreover, I believe that requiring service of Labor Code section 5710 petitions on injured workers will serve to confuse rather than inform them and may very well create completely unnecessary friction between injured workers and their attorneys. Injured workers may well be led to believe that they will be responsible for payment of requested attorney's fees. Therefore, I respectfully submit that that the requirement of service of Labor Code section 5710 petitions on injured workers be deleted from Proposed Regulation 10547.

Proposed Regulation 10758

Proposed Regulation 10758 is a proposed new rule which would permit a workers' compensation judge to "re-designate" any hearing other than a trial as a status conference. Although proposed Regulation 10305, subsection (r), preserves the current definition of the term "Status Conference", according to the *de facto* custom and practice of the WCAB a Status Conference cannot be converted into a Mandatory Settlement Conference (where any dispute may be set for trial) unless both parties to the dispute agree. Therefore, the practical effect of a rule permitting a workers' compensation judge to "re-designate" any hearing other than a trial to a status conference would be to introduce further delay in the resolution of disputes which in many instances be ripe for decision at the hearing in question. Accordingly, I respectfully submit that Proposed Regulation 10758 not be adopted.

Proposed Regulation 10786

Proposed Regulation 10786 is, by far, the most problematic and concerning proposed new rule. Current Regulation 10451.1, which Proposed Regulation 10786 is intended to replace, sets forth a comprehensive "roadmap" for the parties to a medical-legal expense dispute, as well as the WCAB, to follow to resolve the dispute. Proposed Regulation 10786, on the other hand, only "tells half the story". Proposed Regulation 10786 fails to address any aspect of the dispute resolution process other than, and prior to, the assertion by the defendant of a "non-IBR medical-legal dispute" as a basis for denying payment for the claimed medical-legal expense. The included comments suggest that the reason for deletion of all of the provisions contained in current Regulation 10451.1 pertaining to earlier and other aspects of the medical-legal expense disputes resolution process is that they are duplicative of the relevant provisions of Labor Code section 4622. I would point out that the issue of duplication as between relevant statutes such Section 4622 and the provisions of current Regulation 10451.1 was extensively discussed by the WCAB in its Initial Statement of Reasons ("2013 ISOR")[1], and the Appeals Board provided ample justification for the need for potentially duplicative provisions. I submit that the WCAB's arguments are as forceful now as they were in 2013.

Moreover, concerning the need to establish a specific new form of petition for the resolution of disputes concerning medical-legal expense disputes which are not subject to the Independent Bill Review process and a set of specific procedures for the handling of such disputes, the 2013 ISOR stated as follows:

[1] 2013 ISOR, pp. 12 – 14.

As discussed above, for the most part, medical-legal disputes have special resolution procedures. In general, disputes over amounts payable under an official fee schedule must be resolved through the procedures established by Labor Code sections 4622(a) and (b), 4603.3, and 4603.6. On the other hand, other medical-legal disputes must be resolved through the procedures established by Labor Code sections 4622(a), 4603.3, and 4622(c). In particular, section 4622(c) provides, in relevant part: "If the employer denies all or a portion of the amount billed for any reason other than the amount to be paid pursuant to the fee schedules in effect on the date of service, the provider may object to the denial within 90 days of the service of the explanation of review. … If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection." (Italics added.)

Labor Code section 4622(e)(2) expressly provides that: "The appeals board shall promulgate all necessary and reasonable rules and regulations to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced." Therefore, proposed Rule 10451.2 would provide that, where the circumstances described in section 4622(c) are present, the defendant must concurrently file both a "Petition for Determination of Non-IBR Medical-Legal Dispute" and a declaration of readiness, together with a proof of service. Proposed Rule 10451.2 would also provide that, if the defendant has objected to the provider's medical-legal billing on both amount payable and non-amount payable grounds, the WCAB shall hear and determine only the latter issue, unless a timely IBR appeal is concurrently pending before it.[2]

Once again, I submit that these arguments remain as forceful now as they were in 2013.

Similarly, Proposed Regulation 10786 would delete **all** of the waiver provisions (both on the part of medical-legal service providers as well as defendants) contained in current Regulation 10451.1, Subsection (f). The comments to Proposed Regulation 10786 provide no explanation for their deletion, and I cannot conceive of any reasonable justification for their deletion. The legal concept of waiver is well-recognized under California workers' compensation laws with the instances where waiver has been found are far too many to list in this letter. Having litigated literally thousands of "non-IBR medical-legal disputes", I can state with great conviction and no hesitation that the waiver provisions contained in contained in current Regulation 10451.1, Subsection (f), incentivize both medical-legal service providers and defendants to act in good faith to resolve medical-legal expense disputes by providing a powerful penalty if they do not. Therefore, I respectfully submit that Proposed Regulation 10786 retain the waiver provisions contained in current Regulation 10451.1, Subsection (f).

Turning to the extent of Proposed Regulation 10786, Subsections (a) – (d), would require the parties to a "non-IBR medical-legal dispute" to proceed to a "status conference" as the initial hearing concerning any such dispute. For the reasons stated above as to the current "custom and

[2] 2013 ISOR, pp. 13-14.

practice" of litigants and workers' compensation judges regarding status conferences, such a requirement would in many, if not most, instances introduce additional, unnecessary delay into the process of resolving such disputes. Once again, based upon my extensive experience litigating "non-IBR medical-legal disputes", I can state with great conviction and no hesitation that such disputes are generally straightforward with very little in the way of disagreement as to the underlying facts. As such, I submit that these disputes should remain the subject of expedited, summary resolution or, if necessary, adjudication, as is permitted under and facilitated by current Regulation 10451.1. Therefore, I respectfully submit that Proposed Regulation 10786 not require the parties to a "non-IBR medical-legal dispute" to proceed to a "status conference" as the initial hearing concerning any such dispute.

Proposed Regulation 10786, Subsection (b), would eliminate the right of a medical-legal service provider to file a Declaration of Readiness to Proceed ("DOR") along with a petition for determination of a non-IBR medical-legal dispute while preserving this right on the part of a defendant. I cannot conceive of any reasonable justification for the proposed inequity. Therefore, I respectfully submit Proposed Regulation 10786 should not eliminate the right of a medical-legal service provider to file a Declaration of Readiness to Proceed along with a petition for determination of a non-IBR medical-legal dispute.

Proposed Regulation10786, Subsection (c), is, by far, the most pernicious aspect of the problematic and concerning proposed new rule. This provision expressly permits the WCAB to defer determination of any petition for determination of a non-IBR medical-legal dispute until the injured worker's case-in-chief is resolved or abandoned. I cannot conceive of any reasonable justification for permitting such deferment when, as the Appeals Board hardly needs to be reminded, a medical-legal service provider is entitled to payment for its expenses irrespective of the outcome of the case-in-chief. *Subsequent Injuries Fund v. Industrial Acc. Com. (Roberson)*, 59 Cal.2d 842, 844 (1963); *Beverly Hills Multi-Specialty Medical Group v. Workers' Comp. Appeals Bd.*, 26 Cal.App.4th 802 (1994). The proposed deferment provision would essentially place medical-legal service providers in the same position as lien claimants whose right to payment is directly related to and determined by the outcome of the case-in-chief. *See, Angelotti Chiropractic v. Baker*, 791 F.3d 1075 (2015). The right of litigants, most especially injured workers, to access medical-legal services to assist in the resolution of their workers' compensation benefit claims is essential to carry out the constitutional mandate that the workers' compensation laws of this State: "accomplish substantial justice in all cases expeditiously, inexpensively, and without incumbrance of any character." *Cal. Const. Art. XIV, Sec. 4.* In particular, at a time when the number of panel Qualified Medical Providers has reached a critically low level, I submit that it would be counterproductive and, indeed, perilous to permit **any delays** in the resolution of disputes concerning medical-legal expenses, most especially non-IBR medical-legal disputes. Therefore, I respectfully submit Proposed Regulation 10786, Subsection (c), should be deleted.

Proposed Regulation 10786, Subsection (e), would eliminate the detailed definition of "Bad Faith Actions or Tactics" in relation to medical-legal expense dispute resolution as is contained in current Regulation 10451.1, Subsection (g). The comments to Proposed Regulation 10786 state that these definitions are to be deleted "because the standards for the application of sanctions are already found within Labor Code section 5183 and rule 10421." As with my comments regarding the waiver provisions contained in current Regulation 10451.1, Subsection (f), based upon my

extensive experience litigating "non-IBR medical-legal disputes", I can state with great conviction and no hesitation that the definition of "bad faith conduct and tactics" contained in current Regulation 10451.1, Subsection (g), similarly incentivize both medical-legal service providers and defendants to act in good faith to resolve medical-legal expense disputes by providing a powerful penalty if they do not. Notwithstanding the more general language contained in Labor Code section 5183 and Proposed Regulation 10421, the current incentivization of good faith behavior would be significantly diluted if the detailed definition of "Bad Faith Actions or Tactics" contained in current Regulation 10451.1, Subsection (g), were deleted. Therefore, I respectfully submit that Proposed Regulation 10786 retain the definitional provisions contained in current Regulation 10451.1, Subsection (g).

Proposed Regulation 10789

Proposed Regulation 10789 represents a "wholesale" revision of current Regulation 10417 concerning "Walk-Through Documents". Please see my comments above regarding Proposed Regulation 10786. Current Regulation 10451.1, Subsection (c)(3)(B), provides that a petition for determination of a non-IBR medical-legal dispute by a medical-legal service provider may, but need not, be accompanied by a DOR. I cannot conceive of any reasonable justification why **either a defendant or a medical-legal service provider** should not be permitted to submit a petition for determination of a non-IBR medical-legal dispute for determination on a "walk-through basis". To the extent that such a petition is presented to a workers' compensation judge without the filing of a DOR, the judge could either: (a) issue a Notice of Intention to order that relief and permit the opposing party to object to proposed order is satisfied that the moving party has set forth a prima facie showing of entitlement to the requested relief; or (b) deny the petition, with or without prejudice, if a satisfactory showing is not made and, if necessary and warranted, impose sanctions and attorney's fees if the judge determines that the petition was not presented in good faith. Allowing petitions for determination of a non-IBR medical-legal dispute to be presented in this manner would further facilitate and accelerate the determination of such disputes. Therefore, I respectfully submit that Proposed Regulation 10789 expressly include a petition for determination of a non-IBR medical-legal dispute for determination on a document which may be submitted on a "walk-through basis".

Proposed Regulation 10818

Proposed Regulation 10818 addresses the recording of proceedings before the WCAB. Proposed Regulation 10818, Subsection (c)(6), provides:

> *The workers' compensation judge shall not permit recording of the following:*
>
> (3) *Proceedings held in chambers which are not transcribed by a hearing reporter;*
>
> (4) *Proceedings closed to the public; and*
>
> (5) *Conferences between an attorney and a client, witness, or aide, between attorneys, or between counsel and the workers' compensation judge at the bench, unless transcribed by a hearing reporter.*

In recent years, I have personally participated in and become aware of numerous instances in which counsel have requested that *in camera* and other informal discussions with a workers' compensation judge be transcribed so that an official record of the discussions is created for purposes of later review and those requests have been denied by the workers' compensation judge. Permitting such discussions to remain "off the record" represents an injustice to all concerned. Therefore, I respectfully submit that Proposed Regulation 10818 expressly require that a request that *in camera* and other informal discussions with a workers' compensation judge be transcribed be granted unless "good cause" is shown and that such "good cause" be defined in Proposed Regulation 10818 and, further, that any party aggrieved of the denial of a request for transcription be permitted to seek immediate relief from the Presiding Judge of the relevant WCAB District Office.

I would also point that Proposed Regulation 10818 seems not to acknowledge and address the WCAB's recent utilization of lien hearings by way of "telepresence", as well as the increased use of "telepresence" appearances such as by way of CourtCall for all manner of proceedings before the Appeals Board. Therefore, I respectfully submit that Proposed Regulation 10818 include appropriate provisions for videoconferencing and video-recording of such "telepresence" hearings and appearances.

Proposed Regulation 10862

Proposed Regulation 10862 addresses the filing of lien claims. This new rule proposes various deletions to current Regulation 10770, including Subsection (a)(3) which provides, in relevant part: "Claims for medical-legal costs and other claims of costs are not allowable as a lien against compensation. Nevertheless, a claim for medical-legal costs or other claims of costs may be filed as a lien claim." The supporting comments attempt to collapse the critical distinction between cost claims and lien claims and suggest that claimants seeking reimbursement for costs (in particular, medical-legal service providers) must now be required to resort to filing liens. One such comment states: "Propose removing claims for medical legal costs because Labor Code section 4903(b) was amended effective January 1, 2015 to include medical legal expenses as Labor Code section 4903(b) liens." I respectfully submit that this statement is legally inaccurate. Labor Code section 4903 provides, in relevant part:

> *The appeals board may determine, and allow as liens against any sum to be paid as compensation, any amount determined as hereinafter set forth in subdivisions (a) through (i). If more than one lien is allowed, the appeals board may determine the priorities, if any, between the liens allowed. The liens that may be allowed hereunder are as follows:*
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> *
> *
> *
>
> *(b) The reasonable expense incurred by or on behalf of the injured employee, as provided by Article 2 (commencing with Section 4600), and* ***to the extent the employee is entitled to reimbursement*** *under Section 4621, medical-legal expenses as provided by Article 2.5 (commencing with Section 4620) of Chapter*

2 of Part 2, except those disputes subject to independent medical review or independent bill review.

(Emphasis added).

I respectfully submit that the above language clearly limits the allowance of a lien for medical-legal expense to those instances where the injured worker, rather than the provider of the services, is directly seeking reimbursement for such expenses and, by exclusion, exempts a party claiming reimbursement for costs, including a provider of medical-legal services, from the requirement to seek reimbursement by way of a lien pursuant to Labor Code section 4903, Subsection (b). Therefore, I respectfully submit that Proposed Regulation 10818 retain the language in current Regulation 10770 regarding "claims for medical-legal costs" and "other claims of costs", most especially, Subsection (a)(3).

Proposed Regulation 10890

Proposed Regulation 10890 provides further clarification of the requirements for compliance with Labor Code section 4903.6 by lien claimants. Proposed Regulation 10890, Subsection (a), provides: "Any section 4903(b) lien, **any lien for medical-legal costs**, and any application related to any such lien shall have attached to it a verification under penalty of perjury which shall contain a statement specifying in detail the facts establishing that both of the following have occurred …." (emphasis added). Please see my comments above regarding Proposed Regulation 10818. For these same reasons, there is no legal basis for requiring that a provider of medical-legal services seeking direct reimbursement for the costs of such services to be required to file a lien pursuant to Labor Code section 4903, Subsection (b), and comply with all of the attendant procedural requirements, including the payment of lien filing fees unless the provider has elected to file a "claims of costs filed as a lien". Therefore, I respectfully submit that Proposed Regulation 10818, Subsection (a), be revised to include and refer to "claims of costs filed as a lien" (rather than "any lien for medical-legal costs"**)** consistent with the Appeals Board's current procedural regulations.

Proposed Regulation 10892

Proposed Regulation 10892 addresses the filing of DOR's by or on behalf of lien claimants. Proposed Regulation 10892 begins with the introductory statement: "No Declaration of Readiness to Proceed shall be filed for a section 4903(b) lien, **or for a lien claim for medical-legal costs**, without an attached verification executed under penalty of perjury …." (emphasis added). Please see my comments above regarding Proposed Regulations 10818 and 10892. For these same reasons, there is no legal basis for requiring that a provider of medical-legal services seeking direct reimbursement for the costs of such services to be subject to the provision of Proposed Regulation 10892 unless the provider has elected to file a "claims of costs filed as a lien". Therefore, I respectfully submit that Proposed Regulation 10892 be revised to include and refer to "claims of costs filed as a lien" (rather than "any lien for medical-legal costs"**)** consistent with the Appeals Board's current procedural regulations.

Proposed Regulation 10900

Proposed Regulation 10900 address matters which are or may be subject to mandatory arbitration. In recent years, I have seen an alarming increase in the number of disputes between prior and subsequent applicant counsel regarding the division of attorney's fees after a settlement or an Award by the WCAB which result in multiple hearings, including multi-day trials, before the Appeals Board. Given the scarcity of judicial resources and the universally-recognized requirement that trial preference be given to disputes involving the injured worker's case-in-chief, I believe that the Appeals Board should give serious consideration to requiring that disputes concerning the division of attorney's fee be submitted to mandatory arbitration.

Proposed Regulation 10964

Proposed Regulation 10964, which is intended to replace current Regulation 10848, addresses so- called "Supplemental Petitions" in the context of petitions for reconsideration, removal or disqualification. Proposed Regulation 10964, Subsection (b), is a new rule which provides: "A party seeking to file a supplemental pleading shall file a petition setting forth good cause for the Appeals Board to approve the filing of a supplemental pleading and shall attach the proposed pleading." Petitions for reconsideration, removal or disqualification are subject to relatively short filing deadlines (20 days in the case of reconsideration or removal and 10 days in the case of disqualification) . On the other hand, the most likely scenarios in which a party who has filed a timely petition seeking such relief would also seek to file a supplemental petition would be those in which the record proceedings below are particularly voluminous and thus not feasible to be addressed within the prescribed time limits. As such, I respectfully submit that Proposed Regulation 10964, Subsection (b), be revised to make clear that a petition seeking leave to file a supplemental petition may be filed outside of the time limits for the underlying petition, provided that the underlying petition itself has been filed within those time limits.

Conclusion

It is my hope that the WCAB will acknowledge the time and effort which I have spent in analyzing the Proposed Updated Rules and in formulating the above comments by giving those comments the consideration which they deserve, and I look forward to continuing to participate in the Appeals Board's rulemaking proceedings in this regard.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

§ 10751. Appearances by Representatives Not Identified on Notice of Representation.
(a) An attorney or non-attorney representative may appear on a party's behalf if identified on a notice of representation.
(b) An attorney or non-attorney representative who has not been identified on a notice of representation shall file a notice of appearance that includes the full legal name of the represented party and the name, address and telephone number of the attorney or non-attorney

representative and associated entity, if any.

Comment: This rule ignores the business realities of attending hearings. This rule would require a notice of representation to include a list of persons who might potentially appear on behalf of a law firm or a non-attorney representation agency.

To prohibit a person from appearing simply because the person was not identified at the time of the notice of representation is an unreasonable restriction on a party's Sixth Amendment right to have a representative of their choice appear for them at the time of a hearing.

This rule also ignores the fact that new person may join a firm or agency or that the firm or agency may contract out to persons that may not have been readily identifiable at the time of the notice of representation.

This rule is unreasonable and compliance by firms or agencies who provide attorneys or hearing representatives on an as-needed basis to its clients.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

§ 10886. 10702. [A1] Service of Settlements on Lien Claimants.
Where a lien claim is on file with the Workers' Compensation Appeals Board, and a cCompromise and rRelease agreement or sStipulations with rRequest for aAward or order is filed, a copy of the cCompromise and rRelease agreement or sStipulations with Request for Award shall be served on the lien claimant.

No lien claim shall be disallowed or reduced unless the lien claimant has been given notice and an opportunity to be heard.

Comment: Certain liens (under Labor Code Section 4903(c)) which operate directly against applicant's benefits, must have timely knowledge of any case-in-chief settlement document which improperly disburses the funds subject to the lien. There is often a significant delay between a settlement and the time that the settlement documents are actually served on a lien claimant.

Legal Service Bureau suggests that to provide a lien claimant an opportunity to take action prior to the funds being disbursed by a defendant, that the rule contain a requirement as follows:

Where a lien claim is on file with the Workers' Compensation Appeals Board, and a compromise and release agreement or stipulations with request for award or order is filed, a copy of the compromise and release agreement or stipulations with request for award shall be served on the lien claimant **within 5 days of the Order or Award being issued**.

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Dan Escamilla, Esq.
Legal Service Bureau

Proposed Rule 10520 subsection (c): If a non-attorney representative who is not an employee of an attorney or law firm is executing the pleading being filed or served, the pleading shall include a heading containing the non-attorney representative's name followed by the words "Non-Attorney Representative," the name of the entity, if any, that employs the non-attorney representative, business address and business telephone number.

Comment: The requirement that a representative's name be followed by the words "**Non-Attorney Representative**" serves no useful purpose other than to highlight the fact that the filer of a document is a non-attorney.

No other governmental entity in the state requires a party to disclose its lack of licensure for a certain activity it is properly performing in the course of employment.

The fact that a document is filed by a person whose name is not followed by a CA State Bar number, which attorneys are required to place, is evidence enough that the person filing the document is a non-attorney.

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Dan Escamilla, Esq.
Legal Service Bureau

Comment: The proposed rule strikes the following language in subsection (e):

(2) An "attorney" includes a lay representative of a party or lien claimant.
This potentially removes the ability of a non-attorney hearing representative to argue that the term "attorney's fees" should include "hearing representative fees."

It is suggested that the following language be included in the new proposed rule:
"Attorney's fees" as referred to in Labor Code Section 5813 (a) includes a fees of a non-attorney representative.

The professional fees incurred by a non-attorney hearing representative should be, under the Board's rules, able to be awarded as attorney's fees under Section 5813.

Labor Code Section 5813 (a) provides: The workers' compensation referee or appeals board may order a party, the party's attorney, or both, to pay any reasonable expenses, including attorney's fees and costs, incurred by another party as a result of bad-faith actions or tactics that are frivolous or solely intended to cause unnecessary delay. In addition, a workers' compensation referee or the appeals board, in its sole discretion, may order additional sanctions not to exceed two thousand five hundred dollars ($2,500) to be transmitted to the General Fund.

The Board's rules clearly place attorney's and non-attorneys on the same playing field. (See e.g. Labor Code § 4907 holding non-attorney "to the same professional standards of conduct as attorneys.")

If the term "attorney's fees" is limited to fees incurred by attorneys, and is not defined to include fees incurred by non-attorney hearing representatives, despite their equivalent role in workers' compensation proceedings, a violation of Constitutional due process and equal protection could result.

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Dan Escamilla, Esq.
Legal Service Bureau

(l) A non-attorney representative whose privilege to appear has been removed or suspended may petition the Appeals Board for reinstatement of the privilege after a period of not less than one year has elapsed from the date on which the decision of the Appeals Board took effect, or from the date of the denial of a similar petition.

Comment: The Board has previously (in 2013) issued a 90-day suspensions to a hearing representative. A one (1) year suspension is excessive and because the suspension of the privilege to appear before the WCAB is not permanent and may, after a period of time, be reinstated, the initial suspension period should not exceed 30 days.

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Dan Escamilla, Esq.
Legal Service Bureau

In this representative's 28 year experience, there have been instances where it appears that the represented employer and/or claims adjuster is unaware that his or her interests are being represented by a non-attorney employee of a law firm. There has also been an increase of unqualified non-attorney representatives from law firms who are sent to conference hearing for the sole purpose of asking for an additional conference date as a tactic to create additional billable hours for the defense firm.

Because the employment of the non-attorney, by the law firm, could deceive a represented employer and/or claims adjuster into believing that the law firm is sending a licensed attorney to a WCAB hearing to represent its interests, there is good reason to require the non-attorney to submit a disclosure, signed by both the represented employer and claims adjuster, along with names and telephone numbers of the persons signing to confirm the signatures, acknowledging that the non-attorney is not a licensed member of the State Bar of California and that the non-attorney will be representing their interests before the WCAB.
In addition to the disclosure, it would also be beneficial to the workers' compensation community for the attorney who oversees a non-attorney to submit a declaration that provides evidence that

the non-attorney has received at least 6 months on-the-job training prior to being allowed to appear alone at a WCAB hearing.

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The WCAB exercises all judicial powers vested in it under the Labor Code and consists of seven members appointed by the Governor with the advice and consent of the Senate. Five of the seven members must be attorneys admitted to practice in California. Two of the members may be non-attorneys.

The WCAB also permits non-attorneys to appear in proceedings before it. (See Labor Code Sections 5700 and 5501). Non-attorneys play an important role in California workers' compensation proceedings. Many of these non-attorneys have extensive experience before the Board and some even have law degrees.

While non-attorneys are permitted on the Board and as litigant representatives, there is no provision allowing for non-attorneys to serve as workers' compensation judges.

Section 10355 should include a subsection which, like the rules relating to the appointment of commissioners, allows for the appointment of a non-attorney as a pro tempore workers' comepnsation judge to handle conference hearing calendars, including mandatory settlement conferences or status conferences. It is also suggested that the subsection require any appointed pro tem WCJ to be a person "experienced in WCAB proceedings" (whether attorney or non-attorney) who has handled workers' compensation proceedings for at least ten (10) years.

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Legal Service Bureau

Comment: Legal Service Bureau opposes repeal of this rule because this rule is useful and necessary to address liens at the earliest opportunity possible, and to avoid protracted litigation on liens which creates an adverse impact on the availability of the Board's judicial resources and an unnecessary expense to lien claimants and their representatives.

The only reason this rule is not currently effective in reducing lien litigation after settlement of a case-in-chief is because there is no enforcement mechanism or effective sanction against a defendant for non-compliance with the rule and there no requirement that a defendant's settlement efforts be made in a “reasonable amount” or in an amount which is adequate given a defendant’s exposure to the lien, with the statutory increase and interest.
When Rule 10888 was first enacted in January of 2003, adjusters and defense attorneys took it seriously and made valid efforts to settle liens. The first few months of its operation, and very likely due to the memos to WCJs reminding them of the need for the parties’ compliance,

resulted in a surge of lien settlements. Anytime a WCJ is required to push a defendant toward negotiations with a lien claimant, the likelihood of lien settlement increases exponentially. There is also a major incentive for an adjuster, who is settling a case-in-chief, to resolve the entire claims file and avoid further defense costs involved with lien proceedings.

Unfortunately, the good faith by the defense industry which is necessary for the operation of this section, has eroded and current practice among adjusters and defense attorneys is to make nuisance value or $1.00 settlement offers to satisfy the "good faith settlement attempt" requirement and if a lien claimant wants to obtain any settlement above a 10% nuisance value, they must “put in their time” by attending numerous hearings (allowing defendants’ attorneys to generate hourly billings so they too can make a fee on the file) until a reasonable settlement offer is made.

In the current climate of the Board, not only do defendants ignore their obligation to “make a good-faith attempt to contact the lien claimants and resolve their liens,” but when a lien trial is finally set, the Board places lien trials as lowest priority on the Court’s calendar. Lien Trials will usually be at the bottom of the priority list of at least 4 or 5 other trials that have preference.

Typically, in this representative’s 28 years of experience, an excessive number of lien trial settings (sometimes in excess of 10 trial settings) occur before a lien claim is actually tried and submitted for a decision. Indolent WCJs and unethical defense attorneys who have no incentive to settle a lien and every incentive to churn a case, or continue to litigate a case for the sole purpose of generating unlimited additional hourly billings (which is a common practice with CIGA attorneys), are typical factors which promote and encourage delay. Such delays violate the requirement under Article XX, section 21 of the California Constitution which mandates the creation of a system of workmen’s compensation that, in the words of the Constitution, will be administered so as to “accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character;...”

Creating a disincentive for the defense to avoid settling those liens which are “liens of record” at the time of the settlement of the case-in-chief (instead of waiting for the other liens that may be filed later), is necessary to prevent the onset of protracted lien litigation. Adding a significant monetary penalty for lack of strict compliance with Rule 10888 and requiring that the settlement efforts be “genuine,” or “reasonable given the exposure of a defendant to the lien principle as well as the statutory increase and interest,” would go far in accomplishing the expeditious and inexpensive resolution of liens.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

Legal Service Bureau opposes repeal of this rule because it will eliminate the mandated right of “agents and physicians” “to examine and make copies of all or any part of physician, hospital, or dispensary records that are relevant to the claims made and the issues pending in a proceeding before the Workers’ Compensation Appeals Board.”

Nothing in Health & Saf. Code, §§ 123100 et seq. or Evid. Code, § 1158 provides a right for a lien claimant (who is a third party to the litigation) or its agent (attorney or hearing representative) to obtain the medical records.

Repealing this section will result in a due process violation for lien claimants who should be entitled to receive any and all medical reports concerning the injured worker since these reports are often necessary to prove up a lien claimant's case (i.e. need for pharmaceuticals and extraordinary circumstances to justify fees above the OMFS).

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

Comment: The automatic right to reassignment provided in this rule is necessary due to the unfortunate reality that a party which prevails in its challenge to a WCJ's determination, in this litigant's 28 year experience filing many hundreds of petitions for reconsideration, often creates an animosity by the WCJ against the petitioner since the WCJ is viewed as effectively "losing" a legal battle with the petitioning party. Unfortunately, this hearing representative has seen such "sour grapes" animosity by WCJs first hand (especially among WCJs who come for a unbalanced career history of only workers' compensation defense firms) and believes that the opportunity to exercise the automatic right of reassignment is critical to the petitioning party's due process in post-reversal proceedings.

A hearing may run afoul of due process protections, not only if there is a showing of actual bias but also when there is an appearance of bias. (Morongo Band of Mission Indians v. State Water Resources Control Board, 153 Cal.App.4th 202, 210 ("Morongo") [actual bias is no longer the "touchstone for disqualification in administrative hearings."]; Haas, p. 1029 ["We need find no instance of actual judicial bias"]; Nightlife Partners Ltd. v. City of Beverly Hills (2003) 108 Cal.App.4th 81, 90 ("Nightlife Partners") ["Just as in a judicial proceeding, due process in an administrative hearing also demands an appearance of fairness and the absence of even a probability of outside influence on the adjudication."] (emphasis in original); Yaqub v. Salinas Valley Memorial Healthcare System (2004) 122 Cal.App.4th 474, 486 ["The question is not whether the judge is actually biased, but whether a person aware of the facts might reasonably entertain a doubt that the judge would be able to act without integrity, impartiality and competency."].)

Since the reversal of a WCJ could create the appearance of bias as to subsequent adverse determinations by the same WCJ, as a matter of due process it makes sense to allow a party the opportunity to seek automatic reassignment after reversing the WCJ on reconsideration (or even removal). At a minimum, the appearance of bias occurs when "advocacy and decision-making roles are combined." (Howitt v. Superior Court (1992) 3 Cal.App.4th 1575, 1585.)

A WCJ is necessarily required to "advocate" in support of the decision being challenged through the Report and Recommendation on Petition for Reconsideration (a procedural requirement unique to the WCAB). In doing so, the WCJ becomes an advocate of the party in whose favor

the decision issued and an appearance of bias will thereby be created as to any subsequent proceedings.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

Legal Service Bureau supports the repeal of this rule because it does not adequately provide a procedure for determination of all disputes over medical treatment.

For instances, included in the “Medical Treatment Disputes Not Subject to Independent Medical Review and/or Independent Bill Review” should (but does not) include any dispute relating to the applicability of the OMFS to the charges billed by the lien claimant.

Independent bill review (IBR) “applies solely to disputes directly related to the amount payable to a medical treatment provider under an official fee schedule in effect on the date the medical treatment was provided.” There is no procedure in place for those lien disputes which are not subject to the official medical fee schedule. A physician claiming a fee above the OMFS based on extraordinary circumstances would not have a remedy under the rule as currently worded.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

This rule should not be repealed. Rather, the rule in which it is in conflict, (current rule 10770.1.1(a)(2); proposed rule 10820(a)(2)) should be repealed for the following reasons:

Rule 10412 appears to promote judicial economy and the principle of forum conveniens by keeping the venue consistent during the entire case. With regard to liens, the Board has moved away from these common-sense principles.

Rule 107701.1(a)(2) (proposed rule 10820(a)(2)) should be repealed since it has been used to change the venue for lien disputes by doctors doing business in the Los Angeles and Long Beach areas to Oxnard, a venue in Ventura County. There is no logical basis for changing the venue of lien disputes and it is widely viewed as a way to cause inconvenience to doctors and their hearing representatives due to the additional travel and time required to appear in Oxnard.

"Traditional notions of fair play and substantial justice" are considerations announced by the Supreme Court in determining whether subjecting a party to litigation in a distant forum is a violation of due process. See International Shoe Co. v. State of Washington, 326 U.S. 310, 66 S.Ct. 154, 90 L.Ed. 95 (“International Shoe”). The Board is also bound by Article XX, section 21 of the California Constitution which mandates the creation of a system of workmen's compensation that, in the words of the Constitution, will be administered so as to "accomplish

substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character;..."

Transferring lien hearings away from the WCAB district office where proceedings on the case-in-chief has been held, is a Board action which is antithetical to the Constitutional mandate of administering a system which is expeditious, inexpensive and without encumbrance of any character and is contrary to traditional notions of fair play and substantial justice. Such transfers also serve to unfairly encumber and drive up the price of doctors' access to the Board since, unlike workers' compensation insurance carriers and TPAs, most doctors are not doing business throughout the state nor are they generally represented by law firms with multiple office locations in California.

While it is not common for doctors themselves to appear at WCAB hearings, some hearing representatives work out of the doctor's office or within the same general geographic area where the doctor is located. When hearings on doctors' liens are transferred to the Oxnard venue from Los Angeles and Long Beach, significant additional travel is required. The initial transfers of liens was justified by the unmanageable volume of liens in Los Angeles. However, we are no longer seeing 6,000 liens with DORs pending backed up in Los Angeles like we did in June of 2011. (Oxnard WCAB to Help Los Angeles WCAB with Lien Hearings, Workcompcentral.com 6/15/11.)

The purpose of the due process clause in the Constitution is to insure the fair and orderly administration of the laws (International Shoe, at 319). The current process of transferring lien hearings from Los Angeles and Long Beach to Oxnard creates an unreasonable burden on lien claimants and their representatives and should be discontinued.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

§ 10626. Examining and Copying Hospital and Physicians' Records.

Subject to Labor Code section 3762, and except as otherwise provided by law, all parties, their attorneys, agents and physicians shall be entitled to examine and make copies of all or any part of physician, hospital, or dispensary records that are relevant to the claims made and the issues pending in a proceeding before the Workers' Compensation Appeals Board.
Authority: Sections 133, 5307, 5309 and 5708, Labor Code.
Reference: Section 4600, Labor Code.

Explanation:

A version of this rule has been in effect since at least the 1970s. However, it does not conform to modern practice. Moreover, this Rule is duplicative of statute. As an initial matter, beginning at section 123100, the Health & Safety Code establishes a patient's absolute right to receive and review copies of their medical records, and sets forth the specific conditions and requirements

for this review. (Health & Saf. Code, §§ 123100 et seq.) Further, the Evidence Code provides that medical providers "shall make all of the patient's records … available for inspection and copying by the [patient's] attorney at law or his, or her, representative, promptly upon the presentation of the written authorization." (Evid. Code, § 1158.)

Comment:
Legal Service Bureau opposes repeal of this rule because it will eliminate the mandated right of "agents and physicians" "to examine and make copies of all or any part of physician, hospital, or dispensary records that are relevant to the claims made and the issues pending in a proceeding before the Workers' Compensation Appeals Board."

Nothing in *Health & Saf. Code*, §§ 123100 *et seq*. or *Evid. Code*, § 1158 provides a right for a lien claimant (who is a third party to the litigation) or its agent (attorney or hearing representative) to obtain the medical records.

Repealing this section will result in a due process violation for lien claimants who should be entitled to receive any and all medical reports concerning the injured worker since these reports are often necessary to prove up a lien claimant's case (i.e. need for pharmaceuticals and extraordinary circumstances to justify fees above the OMFS).

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

Proposed repeal of § 10454. Automatic Reassignment after Reversal on Reconsideration.

Notwithstanding rule 10453, where the Appeals Board reverses a decision of a workers' compensation judge on an issue of the statute of limitations, jurisdiction, employment, or injury arising out of and in the course of employment, and remands the case for further proceedings, the party who filed the petition for reconsideration that resulted in the reversal shall be entitled to automatic reassignment of the case to another workers' compensation judge upon a motion or petition requesting reassignment filed at the district office within 30 days after the decision of the Appeals Board becomes final.

Explanation:

We do not believe the automatic right to reassignment provided in this rule is advisable, or consistent with general norms of judicial practice. Specifically, we note that judges have an ethical obligation to decide the cases assigned to them, unless they are disqualified from doing so. (See Code of Judicial Ethics, Canon 3B(1).) Erroneous rulings are not a basis for seeking to disqualify a judge, especially when they are subject to review. (See, e.g., *McEwen v. Occidental Life Ins. Co.* (1916) 172 Cal. 6, 11; *Mackie v. Dyer* (1957) 154 Cal.App.2d 395, 400.) Vesting a party who prevails before the Appeals Board on certain issues with an automatic right of assignment undermines the general principle that judges should decide the cases assigned to

them, and risks implying that some erroneous rulings may in fact be a valid basis for seeking judicial reassignment.

Comment: The automatic right to reassignment provided in this rule is necessary due to the unfortunate reality that a party which prevails in its challenge to a WCJ's determination, in this litigant's 28 year experience filing many hundreds of petitions for reconsideration, more often than not, creates an animosity by the WCJ against the petitioner since the WCJ is viewed as effectively "losing" a legal battle with the petitioning party. Unfortunately, this hearing representative has seen such "sour grapes" animosity first hand and believes that the automatic right of reassignment is critical to the petitioning party's due process in post-reversal proceedings.

Since the reversal of a WCJ could create the appearance of bias as to subsequent adverse determinations by the same WCJ, as a matter of due process it makes sense to allow a party the opportunity to seek automatic reassignment after reversing the WCJ on reconsideration (or even removal).

A hearing may run afoul of due process protections, not only if there is a showing of actual bias but also when there is an appearance of bias. (*Morongo Band of Mission Indians v. State Water Resources Control Board*, 153 Cal.App.4th 202, 210 ("Morongo") [actual bias is no longer the "touchstone for disqualification in administrative hearings."]; Haas, p. 1029 ["We need find no instance of actual judicial bias"]; *Nightlife Partners Ltd. v. City of Beverly Hills* (2003) 108 Cal.App.4th 81, 90 ("Nightlife Partners") ["Just as in a judicial proceeding, due process in an administrative hearing also demands an appearance of fairness and the absence of even a probability of outside influence on the adjudication."] (emphasis in original); *Yaqub v. Salinas Valley Memorial Healthcare System* (2004) 122 Cal.App.4th 474, 486 ["The question is not whether the judge is actually biased, but whether a person aware of the facts might reasonably entertain a doubt that the judge would be able to act without integrity, impartiality and competency."].)

At a minimum, the appearance of bias occurs when "advocacy and decision-making roles are combined." (*Howitt v. Superior Court* (1992) 3 Cal.App.4th 1575, 1585.)

A WCJ is necessarily required to "advocate" in support of the decision being challenged through the Report and Recommendation on Petition for Reconsideration. In doing so, the WCJ becomes an advocate of the party in whose favor the decision issued and an appearance of bias will thereby be created as to any subsequent proceedings.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

Proposed repeal of § 10451.2. Determination of Medical Treatment Disputes.

(a) The following procedures shall be utilized for the determination of all disputes over medical treatment and related goods and services.

(b) For purposes of this section, "medical treatment" means any goods or services provided in accordance with Labor Code section 4600 et seq., including but not limited to services rendered by an interpreter at a medical treatment appointment.

(c) Medical Treatment Disputes Not Subject to Independent Medical Review and/or Independent Bill Review

(1) Where applicable, independent medical review (IMR) applies solely to disputes over the necessity of medical treatment where a defendant has conducted a timely and otherwise procedurally proper utilization review (UR). Where applicable, independent bill review (IBR) applies solely to disputes directly related to the amount payable to a medical treatment provider under an official fee schedule in effect on the date the medical treatment was provided. All other medical treatment disputes are non-IMR/IBR disputes. Such non-IMR/IBR disputes shall include, but are not limited to:

(A) any threshold issue that would entirely defeat a medical treatment claim (e.g., injury, injury to the body part for which treatment is disputed, employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction);

(B) a dispute over a UR determination if the employee's date of injury is prior to January 1, 2013 and the decision is communicated to the requesting physician prior to July 1, 2013;

(C) a dispute over whether UR was timely undertaken or was otherwise procedurally deficient; however, if the employee prevails in this assertion, the employee or provider still has the burden of showing entitlement to the recommended treatment;

(D) an assertion by the medical treatment provider that the defendant has waived any objection to the amount of the bill because the defendant allegedly breached a duty prescribed by Labor Code sections 4603.2 or 4603.3 or by the related Rules of the Administrative Director;

(E) an assertion by the defendant that the medical treatment provider has waived any claim to further payment because the provider allegedly breached a duty prescribed by Labor Code section 4603.2 or by the related Rules of the Administrative Director;

(F) dispute over whether the employee was entitled to select a treating physician not within the defendant's medical provider network (MPN);

(G) an assertion by the defendant that an interpreter who rendered services at a medical treatment appointment did not meet the criteria established by Labor Code sections 4600(f) and (g) and 5811(b)(2) and the Rules of the Administrative Director, as applicable; and

(H) an assertion by the defendant that an interpreter was not reasonably required at a medical treatment appointment because the employee proficiently speaks and understands the English language.

(2) Medical treatment disputes not subject to IMR and/or IBR shall be resolved as follows:

(A) if the dispute is between an employee and a defendant, the procedures for claims for ordinary benefits shall be utilized, including the procedures for an expedited hearing, if applicable; and

(B) if the dispute is between a medical treatment provider and a defendant, the procedures applicable to lien claims shall be utilized, including the filing of a lien claim under Labor Code section 4903(b) and the payment of a lien filing fee or lien activation fee, if applicable.

(3) If a non-IMR/IBR dispute is resolved in favor of the employee or the medical treatment provider, then any applicable IMR and/or IBR procedures established by the Labor Code and the Rules of the Administrative Director shall be followed. In addition:

(A) Any appeal of an IMR determination of the Administrative Director shall comply with the procedures of section 10957.1; and

(B) Any appeal of an IBR determination of the Administrative Director shall comply with the procedures of section 10957.

Authority: Sections 133, 4603.2(f), 4604, 5304, 5307, 5309 and 5708, Labor Code.
Reference: Sections 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.6, 4604.5, 4610, 4610.5, 4610.6, 4616.3, 4616.4 and 4903(b), Labor Code.

Explanation:

This rule does not provide additional information to the practitioner beyond what is in the relevant statutes and rules. In particular, Labor Code section 5502(b)(2) provides that an employee may request an expedited hearing regarding "[t]he employee's entitlement to medical treatment pursuant to section 4600, except for treatment issues determined pursuant to sections 4610 and 4610.5."

Comment:
Legal Service Bureau supports the repeal of this rule because it does not adequately provide a procedure for determination of all disputes over medical treatment.

For instances, included in the "Medical Treatment Disputes Not Subject to Independent Medical Review and/or Independent Bill Review" should be any dispute relating to ***the applicability of the OMFS*** to the bill.

Independent bill review (IBR) "applies solely to disputes directly related to the amount payable to a medical treatment provider under an official fee schedule in effect on the date the medical

treatment was provided." There is no procedure in place for those lien disputes which are not subject to the official medical fee schedule.

July 5, 2019
Dan Escamilla, Esq.
Legal Service Bureau

Proposed repeal of § 10412. Proceedings and Decisions After Venue Change.

When an order changing venue is issued, all further trial level proceedings shall be conducted at, and all further trial level orders, decisions, and awards shall be issued by, the district office to which venue was changed until another order changing venue is issued.

Authority: Sections 133, 5307, 5309 and 5708, Labor Code.
Reference: Sections 126 and 5501.6, Labor Code.

Explanation:

This rule may be construed as contradicting current rule 107701.1(a)(2) (proposed rule 10820(a)(2)) which provides that "a lien conference may be set at any district office without necessity of an order changing venue."

Comment:

This rule should not be repealed. Rather, the rule in which it is in conflict, (current rule 10770.1.1(a)(2); proposed rule 10820(a)(2)) should be repealed for the following reasons: Rule 10412 appears to promote judicial economy and the principle of forum conveniens by keeping the venue consistent during the entire case. With regard to liens, the Board has moved away from these common-sense principles.

Rule 107701.1(a)(2) (proposed rule 10820(a)(2)) should be repealed since it has been used to change the venue for lien disputes by doctors doing business in the Los Angeles and Long Beach areas to Oxnard, a venue in Ventura County. There is no logical basis for changing the venue of lien disputes and it is widely viewed as a way to cause inconvenience to doctors and their hearing representatives due to the additional travel and time required to appear in Oxnard. "Traditional notions of fair play and substantial justice" are considerations announced by the Supreme Court in determining whether subjecting a party to litigation in a distant forum is a violation of due process. See *International Shoe Co. v. State of Washington*, 326 U.S. 310, 66 S.Ct. 154, 90 L.Ed. 95 ("*International Shoe*"). The Board is also bound by Article XX, section 21 of the *California Constitution* which mandates the creation of a system of workmen's compensation that, in the words of the Constitution, will be administered so as to "accomplish substantial justice in all cases expeditiously, inexpensively, and without encumbrance of any character;..."

Transferring lien hearings away from the WCAB district office where proceedings on the case-in-chief has been held, is a Board action which is antithetical to the Constitutional mandate of administering a system which is expeditious, inexpensive and without encumbrance of any character and is contrary to traditional notions of fair play and substantial justice. Such transfers also serve to unfairly encumber and drive up the price of doctors' access to the Board since, unlike workers' compensation insurance carriers and TPAs, most doctors are not doing business throughout the state nor are they generally represented by law firms with multiple office locations in California.

While it is not common for doctors themselves to appear at WCAB hearings, some hearing representatives work out of the doctor's office or within the same general geographic area where the doctor is located. When hearings on doctors' liens are transferred to the Oxnard venue from Los Angeles and Long Beach, significant additional travel is required. The initial transfers of liens was justified by the unmanageable volume of liens in Los Angeles. However, we are no longer seeing 6,000 liens with DORs pending backed up in Los Angeles like we did in June of 2011. (*Oxnard WCAB to Help Los Angeles WCAB with Lien Hearings*, Workcompcentral.com 6/15/11.)

The purpose of the due process clause in the Constitution is to insure the fair and orderly administration of the laws (*International Shoe*, at 319). The current process of transferring lien hearings from Los Angeles and Long Beach to Oxnard creates an unreasonable burden on lien claimants and their representatives and should be discontinued.

As shown by the map below, Oxnard is a venue which is far from Los Angeles and Long Beach. Attorneys, hearing representatives and witnesses coming to Oxnard on cases which were previously set in Los Angeles or Long Beach are set on calendars at 8:30am or 1:30pm. Unless traveling to Oxnard the night before and incurring the cost of a hotel, a person will encounter either the morning rush hour traffic or the lunch rush hour traffic on the freeways going to Oxnard.

With regard to LAO to OXN venue changes: Those from areas South and East of the Los Angeles WCAB district office must travel an additional 58.5 miles North on the US-101 freeway which, during rush hour, can add up to an additional two (2) hours to the drive. South Central Los Angeles and East Los Angeles are both lower income areas and the Board's policy of moving lien cases from the Los Angeles district office to the Oxnard district office creates a disparate impact on persons traveling from these impoverished areas to Oxnard. There is no convenient public transportation and vehicle travel on crowded Southern California freeways, while paying some of the highest gas prices (and taxes) in the nation, can be arduous and cost-prohibitive to those traveling to Oxnard. Litigating smaller liens in Oxnard may result in only Pyrrhic victories due to the significant travel costs and travel time involved in the litigation. Persons coming from the wealthier areas of Beverly Hills and Hollywood due to the closer proximity to Oxnard, are still adversely impacted but do not suffer the same level of adverse impact as those coming from the lower income areas of South Central Los Angeles and East Los Angeles.

With regard to LBO to OXN venue changes: Those coming from South of the Long Beach District Office must travel an additional 78.2 miles via the I-405 North and US-101 North. With no traffic, the drive will take 75 minutes according to Google maps, but this time is also dramatically increased during rush hour, again, creating a drive that can take over (2) hours each way.

This map is illustrative of the distance to Oxnard.

July 5, 2019
Dawn Benton, MBA, Executive Director
California Chiropractic Association

The California Chiropractic Association opposes the proposed change to regulation 10786(c) as it would place an undue burden on QME's who would be subject to additional delays before their bill is paid.

July 5, 2019
Veronica Jenks

I disagree with this new proposed rule "10790 Interpreters". It is unnecessary and confusing considering that the CCR article 9795.3 already includes language for interpreting at different settings, medical and legal. It also stablished fees and it was so well thought out that it includes language such as Market Rate which covers changes in fees according to rates for different languages and settings. I believe this new rule is adopted it will only create more confusion and delays in payment to Interpreters and language service providers.

July 5, 2019
Linda Nakell, Ph.D.

I have been a QME for 11 years. I am strongly opposed to the proposed changes in Regulation 10451.1. The proposed changes take away my right to be heard on a non-IBR petition prior to resolution of a case. This is extremely short sighted. it will encourage payors to deny or downcode medical-legal bills without any legitimate reason. This will undoubtably cause more evaluators to leave the system. We still have to pay our rent and expenses, even as we wait for payment. It can take years for a case to settle. I have patients who have been at maximal medical improvement for many years, and has not settled.

In general the rules favor the payers, and making payers less accountable will only increase delays in treatment and decrease the quality of care. Please preserve the ability of Med-Legal providers to file a DOR force defendants to issue a 4603.3 compliant EOR.

Many quality providers are no longer treating injured workers because of long delays in payment that require providers to monitor case status for years and accept long delays before any payment. At any time they can miss a deadline and forfeit money to which they are ethically entitled. Simple solutions that promote acting in good faith should be put in place.

In my opinion the current proposals encourage bad faith actions.

July 5, 2019
Teresita Morales, Ph.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:
- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 5, 2019
Dan Watson, Ph.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

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- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

The question featured by these changes is simply why are the insurers favored. At this time, they can stop treatment, medications, procedures, ad nauseum. This appears to be one further step to let the insurers find one more way to avoid paying for services rendered.

July 5, 2019
Kerrie Pratt, DC

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would allow payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN”, “Claim is denied," or "I never received the bill," even though we have proof of the certified mail, signature with a returned green slip. The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

The following solutions for non payment to a QME/Agreed QME or AME should be allowed:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB deal with the specific issue. There is a reason QME and AME's are neutral doctors. The reason we are here is to solve worker's compensation related injuries. The word "neutral" is the key. We are not acting as the primary treating doctors when we see the Panel QME applicants. I think the WCAB would lose a larger number of quality QME and AME's because the suggested regulations aren't in equity for the time an energy that it takes to do this type of work. It's a special skilled doctor that can do medical legal work and not being paid in a timely and equitable fashion will, I'm sure, lead to a decrease in the QME's and thus overload the system and cause everyone to go back to the drawing board.

July 5, 2019
Robert L. Weinmann, MD, Editor
The Weinmann Report

The key to this harmful proposed regulatory change in Regulation 10451.1 is that it will obliterate the right to be heard on a non-IBR petition if the Defense does not file a Declaration of Readiness. This change will allow arbitrary and spiteful denials of payment, alterations of submitted billings, and even total bill denials. The result will be a slap in the face to the QME community and a body-blow to injured workers. It is an example of bad faith legislation that has a good chance of passage.

July 5, 2019
Todd Baldini
ExamWorks

I am the California Regional Vice President of ExamWorks, LLC ("ExamWorks") a med-legal practice management company which, amongst other medical-legal services, administers the services of AME/QME physicians. ExamWorks is opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away the AME/QME evaluators' rights to be heard on a non-IBR petition prior to resolution of the case in chief in the event the defense elects not to file a Declaration of Readiness (DOR) to proceed.

These changes could potentially result in payors underpaying or denying medical-legal bills, a practice which is already rampant and with little to no policing. Carriers routinely deny legitimate QME and AME bills for debatably invalid reasons such as "Provider not in MPN" or "No RFA submitted". The only recourse providers currently have is to file a non-IBR petition and DOR. Such delays and denials would increase if providers are not able to be heard prior to resolution of the case in chief.

Furthermore, this proposed change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to decline. The system cannot afford to lose more QMEs, and this misguided proposed change to the regulations would exacerbate today's unprecedented shortage of QMEs.

Accordingly, ExamWorks submits the following recommendations:

(6) Medical-Legal Providers should continue to be allowed to file DORs.
(7) Defendants should be obligated to issue an EOR compliant with LC 4603.3.
(8) The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
(9) Implementation of a regulation indicating the medical-legal providers do not have to file a lien when there is a dispute.
(10) A list of "Bad Faith" tactics should be included in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal providers' billing based on a dispute

over injury, or injury to a particular body part, lack of authorization or not being in the MPN; and/or other reasons that are inapplicable to medical-legal evaluations.

To date, ExamWorks has filed over 250 objections to inappropriate denials. Notably, not one time has the defendant filed the DOR in spite of their obligation to do so per CCR 10451.1. The proposed changes, would require evaluators to wait to resolve these inappropriate denials and while remaining non-biased to the parties as the med-legal evaluating physician.

July 5, 2019
Michael Amster, MD

I am a QME and I am strongly opposed to the the proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects NOT to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills.

This practice is already rampant and unchecked by payors. Carriers routinely deny legitimate QME and AME bills for completely bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

This change will result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms MUST be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

The proposed changes to Regulation 10451.1.seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue.

Thank you for being open to my opposition to the proposed changes.

July 5, 2019
Maria Mayoral, MD

I have been a QME for 35 years, and am fully Bilingual and Bicultural (in Spanish). I have been a Supervisor at the Spanish Speaking Clinic at UCLA for over 35 years and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen

their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 5, 2019
Gerald Weingarten, MD

I feel that you proposed new rules for disputed payments of medical legal pqme and ame reports is highly unfair. To file a lean and wait till a case is settled could take years and incur additional legal fees. It will lead to a further decrease in the number of qmes and an increase in medical legal charges. Please reconsider this proposal.

July 5, 2019
Kenneth Geiger, MD

I'm a QME and am QUITE opposed to the proposed changes to Regulation 10451.1. If I can't be heard in court on a non-IBR petition prior to the settlement of the case-in-chief, this would increase the likelihood that the insurance carriers would delay, underpay and find other causes to avoid payment of proper bills. This is already rampant on treatment and Medical-Legal bills. For example, I recently received payment for a Med-Legal evaluation that i performed 10 years previously !!! Imagine asking a plumber to repair a leaky faucet and telling him you'll pay the bill in 10 years. What's the chance he or she will make the repair. The availability of QME is apparently decreasing. Let's not force more out of the system due to treatment by the carriers.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.

Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

July 5, 2019
Dan Mora

Thank you for your time and attention to this matter.

The replacement of section 10451.1, and insertion of section 10786, proposed by the WCAB, could have unintended consequences to the WCAB, and could affect the injured worker's right to due process discovery. We plead for the Administration to rescind this proposed change.

Discovery services are separate from medical treatment and critical to the benefit deliver system, producing evidence under the WCAB's jurisdiction and affording all parties the ability to view documented facts. The correlation between a healthy provider community and their ability to be paid, can not be understated.

The elimination of the provider's ability to file a Declaration of Readiness to Proceed is unjust. Providers need be afforded an expedited path to the WCAB for Non-IBR disputes. The sole remedy, without 10451.1, is the lien system. Given the fee schedule rates of $180 for records and $75 for non-records, the average invoice is below the lien filing fee of $150. $150 plus the resource to prepare and file the lien, and appear at court, with no provision for attorney's fees, the cost makes this process unworkable from any viewpoint, and anything but expedited.

It is estimated that over 156,000 copy service invoices are objected to annually. The potential unintended consequence is threefold: One, a dramatic increase in WCAB resource to attend the additional DOR filings, and two, a correlated increase in employer defense costs. Thirdly, the change provides a monetarily incentivized justification of non-payment for legitimate provider services, again threatening the health of the provider community.

July 5, 2019
Marcel O. Ponton, Ph.D.

I have been a QME for 21 years, and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. While this may be intentional by the carriers, it is certainly terrible for injured workers. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.

Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.

Rule indicating the medical-legal providers do not have to file a lien when there is a dispute. This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This "solution" is throwing the baby out with the bath water.

July 5, 2019
Diane Worley
CAAA

The California Applicants' Attorneys Association offers the following comments regarding the proposed draft revisions (including recommended repeals) of the WCAB Rules of Practice and Procedure, Section Numbers 10300 through 10995, which are currently posted on the WCAB Forum.

Initially, we provide comments on the proposed repeal of the following sections.

§ 10412. Proceedings and Decisions After Venue Change.
This section should not be repealed. In some instances, an applicant must appear at a lien conference set after the case in chief has resolved. Requiring an order to change venue protects the applicant from the burden of having to travel to an inconvenient location. Comments on current rule 10770.1(a) (2) (proposed rule 10875) which provides that "a lien conference may be set at any district office without necessity of an order changing venue" are set forth below.

§ 10878. Settlement Document as an Application.
This section should not be repealed. In many instances the first and only filing in a case is the settlement document. This filing must be treated as an application so an ADJ number can be assigned in order for the case to be given to a judge to review and issue an order approving the settlement. A declaration of readiness to proceed is not necessary, nor is one filed in these

circumstances. Therefore, this regulation continues to be relevant and matter greatly to the workers' compensation community.

Next, we provide comments on the proposed revisions to the following sections.

§ ~~10462 10464.10466~~.**10540**. **Petition to Terminate Liability for Continuing Temporary Disability.**
Renumbered rule §10540(a) (former rules 10462,10464, 10466) has been revised to require a petition to terminate liability for temporary total disability indemnity under a findings and award, decision or order of the Workers' Compensation Appeals Board be filed at least one week prior to termination of temporary disability. This proposed regulatory language resolves the conflict with the enabling statute, Labor Code §4651.1, with the existing regulatory language which only requires the petition to be filed "within 10 days of the termination of payments…". This means presently benefits can be terminated prior to filing of the petition, contrary to the statute. We support this change in rule 10540 (a) as it protects the injured worker from termination of benefits without notice.

§ ~~10957.1.~~ 10575. Petition Appealing Independent Medical Review Determination
Renumbered rule 10575 (formerly rule 10957.1) limits a petition appealing an adverse IMR determination to the five grounds set out in LC section 4610.6(h). While the statutory grounds for appealing an IMR are indeed set forth in 4610.6(h) this language is problematic as it does provide for summary dismissal if some additional legal argument is raised. While the judge reviewing the IMR appeal is guided by the enumerated statutory grounds in overturning or upholding the IMR decision, the applicant may have legal issues to be preserved for further appeal and these legal rights will be quashed by the proposed language in this regulation.

As a result, to avoid any further administrative or legal challenge to this proposed regulation it is recommended that this language" (b) Any petition that fails to comply with any of the following requirements shall be subject to summary dismissal: (1) The petition shall be limited to raising one or more of the five grounds specified in Labor Code section 4610.6(h). " be changed to read "(b) Any petition shall comply with the following requirements: (1) The petition shall raise one or more of the five grounds specified in Labor Code section 4610.6(h)." This language would be consistent with current rule 10575 ,subdivision (b), paragraph (2) which recognizes that the petition must also set forth specifically and in full detail the factual and/or legal grounds upon which the petitioner considers the IMR determination to be incorrect, and every issue to be considered by the Workers' Compensation Appeals Board, otherwise the petitioner will be deemed to have waived these objections concerning the IMR determination. A petitioner may have statutory, constitutional or other legal grounds for challenging the IMR determination that aren't specified in Labor Code section 4610.6 (h). The limitation in subdivision (b), paragraph (1) must be removed to eliminate this inconsistency and protect the due process rights of the petitioner, specifically the opportunity to be heard on all issues relating to the IMR determination, without waiving the right to set forth those issues in the petition.

§ ~~10508~~ 10600 –Time for Actions

Renumbered rule 10600 (replacing rule 10508) regarding time of action (to respond to something or take some action) tries to define the correct way to calculate the time. It refers to a "legal holiday" as not counting when one computes the time.

However, it is unclear if the regulation is referring to a federal legal holiday, a California legal holiday (declared by the Governor to be an official State holiday, or a day listed at Calhr.ca.gov.), or both?

The term “legal” holiday must be expressly defined in the regulation to avoid confusion and litigation.

§~~10507~~ 10605. Time Within Which to Act When a Document is Served by Mail, Fax, or E-Mail.

Renumbered rule 10605 (formerly rule 10507) allows insurers who decide to setup shop outside of California, or the United States, additional time to act when a document is served. This provides an unfair advantage over injured workers. How can an injured worker get less time than an out-of-state insurance company to act?

This proposed rule deviates from CCP 1013 which provides a uniform 5 -day extension of time for service within California for all forms of service other than personal. Given the realities of the speed of modern communications, we believe that the rationale for allowing a longer time period for out of state addresses no longer applies. Therefore, we would suggest that the 5- day rule should be extended to the entire United States, and that a longer period of 10 days only be allowed for service to a physical address outside of the United States.

If the method of service actually used was fax, e-mail, or another agreed-upon method of electronic service, then the time to act should be a uniform 5 days, regardless of the physical address of the recipient.

§~~10393~~ **10620 – Filing Proposed Exhibits**

Renumbered rule 10620(formerly rule 10393) is impractical for the filing of exhibits for an expedited hearing. Given that an expedited hearing has to be set within 30 days of the filing of a Declaration of Readiness to Proceed, a shortened time, such as 10 days before the expedited hearing for filing of proposed exhibits would be more feasible. 20 days for filing of exhibits before trial would be acceptable based on current practice.

§10629 – Designated Service

New rule 10629, subsection (c) now requires “within 10 days from the date on which designated service is ordered, the person designated to make service shall serve the document and shall file the proof of service.”

A requirement to file the proof of service in every case is at variance with standard practice at the Workers’ Compensation Appeals Board and unnecessary as it is rare that proof of service of a document is contested.

A better practice is to require the party designated to make service to maintain the original proof of service until ordered to file it at the Workers' Compensation Appeals Board -- if and when a dispute arises.

§~~10601, 10607,10608, 10615, 10616~~ **10635. Duty to Serve Documents.**
Renumbered rule 10635, subsection (b) (formerly rules 10601, 10607, 10608, 10615, 10616) requires some clarification in the last sentence which now reads "This request may not be made more frequently than once in a 120-day period unless there is a change in indemnity payments." It is recommended that this sentence be changed to "Following production of the requested printout, another request may not be made more frequently than 120-days from the last production unless there is a change in indemnity payments or new dispute requiring updated payment periods."

Additionally, subsection (b) needs to be further amended to expand on the language "The printout shall include the date and amount of each payment of temporary disability indemnity, permanent disability indemnity, the period covered by each payment, and the date, payee and amount of each payment for medical treatment" concerning what must be included in a computer printout of benefits paid. This language should go on to state "The benefits printout must list ALL benefits paid on behalf of the injured worker. This shall include UR expenses, IMR payments, Medical treatment expenses, payments to AMEs and QMEs, reimbursement to EDD, and medical mileage, in addition to temporary and permanent disability indemnity paid." Essentially everything except defense attorney fees and maybe investigator fees.
The rationale for the above request is as follows:

1. Medical reports and RFAs are rarely served with the UR denial. Sometimes not even the UR denial is served on the Applicant's attorney. This is one of the only ways to verify the dates on which UR has been done based on payments made and when reports are missing.
2. MPN Doctors are refusing to treat because they say their bills are not getting paid. A detailed and complete benefit print out including all medical treatment expenses will confirm whether this is true.

Lastly, subsection (c) (1) requiring an ongoing duty on all parties to continue to serve each other with any medical reports received may have the unintended consequence of creating a lot of duplicative service. If both parties receive the same PTP report and both parties serve this report there will be a lot of wasted time, paper and postage. Adding language that requires service only if a party is not already included on the carbon copy list could help reduce duplicative service.

§~~10393, 10600, 10604, 10622, 10634~~ 10670 – Documentary Evidence
For the reasons set forth in our comment to renumbered rule 10620, renumbered rule 10670 (b) (3) should state "Any document not filed 20 days prior to trial or 10 days prior to expedited hearing, unless otherwise ordered by a judge or good cause is shown."

§ ~~10451.1~~ **10786. Determination of Medical-Legal Expense Dispute**
Renumbered rule §10786 (formerly rule 10451.1) removes the current language in 10451.1(c)(3)(B), which allows a medical-legal provider to file a Declaration of Readiness with

their Petition for a Non IBR Medical Legal Dispute when the employer fails to file the Declaration of Readiness as directed in Labor Code Section 4622(c).

Labor Code Section 4622(d)(2) states: *The appeals board shall promulgate all necessary and reasonable rules and regulations to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced.* Labor Code Section 4622(c) states in part: *If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection.*

Given these two subsections, the only way to "insure compliance" with subsection (c) is to allow the provider to file a Declaration of Readiness in the event the employer fails to execute their responsibility under subsection (c). Without the ability to file a Declaration of Readiness and get the matter on calendar when the employer fails to file the Declaration of Readiness, Labor Code Section 4622 could easily be circumvented by the employer by simply never filing a Declaration of Readiness.

To resolve this it is suggested that proposed new rule 10786, subsection (b) be amended to state: "*(b) A medical-legal provider may file a petition for reimbursement of medical-legal expenses where a defendant has failed to timely object to a medical-legal expense pursuant to Labor Code section 4622 or 60 days have elapsed from a provider objection pursuant to Labor Code section 4622(c) and the defendant has not filed a Declaration of Readiness to Proceed to a status conference. A Declaration of Readiness to Proceed by the medical-legal provider may accompany the Petition. "*

~~§ 10770.1~~ **10875. Lien Conferences and Lien Trials.**

Renumbered rule 10875(a) (2) (formerly rule 10770.1) sets forth language from current rule 10770.1 (a) (2) that "… a lien conference may be set at any district office without the necessity of an order changing venue."

In light of the recommendation in these proposed revisions to the WCAB Rules of Practice and Procedure to repeal rule 10412(as it may contradict this language) we instead recommend that the language in renumbered rule 10875(a) (2) be changed to "…a lien conference will be set at the district office where the application was filed, or where venue was previously set by order, unless an order changing venue has issued at the request of a lien claimant, and there is no objection."

In some instances, an applicant must appear at a lien conference set after the case in chief has resolved. Requiring an order to change venue protects the applicant from the burden of having to travel to an inconvenient location.

July 5, 2019
David Gonzales

I oppose the proposed changes to QME Rule changes.

Physicians now can be heard in court if there is an issue with your QME bill. Under the proposed changes, we would not have a right to be heard until the case in chief settles. Delay in payment is what carriers strive for and this is en courage with these changes. #1) Insurers will be emboldened to deny or reduce a QME bill as we will not have recourse until the case in chief settles and #2) physicians won't be able to pursue our wrongfully denied QME bills until the case settles, which is often years.

If physicians object to defendant's denial of a QME bill, defendants have to file a petition in court. With proposed changes, Our due process is infringed If it is no longer obvious that the defendant is still required to file a petition and this makes it easier for defendants to ignore our objection with no consequences.

The consequences throws the QME trying to get paid for their legitimate work into a quagmire.

This will deter new QMEs from going through the effort to meet the requirements and demands of the job, if payment (non-payment) becomes greater issue.

Please add my objection to the others opposing these proposed changes.

July 5, 2019
Daniel Rosenberg

I am the Director of Revenue Cycle for Integrated Pain Management and am strongly opposed to the proposed changes to Regulation 10451.1.

The proposed changes would eliminate our practice's ability to collect unpaid Med-Legal debt outside of a lien, which can takes years. Eliminating the ability to file a petition and be paid in a (somewhat) timely manner, would effectively remove the incentive for our providers to participate in the Med-Legal system.

Med-Legal reports are frequently denied by carriers. Reasons for denial are often nonsensical; for example, denying a report as a duplicate the first time it's been submitted. SBR and IBR are not sufficient to resolve these kind of disputes. Petitions are the *only* means doctors have of getting paid.

I cannot understand the purpose of the proposed regulations. Is it because the courts are too busy? That's certainly understandable—but the solution is not to punish QMEs trying to be paid for the services they've performed in good faith. The solution is to encourage carriers to perform legitimate bill review, and provide reasonable second bill review.

If the DWC imposed a $5,000 fine for every Med-Legal bill found to be unjustly denied by a carrier, insurance companies would end this entire issue overnight. The money could be used to hire more judges. Currently, it's in the interest of carriers to delay payment as long as possible, which is what they do. Eliminating petitions will only allow them to delay payment longer—years, instead of months.

Without the ability to file petitions, our Med-Legal work will go unpaid for years. Many doctors will likely resign from the system.

July 5, 2019
Jeffrey Keith Bridges, Ph.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
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- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen

their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 5, 2019
George Than

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. These changes will make an already difficult collection of fees IMPOSSIBLE. Seriously, there would be no reasonable way for providers to collect on unreasonable delay and deny tactics. This is not SELF PROCURED billing by providers, but REQUESTED Medical-legal evaluations that are already time consuming and expensive to collect. There will be no reason to pay the providers on time and as of this writing, the insurance companies attempt to negotiate the QME billings as if they are negotiable. Please do not take away the medical legal evaluators rights and recourses. I have been a QME for many years and I have had to file a DOR on QME billing only 2-3 times in the last 30 years. We cannot afford this type of cost cutting nonsense. It does not help providers it only hurts us.

July 5, 2019
Bruce Whitney, Ph.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. Securing payment for QME evaluations under the current rules is presently very difficult. The insurance carriers consistently abuse the system by using best practice policies to delay, deny or discount payment for med-legal evaluations rendered in good faith in accordance with current laws.

The LAST THING we need is another law that would give the insurance carriers more latitude and power to further delay, deny, or discount med-legal evaluations.

My right to compensation for med-legal work as a QME under the law has been steadily diminished over the last decade. Any further limitation that would be imposed for collecting appropriate med-legal billing should not even be considered.

Further stacking the scale in favor of the carrier will likely force more QMEs to leave the system, which of course would even further favor the carrier, compromise the injured workers ability to get care, and unnecessarily further burden doctors working the system.
The proposed legislation is unnecessary and provides no benefit to anyone but the carriers.

July 5, 2019
Micah Scheindlin
Center for Health Policy, California Medical Association

On behalf of our more than 44,000 physician and medical student members, the California Medical Association (CMA) would like to thank you for the opportunity to provide comments on

the Workers' Compensation Appeals Board (hereinafter, "WCAB") proposed rules of practice and procedure. We appreciate WCAB using these proposed rules of practice to modernize its language and practices and eliminate duplicative rules.

While we support the intent of these rules, many of which will help accomplish the goals noted above, we write to articulate our concerns with a provision that we believe will create additional burdens on physicians who work as Qualified Medical Evaluators and make it more difficult for them to continue to serve patients in the workers' compensation system.

§10786. Determination of Medical-Legal Expense Dispute

CMA is concerned with the proposed regulations allowing the WCAB to defer hearings on disputes related to the denial of a portion of a medical-legal provider's billing until the underlying claims of the dispute in question has been resolved or abandoned. This will have the effect of prolonging the disputes and delaying physician compensation, likely for years in some cases.

The issue in question is particularly acute due to the widely acknowledged shortage of physicians who are registered as Qualified Medical Evaluators (QMEs) and therefore able to provide medical-legal services. Many physicians who currently provide these services practice independently and must manage their own network participation and billing, while dealing with payors who use automated systems and have far more resources. CMA is concerned that should the prolonged dispute process result in significant delays in payment, providers will have little incentive to continue to seek QME status and serve patients in the workers' compensation system.

We are encouraged that the remainder of the rules governing billing dispute resolution provide for an expedient process, and hope this issue will be resolved as the rulemaking process moves forward.

July 5, 2019
Diane J. Weiss, MD

I have worked within the field of Workers' Compensation in the State of California since 1988, having done so as a treating psychiatrist; as an evaluator for the applicant; as an evaluator for the defendant; and as a QME, IME, PQME and AME. As such, it would be impossible to over-emphasize my concerns with regard to proposed regulations related to "§ 10786. Determination of Medical-Legal Expense Dispute."

This psychiatrist has over 30 years of experience related to Workers' Compensation in the State of California. Give the latter, it is my well-informed opinion that, should "§ 10786. Determination of Medical-Legal Expense Dispute," part c, be enacted as proposed, psychiatrists would find it impossible to continue to serve as Qualified Medical Examiners (QMEs) if our rights were not protected and if we were not assured of compensation.

While I can appreciate the desire for cost savings, increased efficiency, and the simplification of the Labor Code, the proposed regulation would not suggest it would be advisable, realistic, or feasible for psychiatrists to continue to participate as QMEs.

I am able to offer knowledgeable opinions about the proposals because of my specific experience in Workers' Compensation in the State of California, but I also do provide these opinions given that I am a Life Fellow of the American Psychiatric Association, Board Certified in Psychiatry.

I very much appreciate this opportunity to share my perspective during this informal public comment period, and I look forward to the chance to further collaborate with colleagues and with the DWC in terms of updating the Labor Code.

July 5, 2019
Lisa Camirand/Elsa Tan
State Compensation Insurance Fund

State Compensation Insurance Fund appreciates the opportunity to provide input regarding the Division of Workers' Compensation's (DWC) proposed updated rules of Practice and Procedure. State Fund respectfully submits the following comments for your consideration.

Recommended text changes are indicated by underscore for additional language and ~~strikeout~~ for deleted language.

§~~10451.3.~~10545. Petition for Costs:
Recommendation
Text Changes
(2) Notwithstanding subdivision (g)(1), t~~T~~he Workers' Compensation Appeals Board may, at any time,
issue a notice of intention to allow or disallow the costs sought by the petition, in whole or in part.
The notice of intention shall give the petitioner and any adverse party no less than 15 calendar days
to file written objection showing good cause to the contrary. If no timely objection is filed, or if the
objection on its face fails to show good cause, the Workers' Compensation Appeals Board, in its
discretion, may:

Discussion
State Fund recommends the language remain giving the option for any party and/or the Workers' Compensation Judge to set it for hearing.

§10555 Petition for Credit:
Recommendation
Text Changes

(a) An employer shall not take a credit for any payments or overpayments of benefits pursuant to Labor
Code section 4909 unless ordered or awarded by the Workers' Compensation Appeals Board or a stipulation between the parties. A petition for credit shall include:

(1) A description of the payments made by the employer;

(2) A description of the benefits against which the employer seeks a credit; and

(3) The amount of the claimed credit.

(b) An employer shall not take a credit for an employee's third party recovery pursuant to Labor Code
section 3861 unless ordered or awarded by the Workers' Compensation Appeals Board or a stipulation between the parties. A petition for credit shall include:

(1) A copy of the settlement or judgment; and

(2) An itemization of any credit applied to expenses and attorneys' fees pursuant to Labor Code sections 3856, 3858 and 3860.

Discussion:

State Fund recommends added language to allow for informal resolutions when there is a dispute and allows for credit upon stipulation to such credit in a third party case.

§~~10957.1.~~ 10575 Petition Appealing Independent Medical Review Determination. ~~of the Administrative Director~~:

Recommendation

Text Changes

(c) The petition shall be filed in accordance with Workers' Compensation Appeals Board rule 10615
with the Workers' Compensation Appeals Board no later than 30 days after service by mail of the IMR determination. An untimely petition may be summarily dismissed.

Discussion:

State Fund recommends this language should remain so Workers' Compensation Judges know that they may summarily dismiss untimely Independent Medial Review appeals without requiring parties to object to timeliness.

~~§10393, 10600, 10604, 10622, 10634.~~ 10670. ~~Evidence and Reports~~ Documentary Evidence:

Recommendation

Text Changes

(2) Any document not served at/or prior to the mandatory settlement conference, unless good cause is shown.

Discussion:

State Fund recommends replacing "prior to" with "at or prior to", consistent with LC 5502(d)(3)., and consistent with common practice. The current Labor Code uses "not disclosed or obtained thereafter". Regulations clarify served "at/or prior to" supports the disclosure and obtained requirement of the Labor Code.

State Fund submits for your consideration language deletion in 10877, which will have an impact on the Workers Compensation process and industry.

~~§10770.1(c)~~ 10877. Fees Required at Lien Conference:
Recommendation
Text Changes
(1) If a lien claimant asserts it is an entity listed in Labor Code sections 4903.05(c)(7) or 4903.06(b), it shall be prepared to file proof or submit a stipulation to that effect at the lien conference upon request by the workers' compensation judge~~. The judge, however, may formally or informally take judicial notice that the lien claimant is such an entity. This may include, but is not necessarily limited to, taking judicial notice of prior decisions of the Workers' Compensation Appeals Board and taking judicial notice based on the "common knowledge" or the "not reasonably subject to dispute" provisions of Evidence Code section 452(g) and (h).~~

Discussion
State Fund recommends deleting this language because evidence of their status as an entity under 4903.05(c)(7) should be required.

July 5, 2019
Hank Sigal, MD

I have been a QME for many, many years. I am strongly opposed to the proposed changes in Regulation 10451.1. The proposed changes take away my right to be heard on a non-IBR petition prior to resolution of the case in chief. This is extremely short sighted. It will encourage payers to deny or downcode medical-legal bills without any legitimate reason.

This will undoubtedly cause more evaluators to leave the system. I still have to pay my staff and rent, even as I wait for payment. It can take years for a case to settle. I have patients that have been at maximal medical improvement for 10 years where the case in chief has not settled.
I have cases where I have performed at least 5 evaluation reports and even more supplemental reports, all of which could be used to settle the case, but one party wants a different outcome. There is absolutely no reason for me to wait for payment in such a case. In those circumstances, there is simply no legal dispute that will affect the legitimacy of my charges.

In general the rules already favor the payors. The proposed change would make the payors even less accountable. This will only increase delays in treatment and decrease the quality of care. Please preserve the ability of Med-Legal providers to file a DOR to force defendants to issue a 4603.3 compliant EOR.

Many quality providers are no longer treating injured workers - because of long delays in payment that require providers to monitor case status for years, and accept long delays before any payment. At any time they can miss a deadline and forfeit money to which they are ethically entitled. Simple solutions that promote acting in good faith should be put in place. The current proposals encourage bad faith actions.

July 5, 2019
Kenneth Hammerman, MD

I am a QME and I strongly opposed the proposed changes to regulation 100451.1.
The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a declaration of readiness to proceed. Such a change would in bold in pairs to underplay or deny medical legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills. Such bad faith denials would undoubtedly increase if providers arrived of the current right to be heard prior to resolution of the case and chief.

Further, this change would certainly result in more doctors leaving the QME system and discouraged doctors from becoming QME's. QME head count is currently at an all-time low and continue supplement. The system cannot afford to lose more QME's and this misguided change of the regulations would worsen the unprecedented shortage of QME's today

The following items should be preserved:

Medical legal providers should be allowed to file DOR.
Dependence should be obligated to issue and EOR compliant with LC 460 3–3
The WCAB can only defer the hearing when there is a threshold issue that would legally the feet the entire claim.

A list of bad faith tactic should be in the regulation.

Providing a mechanism for determining the value of the bill-whether judge decides or it goes to IBR.

Rule indicating the medical legal providers do have to file a lien when there is a dispute

July 5, 2019
Mona M. Nemat, Esq.
Brissman & Nemat

10301 – (c) “Appear” – in the legal context, it means availing oneself to the court. The proposed definition is too broad and will encompass anyone doing any act whatsoever, regardless of whether it is before the board or not.

(o) “Party” - this revision is to simplify and include those who obtain hearings by petitions but the proposed definition does not actually include such ‘parties’. Also, making a lien claimant a party when the case in chief has not resolved unfairly requires a them to participate in the case in chief. It also unduly complicates cases in chief and increases the time and expenses involved in resolving them.

10400 – this section requires details in Notices of Representation for non-attorney representatives which could not be required of attorneys. The problem with such requirements is they serve as one more way to get rid of liens. If a non-attorney representative's notice fails at any point, then they will be deemed not to have appeared and the lien can be dismissed. Carriers will not be similarly impacted because they tend to be represented by attorneys. Retention of counsel is often cost prohibitive for lien claimants because often their cash flow is directly correlated with payment of liens.

10626 – repealed – What authority exists to issue subpoenas in workers compensation if this section is repealed? The evidence code is not enforced at the WCAB. How will issues related to authentication and chain of custody be addressed absent explicit authority to obtain records by way of a subpoena?

10755(c)(2) – If a lien calamint fails to have someone available with settlement authority, the judge can close discovery and set the matter for trial on all issues, including the lien? Please clarify if the addition of "on all issues" was intended to have such a drastic impact?

10757 – The deletion of "and no appearance shall be required" does not make sense. Upon settlement of all issues, the board loses jurisdiction over the parties. An appearance cannot still be required.

10786 – This section takes away the ability of a med-legal provider to file a DOR if the defendant fails to do so and thus, takes away all recourse for the provider.
The provider must be added on the OAR as a cost petitioner.

Because this is a limited purpose Petition, the hearing triggered by the filing of a DOR should be a mandatory settlement conference, not a status conference, which does nothing to further resolution and only drives up costs.

Does a lien still need to be filed to preserve the statute of limitations in the event there is a determination that the disputed expense was not medical legal in nature or will they be tolled? Removal of the definitions section and specificity regarding sanctions already in the existing version will lead to even more uncertainty and complexity.

The changes proposed do nothing to further the goals of efficiency and clarity and instead create more uncertainty and continue to punish med-legal providers by creating additional opportunities for delay.

10862 – By deleting language requiring only original lien claims to be filed and no amended lien filings, are amended liens once again allowed/required? Must an amended lien be filed every time there is a new DOS? Does a provider risk being barred as to certain dates of service if it fails to file an amended lien for services that occur after the filing of the original lien?

10872 – (c) states that once a lien claimant files a notice of resolution or withdrawal of lien, the lien claim shall be deemed dismissed by operation of law, meaning the lien claimant is no longer a party to the action. (d) however mandates that a lien claimant must still appear at any hearing

noticed prior to the dismissal unless otherwise excused. No rational is provided for this requirement, which will have a chilling effect on settlements. Parties settle most often in advance of a hearing to avoid the cost of appearance at the hearing, which, for lien claimants, can be substantial when compared to the lien amount. By forcing them to appear despite settlement will dissuade settlements prior to hearings and will further overburden the system. The is especially true in light of the fact that in order to excuse the appearance, the judge must take affirmative action indicating so.

(e) – there must be a corresponding ability for judges to issue a notice of intent to order payment of a lien if the defense fails to appear.

10888 – repealed – the first paragraph should remain in place to ensure that there is at least one good faith attempt made to resolve liens.

July 5, 2019
Steve Colucci, MD

The new rules covering qme payment disputes are patently unfair and may be illegal as they infringe on a qme's right to due process to settle disputes. I urge you to not pass this regulation which favors insurance companies and not injured workers.

July 5, 2019
Kristyn Lum
Aderant

We are writing to comment on the proposed Rules of Practice and Procedure as follows:

1. Proposed Rule 10360

We note that proposed rule 10360(c) does not include a clear triggering event for the 15-day deadline to object to the petition to compel.

Proposed rule 10360(c) states: "The other parties, lien claimants, and the DWC-Legal Unit shall have 15 days within which to file any objection to the petition to compel." [Emphasis added.]

What is the event that triggers the 15 day objection period? Is it the service of the petition, the filing of the petition, or the date of the petition? We note that if the triggering event is service of the petition, the objecting party may be entitled to additional time if the petition is served by means other than personal service pursuant to proposed rule 10605.

We respectfully suggest that proposed rule 10360(c) be clarified to include a clear triggering event. For example: "The other parties, lien claimants, and the DWC-Legal Unit shall have 15 days *after service of the petition* within which to file any objection to the petition to compel."

2. Proposed Rule 10540

We note that proposed rule 10540 contains conflicting deadlines in (a)(1), (b) and (c) for an objection to a petition to terminate liability for temporary total disability indemnity.

Proposed rule 10540(a)(1) states:

> A statement, in underlined capital letters, that an order terminating liability for temporary total disability indemnity may issue unless objection thereto is made on behalf of the employee within 14 days after service of the petition, [Emphasis added.]

Proposed rule 10540(b) states:

> If written objection to the petition to terminate is not received within 14 days of its proper filing and service, the Workers' Compensation Appeals Board may order temporary disability compensation terminated, in accordance with the facts as stated in the petition or in such other manner as may appear appropriate on the record. [Emphasis added.]

Proposed rule 10540(c) states:

> Objection to the petition by the employee shall be filed in writing within 14 days of service of the petition, and shall state the facts in support of the employee's contention that the petition should be denied, and shall be accompanied by a Declaration of Readiness to Proceed to Expedited Hearing.
> [Emphasis added.]

We note that the deadline to object in proposed rules 10540(a)(1) and (c) are triggered by the service of the petition, providing the employee with additional time to object if the petition is served by means other than personal service pursuant to proposed rule 10605. Proposed rule 10540(b), however, requires receipt of the objections within 14 days of filing and service of the petition, thus eliminating the extra time for service pursuant to proposed rule 10605 when the petition is served by means other than personal service.

We respectfully suggest that proposed rules 10540(a)(1), (b) and (c) be uniformly revised to clarify whether the deadline to object should include extra time for service by means other than personal service. If extra time for service should be included, we suggest proposed rules 10540(a)(1), (b) and (c) be revised as follows: "Objection to the petition by the employee shall be filed in writing within 14 days of service of the petition."

July 5, 2019
Robert B. Weber, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 1045.1. The proposed changes would take away my right to be heard o a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payers to underpay or deny medical-legal bills, a prfactice which is already rampant and unchecked. Carreirs routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming a QME. QME numbers are already at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misquided change to the regulations would worsen the unprecedented shortage of QMEs we have today.

The following terms should be preserved:

Medical-Legal Providers should be allowed to file a DOR.

Defendants should be obligated to issue an EOR compliant with LC 4603.3.

The WCAB can only defer the hearing when there is a threshold issue that

would legally defeat the entire claim.

A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable
statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.

Providing a mechanism for determining the value of the bill-whether the judge decides or it goes to IBR.

Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This "solution" is throwing the baby out with the bath water.

July 5, 2019
Stephanie Janiak

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away our rights to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

It is not fair to expect doctors in any capacity to work without the ability to get paid, or dispute what has not been paid.

July 5, 2019
Allen Lee, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for

bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

July 5, 2019
Jacob Rosenberg, MD

I am a QME and president of CSIMS. I and my members are strongly opposed to the proposed changes in Regulation 10451.1. The proposed changes take away my right to be heard on a non-IBR petition prior to resolution of the case in chief. This is extremely short sighted. it will encourage payors to deny or downcode medical-legal bills without any legitimate reason. This will undoubtably cause more evaluators to lave the system. We still have to pay our staff and rent even as we wait for payment. It can take years for a case to settle. I have patients that have been at maximal medical improvement for 10 years where the case in chief has not settled.
I have cases where I have performed at least 5 evaluation reports and even more supplemental reports all of which could be used to settle the case but one party wants a different outcome. There is absolutely no reason for me to wait for payment in such a case. There is no legal dispute that will affect the legitimacy of my charges.

For treaters there are times where there is treatment of a disputed body part or the entire case is denied. Under those circumstances it makes some sense to wait until AOE/COE on the disputes is settled. For cases where the injury and treated body parts are accepted and treatment is

authorized and approved by IBR, the treating physician should have the right to file a DOR and proceed to a ruling by a judge

In general the rules favor the payors making payors less accountable will only increase delays in treatment and decrease the quality of care.
Please preserve the ability of Med-Legal providers to file a DOR
force defendants to issue a 4603.3 compliant EOR
Grant treaters similar rights when AOE/COE is not an issue, treatment has been authorized, and IBR has decided the value of the bill.

Many quality providers are no longer treating injured workers because of long delays in payment that require providers to monitor case status for years and accept long delays before any payment. At any time they can miss a deadline and forfeit money to which they are ethically entitled. Simple solutions that promote acting in good faith should be put in place.
The current proposals encourage bad faith actions.

July 5, 2019
Aaron Shakarian

I oppose the new proposed changes

July 5, 2019
Robert Armani

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1.

The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed.

Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked.

Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

We are the last line of defense for the underdog against the Goliath

July 5, 2019
Gregory Cohen, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME's. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:
• Medical-Legal Providers should be allowed to file a DOR • Defendants should be obligated to issue an EOR compliant with LC 4603.3.
• The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
• A list of "Bad Faith" tactics should be in the regulation, including, but not limited to:
failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
• Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
• Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.
If there is a specific issue affecting the WCAB with petitions for medical-legal costs then changes should be proposed that address that specific issue. This proposed “solution” represents sweeping changes with one apparent goal in mind: to further erode the QME's already flimsy ability to compel full and timely payment on a totally proper medical-legal bill. This is just the latest in a long line of recent changes to the CA WC system designed to benefit insurance companies and further weaken the injured workers leverage in their attempts to ensure a fair resolution to their case.

July 5, 2019
Randi Galli, MD

I have withdrawn my active status at this point as a QME. It is not worth my precious time to work hard only to have the proper reimbursement reduced by an insurance carrier.

July 5, 2019
David C. Hall, Ph.D.

I am a QME/AME. As it is, I am regularly begging to get paid BEFORE you make more regulatroy changes. It is a terrible system as it is. I am a one man show. I don't have a billing office. I get pushed around all the time by the insurance companies. I don't have the time or the staff to protest their lack of payments. Are you going to make it worse for me?

1) I can't afford to wait until the case in chief settles. That can be years. Once I've submitted my ML report, I should get paid in a timely manner without delays over which I have no control.

2) I am in agreement with the need for limits on the bad faith of insurance companies.

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

IF there are problems with the QME process, they should be dealt with specifically and individually. Please don't crush us with this vague and destructive regulatory language.

July 5, 2019
Marvin B. Zwerin, DO

I am an AME and a QME who occasionally find that the carrier has w/o reason reduced or denied my bill for medical-legal services. It is exceedingly frustrating now to get the billing corrected or paid, sometimes more than a year. On that basis, I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QMEs. Obviously, the QME headcount is currently at an all-time low and it continues to decline. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 5, 2019
Douglas Owen

My name is Douglas Owen, D.C. I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed.

As it stands today, insurers are trying to deny medical legal billings for bogus reasons trying to justify the fact that they simply don't like the report. Recently I have been able to go before a judge to settle the dispute which turned out in my favor and the insurer was told by the judge to pay me in full. These new proposed changes would even further embolden payors to underpay or deny medical-legal bills. I have only had one case where the carriers denied paying my report claiming bogus reasoning, however I have heard from colleagues that they have found carriers that routinely deny legitimate QME and AME bills for bogus reasons such as ???Provider not in MPN??? or ???Claim is denied.???

Presently, the only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.??

If?? this bill passes and my billing becomes routinely denied I will no longer remain a QME. I have over 25 years of experience as a med-legal examiner and I know that I will not be the only doctor leaving the system if laws are changed that force us to receive less payment for our services or if it becomes even more difficult to get paid for our services. I am certain that the most qualified of QME doctors will leave a system. We are the only ones who are able to find balance in a system that already favors the insurance companies and punishes injured workers who need treatment and have legitimate claims. ????The QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.????

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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

Please reconsider and do not allow this harmful law to pass.

July 5, 2019
Alan M. Birnbaum, MD

I have been evaluating work injury cases since 1979. I have been a QME ever since the initial examination was given to qualify physicians.

Any erosion of current reimbursement rules and appeal options will force Qualified examiners to only see patients on a PREPAID basis. In other words, a retainer to cover the expected examination time would be required before an appointment would be set. Then NO report would be issued unless its author had been completely paid. In fact, much civil work still requires this handling of evaluation reports.

Similarly, Amazon does NOT ship you anything unless you have made pre-payment typically by credit card. Jeff Bezos understands a basic fact of modern commerce. Let us not force forensic medical specialists into the same system.

July 5, 2019
David M. Reiss, MD

Expecting QMEs to wait until a case is settled to resolve disputes with insurance carriers is inherently unreasonable and unfair. The QME has no control over settling cases or the time frame involved and in no other profession does a dispute over SERVICES RENDERED UNDER STATE-MANDATED FEES require the clinical resolution of a case, that does not require any further services from the QME, before the provider of the services is able to appeal for appropriate payment.

The delay is totally unreasonable and this will incentivize insurance companies to make even more errors (99% in their favor) knowing that if ever, it will take years for them to be held accountable. (I am still awaiting a settlement of a case from 2008, regarding which the defense attorney lied, told me there was an insurance carrier, but the employer turned out to be unemployed - and I STILL have received no payment and my lien has not been heard on over $5000 worth of services provided in 2008.)

This will drive out even more good QMEs, leaving behind mostly those who seek to "make a quick buck" through questionable means and over-billing, thus being willing to "write off" disputes as a "cost of business". Good docs who are billing appropriately cannot afford to do that.

I can't wait for years to get paid what is legally due to me and I will not take part in a system that expects me to do so.

July 5, 2019
Esmond Gee, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

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This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

If the WCAB allows the proposed changes to Regulation 10451.1, QME and AME will essentially be working for the insurance company, working for a "contracted rate" this may affect the physician's judgement and impartiality. If reulation 1045.1 passes, I plan to leave this QME because the amount of time and energy placed into preparing a report is "not worth it."

July 5, 2019
Paul Kratofil

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal fees. I also understand that the changes in these regulations would allow the carriers to delay payment to a QME until the workers’ compensation case is settled. It is unclear how settlement of the underlying case is relevant to payment for services which were requested by the parties and required under the code. QME evaluations are not performed on a lien and panel members are required to perform them. This is in stark contrast to a PTP who elects to provide care in a disputed case. I encourage preservation of the medical legal terms and payment process.

July 5, 2019
Lindsey Urband, MD

I was recently informed that changes to the regulations involving QME objections to rulings involving the QME reports and reimbursement are likely proceeding. Although I have been an QME for only two years, it is apparent to me that there is a dire need for QMEs to support the Worker's Compensation system. I elected to prepare for and pass the QME exam as I felt it was my obligation as an Orthopaedic Surgeon to allow my expertise to act as an independent and impartial evaluator for injured workers and employers equally. In changing regulations that potentially diminish reimbursement and decision-making capacity of QMEs, fewer trained and qualified physicians will be willing to participate in this important component of our Worker's Compensation system. This will result in longer wait times to close cases, poorer access to independent evaluations and, I would anticipate, overall increased dissatisfaction with the Worker's Compensation system on the part of both the injured worker as well as the employers. I strongly suggest these regulations are not changed.

July 5, 2019
Joel Bird, DC

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief. Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME's. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

Again, the carriers already play numerous games such as denying the QME charges with reasons such as the claim is already denied or having a utilization review company deny the billing as the claim has been deemed nonindustrial and right now we even have one utilization review company that sends a denial on every initial QME billing claiming that they have no documentation to support the bill when we all know we sent the report with our bill. In my view this is just an attempt to have the smaller clinics fail to respond for a secondary bill review within 90 days.

The insurance carriers already have numerous ways to deny, reduce and delay our QME billing and these tactics have already led to a significant reduction in the doctors in the system willing to perform QME's at this point. The systems needs to maintain the quantity of QME evaluators it already has and if this bill passes there will be a significant reduction in the QME evaluators available.

It is already hard enough to get treatment for patients and again if we take away the QME process (which this most likely will, because if the doctors cannot get paid they will not do the evaluations,) then we no longer have a recourse for the injured worker and we no longer have a workers compensation system. Possibly the intent of this regulation to start with.
It is already mandatory that we have workers compensation insurance and pay whatever premium they propose to us as employers. I believe that it should be mandatory that the insurance carriers have to pay in a timely fashion for the QME examinations that they themselves promulgated by quite often denying or delaying legitimate workers compensation claims.

Another issue that may not be considered is that if the carriers have no incentive to settle claims then just imagine how many more open claims that will be in the system with a significant increase in mandatory settlement conferences, various petitions, etc. I think adding more work to a system that is already overworked is problematic.

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• Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
• Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

If there is a specific issue affecting the WCAB with petitions for medical-legal costs then changes should be proposed that address that specific issue. This proposed “solution” represents sweeping changes with one apparent goal in mind: to further erode the QME's already flimsy ability to compel full and timely payment on a totally proper medical-legal bill. This is just the latest in a long line of recent changes to the CA WC system designed to benefit insurance companies and further weaken the injured workers leverage in their attempts to ensure a fair resolution to their case.

July 5, 2019
John Paul Beaudoin

I am a psychologist and QME. I strongly propose changes to 1045.1.

Collecting over due payments from Carriers already consumes significant staff time. I am already concerned that time, reimbursement and associated costs make continuing my work as QME marginally worth the work.

Any changes to Regulation1045.1 would likely stop my work as a QME since 2004. I will return to 100% clinical therapy.
The following terms should be preserved:
1.) QMEs should be allowed to file DORs
2.)Defendents should be obligated to issue EORs compliant with LC 4603.3
3.) WBAB can only defer Hearing when there is threshold issued to defeat entire claim.
4.) Bad Faith regulations should be limited.
5.) Provisions for detecting value of bill should be established.

July 5, 2019
William McCarron, DPM

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 5, 2019
Delia M. Silva, Psy.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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July 5, 2019
Maria Palacio

I believe it improper and unfair, that no interpreter who does direct billing, was involved in the wording of LC 10979.

The verbiage as proposed in 10979, is improper and misleading. For example, how can a fee schedule be mentioned, if there is none in place? Please do not delete the only guideline that is currently in Labor Code regarding payment which is market rate, and which must be substantiated by the provider. When the fee schedule is indeed finalized, the Labor Code can be amended.

Also, the words "...the WCAB appointing an interpreter..." and "...fixing compensation..." are misleading. It can and will be used out of context to delay payment.

Although I know that I will be ultimately paid for the interpreting services that I provide at a deposition, a trial or for an AME appointment, after my invoice I will still have to make a written demand, wait the 60 day regulatory period. file a Petition with the Court and hope that it will be responded to in a timely manner.

Second, I object to the proposed version of Regulation 10451.1 (petition for non IBR, medical legal expense) and request that the word "provider" be written into this regulation so that the provider will have a right to file a DOR/Pettion for Payment.

July 5, 2019
Michael Carlish, Ph.D.

I have been a QME For the past three years and I would like to continue in this role for many years. The proposed rule changes would preclude me from continuing to act as a QME, however. Completing these reports are difficult, given the fact that they must follow complicated legal rules, often require tedious record review, and can be scrutinized by lawyers. Unfortunately, continuing to act as a QME would simply not be worth my time if the proposed rule changes were to take effect.

July 5, 2019
Tom Harpley, Ph.D.

I am a QME who is also opposed to 10451.1/section 10786.

July 5, 2019
Therese M. Moriarty, Psy.D.

It has come to our attention that the WCAB wants to change the rules to section 10786 [former 10451.1] that the practitioner's response time to rejections would be made shorter. I ask that you reconsider this change. As a solo practitioner, I've been contemplating whether it makes sense to continue working as a AME/QME. From my perspective, I work on a lien basis. I provide the services and then the insurance company is suppose to be pay me the agreed upon fee. However, that's never how it works. I do provide the services, then the insurance company takes several months to pay and when they do it's often a fraction of what I am owed. I am then expected to take my, valuable, time and fight with them. This is insanity. I do it because I believe the people seeking assistance deserve good practitioners and not just factories that mill out reports and don't do thorough assessments.

Please know that as it stands now I find more impositions need to be placed on the insurance companies (they should be fined for not paying in 30 days and they should not be allowed to nickel and dime) and if this change goes through you will lose dedicated clinicians.

July 5, 2019
Stuart Meisner, Ph.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. I have repeatedly have had problems with carriers' bad faith actions denying or underpaying my bills.The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.

Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

July 5, 2019
Michael Charles, MD
Newton Medical Group

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payers to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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July 5, 2019
Barry Weiner, DPM

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July 4, 2019
Scott Anderson, MD

As a QME for or two decades I write to object to any regulation change that would embolden involved parties to deny payments pending resolution of cases. Such an approach would be manifestly unjust, and will drive QMEs out of the system, to the detriment of injured workers.

July 4, 2019
Alexander Sparkuhl, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payers to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. The number of QME’s is currently at an all-time low and continues to diminish. The system cannot afford to lose more QMEs and this regulatory change would worsen the QME shortage.

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- A mechanism should be provided for determining the value of the bill - whether the judge decides or it goes to IBR. A rule needs to be included indicating the medical-legal providers do not have to file a lien when there is a dispute.

If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 4, 2019
Gregory S. Webber
getRecords/MedLegal LLC

As a medical-legal provider that works broadly across the workers' compensation ecosystem to provide the evidence necessary in an evidence-based system, we rely on the WCAB to fairly adjudicate claims that are (often systematically) unfairly denied or delayed for payment.

In particular, having embraced the 'grand bargain' of the SB863 reforms (reduced costs, prompt compliance/payment, less dispute/friction) the proposed changes to the Rules of Practice and Procedure (especially at 10451.1, now 10786) are quite impactful – effectively removing any consequence for payer non-compliance/non-payment/timeliness.

The changes at 10451.1 (now 10786): 1) remove substantial definitional content that specifies the required 'precision' in determination and execution (in their absence only creating more dispute, friction, and litigation), 2) remove a performance penalty that is there to motivate payer compliance (effectively, the payer will no longer 'forever waive their right to object' if they don't execute in compliance), and 3) will only delay enforcement until after the Case in Chief is settled (extending the period of costly dispute and friction).

Removing definitional precision and the penalty for compliant/timely payer performance while at the same time introducing a likelihood of WCAB enforcement delay moves the regulations out of balance with the 'grand bargain' of SB863 and will only increase the potential for more conflict, delay, and dispute – in the end, all (very) costly to the system and all its stakeholders.

Likewise, other changes (including 10626 and 10888, both proposed for repeal, and 10770(c)(2) and 10770(d)) would also prove costly to the system. Repealing 10626 removes additional definitional content specifying important distinctions between authenticated/non-authenticated evidence. Repealing 10888 absolves payers from good faith efforts to resolve liens and reduce litigation. Changes in 10770 generally impose significant additional burdens regarding the filing and adjudication of liens. Each of the above will only add more cost, dispute, and friction to the system.

In the end these changes (as currently proposed), would deepen 'the paradox of the California Workers Compensation evidence-based system' existing as follows:

Why a system that favors the production of evidence in the form of written information and reports presumably to; 1) increase precision, 2) adhere and measure performance to standards, while at the same time 3) reducing overall costs (together, 'Evidence Based Medicine' as documented in CCR 10606 and elsewhere); and

Where a system that so deeply relies on the production of such information within numerous decisions, treatments, and required reporting steps (UR, IMR, PTP, AME, QME, etc.); and

Even goes on to define and prescribe a special class of services thereon ('Medical Legal', as documented in LC 4622) and therein prescribing a clear, timely, and complete production and payment process for same; and

Prescribes a very precise fee schedule requiring payment (the 'Copy Service Fee Schedule' or 'Medical Legal Fee Schedule') for same; and then

Seeks to weaken enforcement on payer compliance and payment for the very evidence/reports it so strongly requires, only leading to additional and costly dispute and friction for the system as a whole; is indeed a paradox.

Together – it is up to us to resolve the paradox, thereby improving outcomes, speeding resolution, and reducing friction for ALL of California's Injured Workers who so deeply rely on this system for treatment, to heal, and to get back to work! The changes identified above are counter to the constitutional principles inherent in workers' compensation and only deepen the paradox and increase the financial costs for all.

July 3, 2019
William Tappin
Tappin & Associates

This comment relates to the tentative proposed regulations. In particular it addresses Title 8 California Code of Regulations § 10541.1.

Labor Code § 4622 was modified on January 1, 2013 in response to Independent Medical Examiners, Agreed Medical Examiners and Panel Qualified Medical Examiners' concerns over payment of their medical-legal bills for services rendered. The statutory system considers that the employer, carrier or administrator either resolve the case based on the primary treating physician report, or issue an objection to the report and either use an Agreed Medical Examiner or Panel Qualified Medical Examiner to resolve the disputed issue or issues.

The legislature changed Labor Code § 4622 which has always required payment to medical-legal providers within 60 days. It already provided for 10 percent penalty and 7 percent interest. However, it was determined by the legislature that those penalties, in and of themselves, did not generate timely payment of medical-legal bills. The amended Labor Code § 4622 outlines exactly how employers and medical-legal providers must address medical-legal billings. It is very detailed. For example Labor Code § 4622(c) states:

> "If the employer denies all or a portion of the amount billed for any reason other than the amount to be paid pursuant to the fee schedule in fact on the date of service, the provider may object to the denial within 90 days of the service of the Explanation of Review. If the provider does not object to the denial within 90 days, neither the employer nor the employee shall be liable for the amount that was denied. If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a Petition and a Declaration of Readiness to Proceed with the Appeals Board within 60 days of service of the objection. If the employer prevails before the Appeals Board, the Appeals Board shall order the physician to reimburse the employer for the amount of the paid charges found to be unreasonable."

The proposed regulations are inconsistent with Labor Code § 4622. In fact, Labor Code § 4622(e)(2) indicates:

> "The Appeals Board shall promulgate all necessary and reasonable rules and regulations to ensure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules or regulations are enforced."

As a result of the detailed requirements reflected in Labor Code § 4622 the Appeals Board enacted Title 8 California Code of Regulations § 10451.1. This regulation takes seriously the mandate of the legislature. The proposed regulations undermine both the spirit of Labor Code § 4622 and the precise language of Labor Code § 4622.

It appears to me that the Appeals Board is responding to objections by a number of employers, third-party administrators and carriers who are upset because they are being penalized for failure to comply with the statutory requirement reflected in Labor Code § 4622. They were also upset with having to do utilization reviews within 5 days. Nonetheless the courts indicated very specifically that the statutory intent of the legislature was that they do exactly what the statute indicated. This situation is no different. If the employer, carrier or administrator merely followed the regulations and either appropriately paid the billings or appropriately reduced the billings there would be no massive amount of petitions filed. However, many carriers, administrators and employers attempt to unjustifiably down code or completely deny medical-legal bills. There are fee schedules for medical-legal providers both for photocopy and for Agreed Medical Examiners and Qualified Medical Examiners. The carriers should follow the fee schedule or properly dispute it.

The development of rules and regulations in order to interpret a statute are generally appropriate when they are consistent with the statute. Many of the proposed changes in Title 8 California Code of Regulations § 10541.1 are inconsistent with Labor Code § 4622.

The purpose of Labor Code § 4622 was specifically to allow Agreed Medical Examiners and Qualified Medical Examiners to be able to timely dispute refusals to pay the appropriate amounts. The Appeals Board is presently working on a way to address potential over-billing by physicians. That should be the focus of the regulations. The focus should not be to undermine the requirements of Labor Code § 4622 and preclude Agreed Medical Examiners and Qualified Medical Examiners to pursue the avenues provided by the legislature to obtain proper just, and timely payment for their services. Many doctors have responded that they do not want the change to be made to 10451.1. That is understandable. The Appeals Board can establish procedures to address petitions for non-IBR medical-legal disputes filed by physicians. The petition itself should state the underlying facts along with points and authorities indicating that the employer, carrier or administrator has violated the rule and indicate the specific rules violated. At that point the judge could issue a notice of intent to award the medical-legal fees, penalties and interest as reflected in Labor Code § 4622. The defendant would have an opportunity to object and if they object the matter would be set for a hearing (status conference, Mandatory Settlement Conference or Trial) and the judge could determine if the defendant had any viable defense. I would suggest that if there is no viable defense and the carrier has violated the guidelines, procedures and timeframes related to payment of medical-legal expenses they be sanctioned not the minimum $500.00 currently reflected but $2,500.00. This would discourage carriers from objecting frivolously. If the matter could not be resolved at the initial hearing it could be set for Trial or the judge could issue an order on the Petition and the employer, carrier or administrator would have the option of doing a Petition for Reconsideration. I would suggest additional penalties be asserted should carriers take that position without supporting documentation.

Please note that pursuant to Title 8 California Code of Regulations § 10561 outlining sanctions subsection (b) outlines bad faith actions for tactics and includes "actions or tactics that result from a willful failure to comply with a statutory or regulatory obligation that results from a willful intent to disrupt or delay the proceeds through the Workers' Compensation Appeals Board or that are done for an improper motive or indisputably without merit."

Doctors have to pay their office rent every month. They have to pay their staff every 2 weeks. They have to pay their electrical bills as do all of us. They have ongoing payment obligations in order to maintain a medical practice. To the extent that physicians do work in this system as a Qualified Medical Examiner or an Agreed Medical Examiner they should also be paid in a timely manner. When I started representing Agreed Medical Examiners and Qualified Medical Examiners I had a well-respected Agreed Medical Examiner tell me that he was going to have to leave the practice because 30 percent of his medical-legal billings (which are very reasonable) were being zeroed out by the defendants. No Agreed Medical Examiner should have to have a full-time person collecting their Agreed Medical Examination bills. It seems to me, and I would love to be corrected if I am wrong, that the Appeals Board is now catering to the employer, carrier and administrator community by taking away the rights available to medical-legal providers under Labor Code § 4622. The fact that the AME and QME communities can file a petition for a non-IBR medical-

legal dispute but cannot pursue it effectively takes away their right. Their rights reflected in Labor Code § 4622 are very clear. The proposed changes to Title 8, California Code of Regulations § 10451.1 undermine the intent of Labor Code § 4622. A right that cannot be timely pursued is no right at all. Physicians cannot afford to wait 6 months, 9 months or even 2 or 3 years before a case is resolved for payment. The proposed changes to Title 8, California Code of Regulations § 10451.1 will result in doctors being financially unable to participate in the system. Unfortunately, the end result of that is that injured workers, who are entitled to expeditious resolution of their cases, will have to wait for the assignment of a QME. Unfortunately, the regulations requiring appointments to be set timely are not being changed.

The more demand for Panel Qualified Medical Examiners with a simultaneous reduction in the number of Qualified Medical Examiners will mean that the remaining Qualified Medical Examiners will not be able to timely set appointments. It means that the remaining AME's and QME's will be very busy because there will be very few of them remaining and they won't be able to timely complete their reports.

The proposed change in Title 8, California Code of Regulations § 10451.1 clearly will have an adverse impact on the system. It will result in fewer Agreed Medical Examiners or Panel Qualified Medical Examiners thus lengthening the time for an injured worker to resolve or try their cases.

The legislative intent reflected in Labor Code § 4622 should also be reflected in Title 8 California Code of Regulation § 10451.1. Agreed Medical Examiners and Panel Qualified Medical Examiners must be able to have an avenue to collect payment, penalty and interest in a timely manner. It would be patently inconsistent with the statute to make an Agreed Medical Examiner or Panel Qualified Medical Examiner wait until the end of a case to pursue payment. The underlying purpose of Labor Code § 4622 both before and after January 1, 2013, was to have those medical-legal providers categorized as Agreed Medical Examiners, Independent Medical Examiners or Qualified Medical Examiners paid within 60 days. A Regulation has to have provisions to ensure that if payment is improperly denied or reduced, the doctors can move forward to obtain payment in a timely manner. By restricting the ability of a doctor to obtain payment by way of a Petition for Determination of Non-IBR Medical-Legal Dispute and a Declaration of Readiness, we've taken 10 steps backward. In effect, the new proposed regulation is fundamentally at odds with Labor Code § 4622. It matters little if they have a right to payment and 10% penalty and 7% interest if there is nothing the doctors can do to obtain that payment within a reasonable period of time. Effectively this constitutes a right without a remedy. The purposed regulation doesn't allow for a timely remedy which is what Labor Code § 4622 requires. If the employers' carriers and administrators can comply with utilization review in 5 days, it seems incredible that they are allowed to assert that they can't pay an Agreed Medical Examiner or Panel Qualified Medical Examiner within 60 days. The legislature has laid out a detailed schematic for both doctors and employers to follow. When the rules are not followed, there has to be some regulatory remedy that effectuates timely payment to the Agreed Medical Examiners and Qualified Medical Examiners. To move forward with the current draft of Title 8 California Code of

Regulation § 10451.1 undermines the clear language of Labor Code § 4622 and will result in longer waits for Agreed Medical Examination and Panel Qualified Medical Examination dates and reports. There will be fewer physicians functioning as Agreed Medical Examiner and Panel Qualified Medical Examiners. The more experienced Agreed Medical Examiners will opt out of the Panel Qualified Medical Examination process and ultimately the rights of the injured worker will be adversely impacted.

July 3, 2019
Gabriela Ruiz
Med Legal, LLC

I urge the WCAB to reconsider the proposed regulations and repeals. As a medical-legal provider and cost petitioner, the proposed changes disrupt the equilibrium that was the very intent of SB863 and copy service fee schedule. There is an essential obligation for specificity, detailed rules and definitions in this complex and comprehensive industry where carriers and providers' nature is to dispute. The implementation of 10451.1 provided clarity that drove either payment or process to dispute and resolve contested services, the proposed amendments would reverse the progress. According to the former Administrative Director Destie Overpeck in the DIR Newsline 2015.-40, the intent of copy service fee schedule mandated by SB863 was to expect fewer disputes and prompter payments yet the unintended consequences of these amendments would increase disputes and litigation.

Repeal of 10626 blindly dismisses and does not address the need for when a subpoena would be required. Instead it rationalizes the repeal by stating that a patient or their representative may copy or inspect the medical records through the use of an authorization. What wasn't considered is the essential requirement of record authentication and chain of custody element that is secured through the use of a subpoena. Moreover, the Health & Safety Code does not address the use of a subpoena but rather implies the patients attorney be liable for the cost, a direct contradiction to LC §4621.

Repeal of 10888 also absolves the defendant from good faith efforts to resolve liens at the time of case settlement and solely relies on the disadvantage of a provider to be required to file a lien or toll their statute of limitations. This repeal negates the onus of the carrier to pay or properly object within the required statutory timelines and once again burdens the provider to incur additional cost to simply get paid.

The ambiguity of amending current §10770 (C) (2) is a clear indication that a provider would be required to file amended liens. This stunts the progress of the WCAB to streamline and simplify a process and would prove to be cumbersome to the WCAB each time a new date of service is incurred.. A provider would be required to amend, file and serve a lien. It can also potentially impact the statute of limitations of a provider.

Amending the current §10770 now §10872 (d) would mandate lien claimants to attend hearings despite the resolution of the lien if the lien was resolved after the last notice of hearing and the WCJ fails to address or excuse the lien claimant from appearing. Under now proposed (c) there

is no remedy if the defendant doesn't pay per the resolution agreement. The amendment provides a lien would be dismissed with prejudice upon filing of the resolution letter. It is the current and standard industry practice of lien claimants and defendants to resolve matters prior to a hearing; this avoids the cost of further litigation, avoids appearances, reduces the court calendar and encourages compromise and settlement between parties.

The most impactful and volatile proposed amendment is to Rule §10451.1. First, the removal of definitions would leave for open interpretation and ambiguity. The definitions within the content of this specific regulation are fundamental to the implementation of the designed process, anything less than keeping them would create a potential misapplication of definitions within other regulations or statutes neither appropriate nor applicable. Next, is the removal of the description and the waiver by a defendant and the right of a provider to file a DOR when the defendant fails to adhere with the statutory requirement. What incentive will the defendant now have to resolve these issues when the access for the provider to bring the matter to resolution is removed? The proposed amendments to this regulation are essentially eliminating the rule book on how to resolve disputes. Thirdly, the removal of the language and definition for mandatory sanctions will remove the motivation for defendants to adhere to the rules yet it constructs a new section for Sanctions that omits any threat of monetary sanction for bad faith tactics as currently defined. Finally, the amendment proposes the ability for the WCAB to defer these matters until the underlying case resolves. This will be problematic and increase the amount of litigation at the WCAB and defeats the purpose of a less frictional system that was intended with SB863.

July 3, 2019
Dan Mora
Gemini Legal

Our group represents a coalition of 12 registered California Professional Photocopiers, many of whom are paid within the system as medical-legal providers under Labor Code Section 4620-4622. We noticed the proposed changes to the Regulation that governs the process by which we enforce payment for our services through the Workers Compensation Appeals Board, and we have the following concerns:

1. Our biggest concern is the REMOVAL in the proposed regulation of CURRENT Regulation Section **10451.1(c)(3)(B)**, which CURRENTLY allows a medical-legal provider to file a **Declaration of Readiness** with their Petition For Non IBR Medical Legal Dispute when the Employer FAILS to file the Declaration of Readiness as directed in Labor Code Section 4622(c).
    a. Labor Code Section 4622(d)(2) states: *The appeals board shall promulgate all necessary and reasonable rules and regulations to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced.*
    b. Labor Code Section 4622(c) states in part: *If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection.*

c. Given these two subsections, the only way to "insure compliance" with subsection (c) is to allow the provider to file Declarations of Readiness in the event the Employer fails to execute their responsibility under subsection (c). Without the ability to file a Declaration of Readiness and get the matter on calendar when the Employer fails to file the Declaration of Readiness, the entire Section 4622 could easily be circumvented by the Employer by simply never filing a Declaration of Readiness.
d. CPP suggests amending proposed subsection (b) to state: "*(b) A medical-legal provider may file a petition for reimbursement of medical-legal expenses where a defendant has failed to timely object to a medical-legal expense pursuant to Labor Code section 4622 or 60 days have elapsed from a provider objection pursuant to Labor Code section 4622(c) and the defendant has not filed a Declaration of Readiness to Proceed to a status conference. A Declaration of Readiness may, but need not accompany the Petition.*

CPP suggests that the Petition for Non IBR Medical Legal Dispute be added to the list of other petitions that may be submitted on a **walk through basis** in proposed **Regulation Section 10789(a)**. This would be consistent with the WCAB's stated goal of changing the definition of a Party in Regulation 10301/10305 and allowing limited purpose hearings in the rules that directly address certain types of cost petitions. (see WCAB comment A37 in the proposed Regulations document.)

July 3, 2019
Sharon L. Hulbert
Vice President/Assistant General Counsel
Zenith Insurance Company

Section 10786 [former 10451.1] – Determination of Medical-Legal Expense Dispute –The reorganized and amended code section would eliminate defendant's duty to file a Petition for Non-IBR and DOR within 60 days after receipt of a 90 - day objection in response to an EOR relating to a Non-IBR issue. The proposed change will now only require the defendant to file a DOR to proceed to a Status Conference at the WCAB within the 60 day time-frame *(this should make things a little more manageable).*

The most important factor in making this process work is clear communication between claims and bill review so that claims knows when to begin the 60 day time-frame to file a DOR. Zenith sees many cases where the Petitioner is required to file an Objection under 4622(c) *(Non-IBR issues)* but instead files a Request for Second Review under 4622(b)(1) *(more consistent with an IBR issue).* In some instances, the Petitioner files both an objection and a request for second review, regardless of the issues raised in the EORs. For example, if Zenith issues an EOR denying payment for a reason "other than fee schedule" and the provider responds with a Request for Second Review *(rather than an objection, or both).* This results in two pathways being followed for the same issue simultaneously.

To resolve dual remedy approach, Zenith suggests **adding** language under 10786, indicating that a "Request for Second Review" does not meet the 90 – day objection requirement pursuant Labor Code Section 4622(c) *(where defendant has denied all or a portion of a provider's billing for medical – legal expenses for any reason other than the amount to be paid pursuant to the fee scheduled in effect on the date the medical-legal goods or services were provided).*

Furthermore, the new language *(section [a])* of 10786 eliminates the word "all", limiting the 90-day objection to situations where the medical-legal provider issues an objection to a "denial of a portion of the medical-legal providers billing". Zenith suggests **adding** the word "ALL" back into section (a) so that it reads "denial of **all or a portion** of the medical-legal providers billing" because both situation will arise when dealing with medical-legal services *(mostly SDT services).*

Section 10520 – Special Requirements for Pleadings Filed or Served by Representatives – under subsection (c) the following was added:

If a non-attorney representative who is not an employee of an attorney or law firm is executing the pleading being filed or served, the pleading shall include a heading containing the non-attorney representative's name followed by the words "Non-Attorney Representative," the name of the entity, if any, that employs the non-attorney representative, business address and business telephone number.

Zenith supports this modification as it will assist with identification of the non-attorney representatives. It also will assist in identifying the proper non-attorney representative when pursuing the proposed enforcement mechanisms established under Sections 10401 and 10402. To strengthen the enforcement aspect of 10520, Zenith suggests **adding** the following provision to 10520:

(d) Any petition filed by a non-attorney representative that does not meet the requirements of this rule shall not be deemed filed for any reason, and shall not be acknowledged or returned to the filer, and may be destroyed at any time without notice.

Section 10545 - Petition for Costs – Subsection (g) of this rule was removed from the rule with theproposal that the petitions be dealt with on a walk through basis rather than by requiring a Declaration of Readiness. Allowing parties to perform a walk-through relating to the Petitions for Costs may increase the number of Notices of Intent to allow or disallow the costs sought by the petitioner because the WCJ feels they have no other option but to issue the Notice of Intent. Therefore, Zenith suggests **modifying** this rule to allow the WCJ the option of placing the issues raised in the Petition for Costs on calendar on the Workers' Compensation Appeals Boards' own motion prior to issuing a Notice of Intent. This will give the WCJ another option when confronted with a Petition for Costs on a walk-through basis and avoid unnecessary time issuing and responding to Notices of Intent issued by the WCJ solely because that was the only option available under the rules.

Otherwise, Zenith recommends not adopting the walk-through approach because of the increased time and effort it can create to address Notices of Intent issued based on the petition alone. Zenith sees many petitions where the parties fail to disclose all the pertinent facts in the petitions such as prior payments made by the payor. If walk-throughs are allowed without giving the WCJ the option of putting the matter on calendar, then it will lead to Notices of Intent being issued

without full facts and require more time for all parties to respond than if the matter were put on calendar at the WCJs discretion.

Section 10629 – **Designated Service** – proposal adding a requirement that the party designated to serve any order by the WCAB "shall" file their Proof of Service with the WCAB. In general, when designated to serve Orders, Zenith E-files a copy of Zenith's Proof of Service with the WCAB *(we also do this for Notices of Intent)*.

Zenith's concern in making this a mandatory "shall" requirement is that if a party is properly served, but someone forgets to file a copy of the Service of Process with the WCAB, Zenith would not want the Service of Process to be found to be incomplete or improper. Therefore, we suggest that Subsection (c) be modified as follows to show that failure to submit a copy to the WCAB will not invalidate an otherwise valid Service of Process:

> Within 10 days from the date on which designated service is ordered, the person designated to make service shall serve the document and shall file the proof of service. Failure to file the proof of service with the WCAB or filing the proof of service with the WCAB after expiration of the 10-day period shall not invalidate an otherwise valid service of process on other parties.

July 2, 2019
Elliot Gross, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. This change would embolden payors to underpay like they already do or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:
(1) To be fair the Medical-Legal Providers should be allowed to file a DOR
(2) Defendants should be obligated to issue an EOR compliant with LC 4603.3.
(3) The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.

(4) A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
(5) Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
(6) Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 2, 2019
Charles Seaman

I am a current Qualified Medical Evaluator and I am writing to express my opposition to the proposed changes to Rule 10451.1. As written, this Rule provides a process for the Qualified Medical Examiner (QME) to object the denial of bills for medical-legal services in a timely manner. The proposed changes to Rule 10451.1 would cause potential delay in payment for QME services that would, in turn, adversely impact the availability and quality of QMEs resulting in delays in the adjudication of claims.

July 2, 2019
Manijeh Ryan, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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2) Defendants should be obligated to issue an EOR compliant with LC 4603.3.
3) The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
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5) Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
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This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This "solution" is throwing the baby out with the bath water.

July 2, 2019
Suzanne Honor-Vangerov, Esq.
Honor System Consulting

There are a number of issues with the proposed changes to the rules regarding the determination of non-IBR medical-legal disputes.

My specific comment appear under each section in italics. At the end are some general comments.

§ 10451.1 10786. Determination of Medical-Legal Expense Dispute[A1]

(a) Within 60 days of service of a medical-legal provider objection to a denial of a portion of the medical-legal provider's billing pursuant to Labor Code section 4622(c), the defendant shall file a Declaration of Readiness to Proceed to a status conference. Upon filing of a Declaration of Readiness to Proceed, the medical-legal provider shall be added to the official address record.

The newly proposed language only mentions a partial denial of payment. Language should be included to specifically say "all or a portion" of the billing. There is no requirement in the regulation regarding the need for the defendant to file a Petition per LC 4622 (c) ***"If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection."*** *Although the Petition need not have the very long name it*

currently has, there still needs to be one and defendants are required by the labor code to submit it. The regulations need to reflect that again.

There needs to be a definition of what qualifies as an objection by the provider. For example: does it need to be in writing? Can a request for SBR that includes objection language suffice?

There is nothing in the rule to address situations where there has been no Application for Adjudication filed. Language should be added to require the defendant to file the Application for Adjudication along with the petition and the DOR.

(b) A medical-legal provider may file a petition for reimbursement of medical-legal expenses where a defendant has failed to timely object to a medical-legal expense pursuant to Labor Code section 4622 or 60 days have elapsed from a provider objection pursuant to Labor Code section 4622(c) and the defendant has not filed a Declaration of Readiness to Proceed to a status conference. Upon filing of a petition for reimbursement of medical-legal expenses:

There is no longer any mention of the requirement to send an Explanation of Review (EOR) as well as an objection. LC 4622 (c) and (e) require the submission of an EOR that complies with LC 4603.3. ***(c) "If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection." (e) "(1) Using the explanation of review as described in Section 4603.3, the employer shall notify the provider of the services, the employee, or if represented, his or her attorney, if the employer contests the reasonableness or necessity of incurring these expenses, and shall indicate the reasons therefor."***

The receipt of the EOR is one of the actions which triggers the provider's objection. Use of an EOR needs to be explicitly required.

Additionally, this eliminates the provider's ability to file the DOR to get a status conference in the event the defendant fails to do so. This leaves the provider hanging with no recourse to appear before the court in a situation where the defendant may have already failed to file a DOR in the first place. The provider should be allowed to file the DOR along with the petition.

(1) The medical-legal provider shall be added to the official address record.

(2) The defendant shall either pay the expenses and file proof of payment or file a Declaration of Readiness to Proceed to a status conference.

(c) Notwithstanding the filing of a Declaration of Readiness to Proceed in accordance with the provisions of subdivisions (a) and (b) of this rule, the Workers' Compensation Appeals Board may

defer hearing and determining this issue until the underlying claim of the employee or dependent has been resolved or has been abandoned.

This section returns the medical-legal provider to the situation that existed before the promulgation of 10451.1 originally. By allowing the WCAB to defer the hearing until the case-in-chief is resolved, the provider may have to wait years to have the issue of payment adjudicated. In the meantime, the parties are using the provider's report to resolve the case. It also puts the provider in the position of having to continue to provide medical-legal services; such as supplemental reports, reevaluations and depositions; to a defendant who is refusing to pay. It makes more sense to resolve these disputes as they arise quickly rather than pushing them down the road to the end of the case. In the event of a threshold issue that completely defeats the defendant's liability, such as those listed in the current language, it makes sense to defer the hearing until that legal issue has been resolved, however, if the event that the defense actually requests the evaluation it should be precluded from denying payment based on the threshold issue. This should be added to the bad faith tactics mentioned below.

(d) The employer and the medical-legal provider are required to appear at the status conference. If the matter is not resolved at the status conference, the matter may be set for a mandatory settlement conference on the medical-legal expense dispute.

(e)[A2] Bad Faith Actions or Tactics:

(1) If the Workers' Compensation Appeals Board determines that, as a result of bad faith actions or tactics, a defendant failed to comply with the requirements, timelines and procedures set forth in Labor Code sections 4622, 4603.3 and 4603.6 and the related Rules of the Administrative Director, the defendant shall be liable for the medical-legal provider's reasonable attorney's fees and costs, if any, and for sanctions under Labor Code section 5813 and rule 10421. The amount of the attorney's fees, costs and sanctions payable shall be determined by the Workers' Compensation Appeals Board; however, for bad faith actions or tactics occurring on or after the effective date of this rule, the monetary sanctions shall not be less than $500.00. These attorney's fees, costs and monetary sanctions shall be in addition to any penalties and interest that may be payable under Labor Code section 4622 or other applicable provisions of law, and in addition to any lien filing fee, lien activation fee or IBR fee that, by statute, the defendant might be obligated to reimburse to the medical-legal provider.

The revised language eliminates the list of bad faith actions or tactics in the earlier version. This list is very helpful as it gives both the provider and the defendant information regarding what types of actions are considered to be bad faith for this section. These reasons, along with others such as lack of authorization, the physician not being a part of the MPN or other reasons inapplicable in medical-legal cases are necessary to discourage inappropriate payor behavior.

(2) If the Workers' Compensation Appeals Board determines that, as a result of bad faith actions or tactics, a medical-legal provider has improperly asserted that a defendant failed to comply with the requirements, timelines and procedures set forth in Labor Code sections 4622 and 4603.6 and the related Rules of the Administrative Director, the medical-legal provider shall be liable for the defendant's reasonable attorney's fees and costs, if any, and for sanctions under Labor Code section 5813 and rule 10421. The amount of the attorney's fees, costs and sanctions payable shall be determined by the Workers' Compensation Appeals Board; however, for bad faith actions or tactics occurring on or after the effective date of this section, the monetary sanctions shall not be less than $500.00.

Other comments: *There is nothing in the new language that gives guidance as to how the amount the provider is entitled to be paid is to be determined. In the previous version, there were waivers for failure of either the defendant or the provider to follow the rules. This has been eliminated. If the WCAB finds that the provider is entitled to payment how is the amount to be calculated? Will the WCAB send to back to the defendant's bill reviewer to re-review the bill in accordance with the court's finding that additional payment is owed? Will the bill be sent to IBR for a determination of the proper payment rate? What if there has never been any payment at all? There is no provision for any of these processes in the Labor Code. What is to prevent this from starting all over again with the defendant failing to pay based on the court's order? Without a final order that makes a determination of the amount owed, the parties are potentially sent back to square one on the issue of payment. This would potentially have the effect of creating multiple hearings on the same issue. The regulation needs to spell out how the payment rate should be determined.*

Also missing from the new language is the rule indicating that a medical-legal provider is not required to file a lien in order to have the dispute heard before the WCAB. This language should be restored.

In addition, term should be selected to refer to the medical-legal provider in these disputes. They are not "lien claimants", they are not "treating physician's". The WCAB forms do not have a designation of "petitioner" or "medical-legal provider" which is what these parties actually are. The judges do not know how to characterize them and often there are delays because the medical-legal provider is treated as if he or she is a lien claimant when that is not the case. I recommend the use of "petitioner" and "respondent" for this since the medical-legal provider is either filing a petition or responding to one filed by the defendant.

July 2, 2019
Jorge Kim

The new proposed WCAB rules show an ongoing disregard for QME's time, value, and compensation. In this regards, I have already cut my QME time down by 75% compared to 1

year ago. With further changes that will be detrimental to how QME's are treated, I foresee exiting this business completely.

July 2, 2019
Drew Peterson, MD

The WCAB has proposed regulatory changes that, if enacted, will harm physician's /my QME practice.

- Currently physicians have a chance to be heard in court if there is an issue with your QME bill. Under the proposed changes, we would not have a right to be heard until the case in chief settles. This means two things. #1) Insurers will be emboldened to deny or reduce a QME bill as we will not have recourse until the case in chief settles and #2) physicians won't be able to pursue our wrongfully denied QME bills until the case settles, which is often years.
- Currently, if we physicians object to defendant's denial of a QME bill, defendants have to file a petition in court. If they don't, we automatically win and are entitled to payment in full. Under the proposed change, it is no longer obvious that the defendant is still required to file a petition and this makes it easier for defendants to ignore our objection with no consequences.
- Several of the examples of what constitutes insurer bad-faith have been removed.
- There is no mechanism for figuring out how much you are owed and who gets to decide.

These **changes are bad for QMEs and AMEs** because they make the rules more unclear, create delays in the resolution of the dispute and will lead to friction.
Please vote against these proposed WCAB changes

July 1, 2019
Mark M. Kosker, DC

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. Medical-Legal Providers should be allowed to file a DOR. Defendants should be obligated to issue an EOR compliant with LC 4603.3. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would reassure payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR.

Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief. A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based

on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low change to the regulations would worsen the unprecedented shortage of QMEs today.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs, then I recommend that the WCAB sharpen their pencil and address the specific issue. This "solution" is throwing the baby out with the bath water.

July 1, 2019
Bruce Roth, DO

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

July 1, 2019
Lawrence Weil, MD

proposed changes and brief thoughts :

- . Under the proposed changes, The physician would not have a right to be heard until the case in chief settles. This means two things. #1) Insurers will be emboldened to deny or reduce your QME bill as no recourse until the case in chief settles and #2) The physician would NOT be able to pursue wrongfully denied QME bills until the case settles, which is often YEARS.
- Currently, if object to defendant's denial of a QME bill, defendants have to file a petition in court. If they don't, you automatically win and are entitled to payment in full. Under the proposed change, it is no longer obvious that the defendant is still required to file a

petition and this makes it easier for defendants to ignore objections-- with no consequences.
- There is no mechanism for figuring out how much you are owed and who gets to decide.

THESE PROPOSED CHANGES ARE BAD POLICY. PLEASE DO NOT ENACT THEM.

July 1, 2019
Eric Levander, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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The following terms should be preserved:

(1) Medical-Legal Providers should be allowed to file a DOR
(2) Defendants should be obligated to issue an EOR compliant with LC 4603.3.
(3) The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
(4) A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
(5) Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
(6) Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

July 1, 2019
Gregory Marusak, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.
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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 1, 2019
Ranga Reddy, MD

it is not fair to change without input from QMEs.I strongly oppose this.

July 1, 2019
Daniel Schainholz, MD

The denial, delay or reduction of QME reimbursements is a breach of trust. Defendants never abide by LC 4622 and provide the self-imposed 10% penalty in my professional experience.

Giving Defendants greater authority to deny claims while reducing recourse for the report writers is inappropriate, insofar as these self-provided discounts to the defendants are unacceptable to the QME report writer under LC 139.2(o).

When a defendant does not pay a valid claim for a report, the trust is broken, and it has the effect of creating an unintended bias against Defendants in future cases.

The position for the WCAB is to protect the rights of the QME report writers, who must devote hours and hours of effort on the promise that compensation will be forthcoming. Weakening those protections only provides an incentive for the big corporate players to act as intermediaries.

Cost-containment is critical, but a more pertinent issue is the commission system that the attorneys charge claimants. The capitation of legal fees would have a positive upstream effect, while paying QME report writers for their efforts.

Defendants can reduce their costs with better preparation of medical records, since while the basic costs of a report are fairly stable, the greatest variable cost is the medical record review.

It is not appropriate to diminish the efforts of the QME report writers, whom the Defendants rely upon for fair and equitable evaluations.

July 1, 2019
Emily Ziegler, Psy.D.

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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July 1, 2019
David Narang, Ph.D.

I am a QME and some of the proposed changes would prevent my ability to continue as such. I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

I would not be able to keep track of which cases have settled (commonly years later) and where I could thus finally pursue payment for my evaluation. This is not practical, and I'm not able to provide extensive evaluations on a wait and hope-for-payment basis, the likely result of the proposed changes. I write also with broad concern for the QME system at large, as many other physicians in the system are also unlikely to be able to remain in the system, resulting in even fewer QMEs being available.

July 1, 2019
Jerry Fabrikant, DPM

I am a single solo specialty practice who peforms QME and AME evaluations.

I have had QME evaluation payments which went unpaid for 1-2 years by a stubborn insurance company. They were totally unresponsive to phone calls and letters until they needed a supplemental report, after which they finally paid for the report, with no interest payments.

The new proposed rules penalize those of us who are diligent in adherence to all the rules, and yet really don't have time to contest unfair treatment. We really rely on you, the WCAB to compel the all powerful insurance lobby to pay in a reasonable time frame.

When they don't treat QME's fairly, we need a simple and expedited method to be paid., After all, they got their reports on time and are able to use our TIMELY REPORTS to settle, continue or deny claims. So why are we QME's going to be penalized using the proposed new rules for payment denial?

July 1, 2019
John Lawrence, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.
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- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen

their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

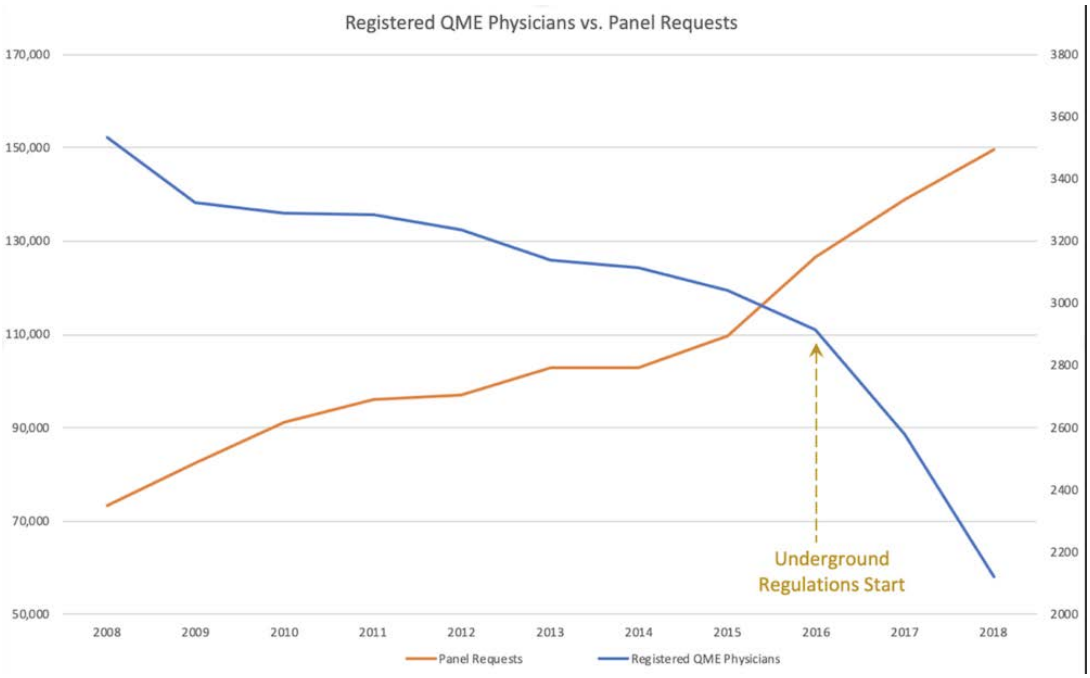
July 1, 2019
Gabor Vari, CEO
California Medical Evaluators

California Medical Evaluators (“CME”) is a leading QME practice management company headquartered in Los Angeles. Our network of QME physicians performs thousands of QME, AME and IME evaluations annually. As a DWC-accredited QME continuing education provider, CME has a special focus on QME training and mentorship in order to improve the overall quality of QME reports.

Before going into detail, we would like to make a few general comments:

1. The QME system is dangerously understaffed, especially in key specialties like orthopedics. The exodus of QMEs has been accelerating in recent years. Injured workers are having difficulty obtaining QME evaluations in a timely manner.
2. QME demand is at a historic high and has been growing at the same time that the QME population has been shrinking. The mismatch between QME physician supply and demand has never been greater.
3. Inadequate reimbursement is one of the main drivers of QME physicians leaving the system. QME fees have not been increased since 2006 despite DWC's statutory mandate under LC 5307.6(a) to do so regularly.
4. The administration identified in 2012 that timely reimbursement for medical-legal providers is a problem and a priority. This led to the adoption of regulation 10451.1 which these proposed regulations seek to gut and replace. By gutting regulation 10451.1 as proposed, QME physicians would lose their ability to seek timely payment of their bills. This would worsen today's unprecedented shortage of QME physicians.

Below is a graph which summarizes the current QME crisis.



I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away QME physicians' rights to be heard on a non-IBR petition prior to the resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to the resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.
The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.

- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

July 1, 2019
Ripu Arora, MD
Peninsula Interventional Pain Management Center

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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July 1, 2019
Andrea R. Bates, MD

Thank you for hearing my concern about the proposed rule and regulation changes and Rule 10451.1. I understand that you allow for public comment through July 5. I am a QME physician and I do not want the new proposed changes as written because as I read it, QME doctors may not pursue wrongly denied QME bills until the case settles.

It is getting more and more difficult for an independent doctor like myself to evaluate injured workers because of the climate of bill automation. I find that sometimes errors are inadvertently made by machines or new employees and once I get a person on the phone, the matter is often cleared up. Sometimes, though, the confusion is not cleared up to no fault of my own. With the proposed regulations, more of my cases will not be paid but rather may be inappropriately or unfairly evaluated for accuracy of payment.

I think that it is very important where the incentive lies because it will impact the way operations occur. If the insurance company inappropriately denies payment, they have staff that can track a case for years. I am just an independent doctor trying to do a good job on my evaluations and do the correct thing for billing and I do not have the staff or memory to follow-up on cases for non-payment years later after settlement. Please kindly consider us regular folk who cannot do business as a big corporation would. Please revise these rules before instituting them as written. Thank you very much.

July 1, 2019
John Carrigg, MD

Hello I am a QME in ENT. I think it a very bad idea to restrict my ability to present my payment case to the courts. It is patently unfair.

July 1, 2019
Frederick Butler II, MD

Fighting Insurance Companies As a QME and Provider is a drain on my time and resources. The current Law, Rules and Regulations allow me to provide evaluations and care with Minimal Energy directed towards making sure I am paid timely and fairly. Please keep the status quo so I may continue to focus on patient care.

July 1, 2019
Vladimir Lipovetsky, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked.

Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The payments for my last 4 reports have been denied based on exceeding Official Medial Fee Schedule, which any carrier knows to not be legitimate, and with these changes I’d be forced to wait until case resolution at the pleasure of the carrier.
The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.
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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

June 29, 2019
Chris M. Cake, DC

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute

Please re-consider these proposed changes, or experienced QME evaluators like myself will leave the med-legal arena. Thank you for your reconsideration.

June 28, 2019
Daniel Lopez
Lopez & Associates, Inc.

In review of the current pending proposed Regulation changes relating to Non-IBR Petitions under Rule 10541.1 and new Regulation 10789, it is our concern that these changes to this

regulation are particularly counter-productive to the legislative intent enacted by SB863 (01/01/2013) to ensure that medical-legal charges were addressed at the time they are relevant. Beginning with the definition of a "PARTY" under 10301(dd)(4), "a medical-legal provider involved in a medical-legal dispute not subject to independent bill review" having been deleted. This section should not be omitted as it will create adverse affects in our ability to resolve disputes distinguished as Non-IBR in a timely manner. This has no other benefit than creating more confusion within the workers' compensation system.

For example, Section 10550/10390 essentially removes a Third-Party Claims Administrator from having the obligations of being a "PARTY" all while they administer the claim on behalf the employer/insurer. Just as a lien claimant stands in the shoes of an applicant, does not the Claims Administrator stand in the shoes of the employer/insurer? The result is allowing a Third-Party Claims Administrator to avoid its responsibilities; including but not limited to the responsibility of providing information in a litigated case, calling itself a non-party and relieving itself from the duties to serve. It is further likely that a Third-Party Administrator will demand a non-party witness fee to produce records that they are obligated to serve and/or conveniently situate outside the State of California and while doing so, this section allows the claims administrator to assert its exemption from a valid WCAB Subpoena Duces Tecum.

The changes in 10451.1/10786 begin by eliminating waiver by the defendant for failure to file the Petition and DOR within 60 days of the providers' final demand for payment. Currently, the obligation of the defendant to file the 10451.1 Petition and DOR is mandated upon defendant but "defendant" (in practice) never files this Petition and never files a DOR.

In Section 10786, which places the obligation of the on the employer. See Comment [A682] proposes re-organizing and amending 10451.1 to require the employer to file a DOR in the event of a dispute. The word employer should not be used as the "employer" is not likely to file any petition and is not likely to file any DOR. The word should be defendant.

In rewriting 10451.1/10786, two major items are missing which is the ability for a medical-legal provider to file a Petition and then later file a DOR. This section is also missing "waiver by defendant" for failure to file a Petition or DOR:

… (f) Waiver of Medical-Legal Expense Issues
(1) Waiver by a Defendant
(A) A defendant shall be deemed to have finally waived all objections to a medical-legal provider's billing, other than compliance with Labor Code sections 4620 and 4621, if:
(i) the provider submitted a properly documented billing to the defendant and, within 60 days thereafter, the defendant either (I) failed to serve an explanation of review (EOR) that complies with Labor Code section 4603.3 and any applicable regulations adopted by the Administrative Director and/or (II) failed to make payment consistent with that EOR; or
(ii) the provider submitted a timely and proper request for a second review to the defendant in accordance with Labor Code section 4622(b)(1) and, within 14 days thereafter, the defendant either (I) failed to serve a final written determination that complies with any applicable regulations adopted by the Administrative Director and/or (II) failed to make payment consistent with that final written determination.

(B) A defendant shall be deemed to have finally waived all objections relating to a medical-legal provider's billing, other than the amount to be paid pursuant to the fee schedule(s) in effect on the date the services were rendered and compliance with Labor Code sections 4620 and 4621, if the provider submitted a timely objection to the defendant's EOR regarding a dispute other than the amount payable and, within 60 days thereafter, the defendant failed to file both a "Petition for Determination of Non-IBR Medical-Legal Dispute" and a DOR with the Workers' Compensation Appeals Board as required by Labor Code section 4622(c) and Rule 10451.1(c)(2)…

Over the past 4 years, 10451.1 has resulted in the settlements of Non-IBR costs in our case relating to subpoenas and copying related services the designation of which is also is missing from this section.

[Missing Designation]:(D) all costs or expenses for copying and related services.
To date this section has worked out well making it possible for a relatively inexpensive copying charge to get resolved without protracted litigation just as SB863 intended. Our ability to file our Petition, become a PARTY, and contact defendant prior to moving forward with a DOR often results in a settlement of the Non-IBR charges. We strongly feel this is a result of our rights as a PARTY which we are afforded under section 10451.1.

Currently, we E-File our Petition and NOR reducing the work load on the WCAB staff. With the Proposed changes, there will be significant increase in the workload of the WCAB staff busy scanning Petitions. Additionally, if a defendant objects to the WCJ's Order to Pay, there is no path for resolution for the medical-legal provider wanting to move forward.

The final point under 10417/10789 is this section should PROPERLY DISTIGUISH the types of Cost Petitions allowable for walk-through as Petition for Cost appears to pertain to section § 10451.3/10545. Petition for Costs.

We suggest that under Walk-Thru documents that (5) Petitions for Costs also include "Petition To Resolve Medical-Legal Dispute Non-IBR" (Reg 10451.1) which is the Title of the Petition in EAMS that we currently file. Our number one choice is having the ability to E-File our Petition and proceed with a DOR when defendant fails to file. The word "employer" should remain "defendant" in this new section as previously stated.

Our overall experience with the WCAB and its staff has been positive. Our E-filed Petition generates a task that allows a WCJ to execute our attached Conditional Order resulting in a streamlined process for both the defendant and provider having true accountability and access for all parties.

June 28, 2019
Ellen Sims Langille, General Counsel
California Workers' Compensation Institute

These comments on the tentative proposed amendments to the WCAB Rules of Practice and Procedure are presented on behalf of members of the California Workers' Compensation

Institute (the Institute). Institute members include insurers writing 81% of California's workers'compensation premium, and self-insured employers with $72.0B of annual payroll (31.6% of the state's total annual self-insured payroll).

Insurer members of the Institute include AIG, Alaska National Insurance Company, Allianz Global Corporate and Specialty, AmTrust North America, Berkshire Hathaway, CHUBB, CNA, CompWest Insurance Company, Crum & Forster, EMPLOYERS, Everest National Insurance Company, The Hartford, ICW Group, Liberty Mutual Insurance, Pacific CompensationInsurance Company, Preferred Employers Insurance, Republic Indemnity Company of America, Sentry Insurance, State Compensation Insurance Fund, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members include Adventist Health, Albertsons/Safeway, BETA Healthcare Group, California Joint Powers Insurance Authority, California State University Risk Management Authority, Chevron Corporation, City and County of San Francisco, City of Los Angeles, City of Pasadena, City of Torrance, Contra Costa County Risk Management, Costco Wholesale, County of Los Angeles, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, East Bay Municipal Utility District, Grimmway Farms, Kaiser Permanente, Marriott International, Inc., North Bay Schools Insurance Authority, Pacific Gas & Electric Company, Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Shasta-Trinity Schools Insurance Group, Southern California Edison, Special District Risk Management Authority, Sutter Health, United Airlines, University of California, and The Walt Disney Company.

Recommended revisions to the proposed regulation are indicated by underscore and strikeout. Comments and discussion by the Institute are identified by italicized text.

General Consideration
The Institute urges the Workers' Compensation Appeals Board to reconsider its adoption of a style change that excludes use of the serial comma (also known as "Oxford comma"). The risk of ambiguity that is created by the mandatory exclusion of punctuation is particularly acute in regulatory drafting and interpretation. The Board's attention is directed to the recent court decision in a class action lawsuit about overtime pay for truck drivers ("Lack of Oxford Comma Could Cost Maine Company Millions in Overtime Dispute").

§10305(a)
Recommendation:
(a) "Administrative Director" means the Administrative Director of the Division of Workers' Compensation or their the Administrative Director's designee.

Discussion:
The Institute applauds the WCAB's efforts to use gender-neutral pronouns throughout these Rules. Unfortunately, the use of a third-person plural pronoun does damage to ordinary rules of grammar, syntax, and comprehension, and may result in unintended legal consequences. The better solution is to avoid the use of pronouns altogether.

§10305(o) - Defining "Party"

Recommendation:

(11) A lien claimant where either:
(A) The underlying case of the injured employee or the dependent(s) of a deceased employee has been resolved or
(B) The injured employee or the dependent(s) of a deceased employee choose(s) not to proceed with his, her, or their case.

Discussion:
Practitioners at the WCAB are accustomed to the existing, sensible rules defining a lien claimant as distinct from a party to the case-in-chief. Rebranding lien claimants as parties is likely to result in unintended legal consequences.

In light of new §10752(d) (relieving a lien claimant from obligation to appear at MSC or trial of the case-in-chief), and with the repeal of former §§10563.1(c) and (d) (requiring certain lien claimants to appear at MSC or trial of the case-in-chief), the concerns raised in the Author's Comment explaining this proposed rule have been rendered moot. The definition of lien claimant as a "party" only in limited circumstances should be restored in full.

§10305(q) – "Significant panel decision" defined
and
§10325(b) – En Banc and Significant Panel Decisions Recommendations:
Delete these proposed regulations.

Discussion:
An expression of the need for a rule, no matter how compelling, cannot fill a gap in legal authority. State Compensation Insurance Fund v. WCAB (Sandhagen) *(2009), 73 CCC 981.*

None of the cited authority (Labor Code §§115, 133, and 5307) actually contemplates the creation of a new level of decisional authority. The Institute is unaware of a pressing need to highlight non-binding panel decisions of general interest. Indeed, the proposal to require a majority vote of the Commissioners prior to application of the designation of a case as "significant" begs the question of why the decision is not simply rendered en banc.

Despite the effort to emphasize the non-binding nature of these panel decisions, the few existing cases that have already received the "significant" designation are in practice treated as binding by both practitioners and judges alike. The Institute recommends that the confusion here is best avoided by the elimination of the designation, rather than its confirmation.

§10488 – Objection to Venue Based on an Attorney's Principal Place of Business Discussion:
The Institute supports this rule providing for an automatic change in venue under certain circumstances.

10540 Petition to Terminate Liability for Continuing Temporary Disability

Recommendation:
(a) A petition to terminate liability for temporary total disability indemnity under a findings and award, decision or order of the Workers' Compensation Appeals Board shall be filed ~~at least one week prior to termination of temporary disability within 10 days of the termination of payments or other compensation~~ and shall conform substantially to the form provided by the Appeals Board and shall include: […]

Discussion:
The proposed regulatory language results in a conflict with the enabling statute, Labor Code §4651.1. The statute provides that there is a rebuttable presumption that temporary disability continues for at least one week following the filing of a petition alleging that disability has decreased or terminated.

By this language, the statute contemplates that the presumption can be rebutted and that the week following the filing of a petition may be noncompensable. In contrast, the proposed rule requires payment of indemnity for the week following the filing of a petition and thus defeats the rebuttable nature of the statutory presumption.

The Institute recommends that the existing language be preserved. Under the statute, when a claims administrator receives evidence supporting termination of temporary disability status, payments may be appropriately discontinued <u>at that time</u> (inasmuch as the injured employee is no longer entitled to continuing temporary disability indemnity), subject only to the rebuttable presumption. The claims administrator's conduct is tempered by the existing requirement to file its petition within 10 days of termination of payments -- as well as other requirements of this section.

§10545 – Petition for Costs
Recommendation:
(g)(1) A petition for costs may be placed on calendar:
<u>(A) On the filing of a declaration of readiness by an employee, a dependent, or a defendant, or a</u> petitioning interpreter that lists the petition as an issue; or
<u>(B) On the Workers' Compensation Appeals Board's own motion.</u>
and

§10789 – Walk-Through Documents
~~(5) Petitions for Costs.~~

Discussion:
The proposed rules delete provisions requiring that a Petition for Costs be accompanied by a Declaration of Readiness, and instead allow these petitions to be dealt with on a walk-through basis. While the WCAB acknowledges that this is a "substantive" change, the Board fails to recognize the very serious dangers presented by the change.

Petitions for Costs, typically filed for interpreting services, have become a tremendous source of system abuse. The potential for abuse was supposed to be addressed by the implementation of a Fee Schedule, designed to eliminate manipulation and misapplication of the rules and leaving

any payment disputes up to the IBR process. Some service providers have taken advantage of the absence of regulation to overcharge for multiple hearings, depositions, and other non-medical events, or even duplication of services. (See, e.g., DWC NEWSLINE*, April 2, 2018, identifying a "reduction in double billing fees for multiple interpretations during the same time slot" as a primary basis for the proposed Fee Schedule.) Unfortunately, despite going through Forum Comments in 2015 and again in 2018, the Interpreter Fee Schedule has never been finalized for implementation.*

WCAB walkthrough procedures are by definition ex parte*, and are ordinarily reserved for non-controversial and undisputed pleadings. But by their very nature, Petitions for Costs are disputed and are entirely unsuitable for resolution on a walkthrough basis. Removing the due process protections provided by the requirement to file a DOR with an opportunity to be heard is misguided, and the requirement should be reinstated.*

§ 10547. Petition for Labor Code Section 5710 Attorney's Fees
Recommendation:
(d) A petition for attorney's fees ~~pursuant to Labor Code section 5710~~ shall not be filed or served until at least 30 days after a written demand ~~for the fees~~ has been served on the defendant(s)~~, stating with specificity the benefits sought under Labor Code section 5710~~. The petition shall append:[…]
~~(4) A verification.~~
(e) Failure to comply with subdivisions (c) and (d)(1)-(3)~~(4)~~ of this rule shall constitute a valid ground for dismissing the petition with prejudice.

Discussion:
Because of the varied nature of benefits in addition to attorney's fees available under Labor Code 5710 (e.g., expenses, wages, copy of transcript, interpreting services) and in light of the proposed availability of monetary sanctions, fees, and costs, it is appropriate to require a written request precisely specifying the benefits being sought. Subdivision (c) and (d)(4) appear to be duplicative, so a deletion of the latter is suggested. Adding consequences for the failure to abide by the rules will help to stem misuse of the proposed procedures.

The Institute applauds efforts to regulate procedures for obtaining fees under Labor Code §5710. Under Labor Code §5710(b)(4), a formal fee schedule for deposition fees was required by July 1, 2018. The Institute continues to await implementation of the formal rulemaking process on this issue, which will provide further context to the proposed procedures under §10547 (e.g., whether and under what circumstances reimbursement is required for attorney travel time).

§10555 – Petition for Credit
Recommendation:
(a) An employer shall not take a credit for any payments or overpayments of benefits pursuant to Labor Code section 4909 unless ~~ordered or awarded~~ approved by the Workers' Compensation Appeals Board. ~~A~~ If filed, a petition for credit shall include: […]

(b) An employer shall not take a credit for an employee's third party recovery pursuant to Labor Code section 3861 unless ~~ordered or awarded~~ approved by the Workers' Compensation Appeals Board. ~~A~~ If filed, a petition for credit shall include: […]

Discussion:
As a practical point, the Institute does not dispute the need for WCAB approval of a claimed credit, nor of the invalidity of a credit asserted unilaterally. However, the mandating of a formal Petition and corresponding formal adjudication is completely unnecessary and frankly unworkable.

(3) *It is not unusual for the employer and/or injured worker to initially provide the claims administrator with an incorrect wage statement, resulting in TD overpayments for a period of time.*
(4) *Frequently, MMI examinations are conducted while TD is being paid and the permanent and stationary reports are received weeks later, resulting in TD overpayments for a period of time and/or support an adjustment to the PD benefit rate.*

The vast majority of claimed credits arise from incidents like these. The routine and informal adjustment of benefit overpayments has not historically required routine judicial intervention, but it is readily available when it is needed. Informal resolution of these credits should be encouraged, requiring only WCAB approval of a negotiated settlement but without a requirement for a formal Petition and adjudication. The regulation as proposed will unnecssarily burden both claims administrators and District Offices.

However, the Institute has concerns that any proposal here is invalid ab initio*:*

> *[N]o regulation adopted is valid or effective unless consistent and not in conflict with the statute. Therefore, it has been said that when a statute confers upon a state agency the authority to adopt regulations, the agency's regulations must be consistent, not in conflict with the statute and that a regulation that is inconsistent with the statute it seeks to implement is invalid. No matter how altruistic its motives, an administrative agency has no discretion to promulgate a regulation that is inconsistent with the governing statutes.* Mendoza v. WCAB (2010) 75 CCC 634, 640 (WCAB en banc) (internal citations and quotations omitted).

There is nothing in Labor Code §4909 that supports the proposition that all claimed benefit overpayments must be formally adjudicated by the WCAB. The Board has no authority to implement proposed rule 10498 and the proposed rule should be deleted accordingly.

10600 –Time for Actions
Discussion:
The new provision regarding computation time (and excluding Saturdays and Sundays) applies only to Filing and Service of Documents pursuant to Article 9. The Institute's primary concern over computation of time relates to Labor Code §4610(i)(1) ("five working days"), the conflict with 8 CCR §9792.9.1(c)(3) ("five business days"), and the incongruous interpretation outlined

in Calif. Dept. of Corrections v. WCAB (Gomez) *(2017) 2017 Cal. Wrk. Comp. P.D. LEXIS 514 (writ denied) (holding that the day after Thanksgiving is a "working day" for purposes of calculating timeliness of UR determination, utilizing analysis equally applicable to all Saturdays).*

The Institute believes that the WCAB should take this opportunity to affirmatively define (in all contexts) both "business day" and "working day" as any day other than a Saturday, a Sunday, a day declared by the Governor to be an official State holiday, or a day listed at Calhr.ca.gov.

§10620 – Filing Proposed Exhibits
Recommendation:
Delete this proposed regulation.

Discussion:
Current rules require that all trial exhibits must be listed on the pre-trial conference statement, but only certain relevant medical reports need to be filed in advance of trial. "No other…documents shall be filed" prior to trial, unless ordered by the WCJ. 8 CCR §10393(b)(1). Instead, all other documents "shall be filed at the time of trial." 8 CCR §10393(c)(3).

In stark contrast to existing rules, the proposed rule requires the advance filing of all documents to be offered at trial. Even in a case of ordinary complexity, this would likely encompass numerous documents including a claim form, wage statement, denial letter, benefit notice(s), benefit printout, QME waiver, notice of offer of regular/modified work, job description, ergonomic reports, treatment reports, correspondence, and excerpts from subpoenaed records. More complicated cases such as those involving death claims or affirmative defenses -- i.e., cases even more likely to proceed to trial -- would include an exponentially greater number of submitted trial exhibits.

The burden on the parties and the District Offices far outweighs the suggestion in the Author's Comment of a benefit in enabling WCJs to review proposed exhibits prior to trial; indeed, as laudable as that goal might be, the workload of most WCJs simply precludes this level of advance preparation. Under the circumstances, it is actually the proposed rule that is "impractical and wasteful of existing resources" as suggested by the Author's Comment. The Institute suggests that the process contemplated by proposed rule 10787(b) is adequate and appropriate to address trial exhibits.

§10629 – Designated Service
Recommendations:
~~(c) Within 10 days from the date on which designated service is ordered, the person designated to make service shall serve the document and shall file the proof of service.~~

Discussion:
A requirement for the Appeals Board's designee to not only serve the document but also file the proof of service with the Workers' Compensation Appeals Board doubles the administrative burden; the additional 10-day deadline not only for service but also for filing renders this rule practically unworkable. A better solution, while still accomplishing the desired result, would be

to require service within 10 days, with the party ordered to maintain the original proof of service until and unless ordered to file it at the Workers' Compensation Appeals Board -- if and when a dispute arises.

§10670 – Documentary Evidence
Recommendation:
(a)(2) Any document not served prior to or at the time of the mandatory settlement conference, unless good cause is shown.

Discussion:
Labor Code §5502(d)(3) provides that discovery shall close on the date of the mandatory settlement conference, and that evidence not disclosed or obtained "thereafter" is inadmissible. There is no requirement in the statute that evidentiary documentation must be served "prior to" the mandatory settlement conference. The recommended language allows parties to exchange documentation up to and including the time of the MSC, in accordance with both the statutory language and standard practice.

§10700 – Approval of Settlements
Recommendation:
(c) Agreements that provide for the payment of less than the full amount of compensation due or to become due and undertake to release the employer from all future liability will be approved only where it appears that a reasonable doubt exists as to the rights of the parties or that approval is in the best interest of the parties. No agreement shall relieve an employer of liability for provision of supplemental job displacement benefits unless the Workers' Compensation Appeals Board makes a finding that there is a good faith issue which, if resolved against the injured employee, would defeat the employee's right to all workers' compensation benefits.

Discussion:
The Institute supports regulatory sanction of the rule announced in Beltran v. Structural Steel Fabricators, 2016 Cal. Wrk. Comp. P.D. LEXIS 366, wherein it was held that the prohibition on settlement of Supplemental Job Displacement Benefit voucher in Labor Code §4658.7(g) is analogous to settlement of vocational rehabilitation benefits, and that where parties establish that there is good faith dispute which, if resolved against injured worker, would defeat injured worker's entitlement to all workers' compensation benefits, the injured worker may settle potential right to Supplemental Job Displacement Benefit voucher by way of Compromise and Release.

§10752 – Appearances Required

Recommendation:
(c) A~~n represented~~ injured employee or dependent shall personally appear at any mandatory settlement conference. Upon failure of the injured employee or dependent to appear at a mandatory settlement conference, the Workers' Compensation Appeals Board may, on its own motion or upon the filing of a petition pursuant to rule 10510, order payment of reasonable expenses, including attorney's fees and costs and, in addition, sanctions as provided in Labor Code section 5813. Before such an order is issued, the alleged offending party or attorney must

be given notice and an opportunity to be heard. Failure to appear shall not alone be a basis for dismissal of the application.

Discussion:
The Institute believes that the purpose of the mandatory settlement conference is best fulfilled by having all signatories to a settlement present at the time of the hearing. A requirement that all parties have settlement authority is valid, but a settlement does not actually occur without parties being physically present and ready to sign a settlement document. Accordingly, attendance must be mandatory regardless of representation status, and absence strongly disincentivized.

§10786 – Determination of Medical-Legal Expense Dispute
Recommendation:
(a) ~~Within 60 days of service of a medical-legal provider objection to a denial of a portion of the medical-legal provider's billing pursuant to Labor Code section 4622(c), the defendant shall file a Declaration of Readiness to Proceed to a status conference. Upon filing of a Declaration of Readiness to Proceed, the medical-legal provider shall be added to the official address record.~~

~~(b) A medical-legal provider may file a petition for reimbursement of medical-legal expenses where a defendant has failed to timely object to a medical-legal expense pursuant to Labor Code section 4622 or 60 days have elapsed from a provider objection pursuant to Labor Code section 4622(c) and the defendant has not filed a Declaration of Readiness to Proceed to a status conference.~~ Upon the filing of a petition for reimbursement of medical-legal expenses pursuant to Labor Code section 4622(c),~~:~~

~~(1) T~~the medical-legal provider shall be added to the official address record.
~~(2) The defendant shall either pay the expenses and file proof of payment or file a Declaration of Readiness to Proceed to a status conference.~~
(~~c~~b) ~~Notwithstanding the filing of a Declaration of Readiness to Proceed in accordance with the provisions of subdivisions (a) and (b) of this rule, the~~ The Workers' Compensation Appeals Board may defer hearing and determining this issue until the underlying claim of the employee or dependent has been resolved or has been abandoned.
(~~d~~c) The employer and the medical-legal provider are required to appear at the status conference. If the matter is not resolved at the status conference, the matter may be set for a mandatory settlement conference on the medical-legal expense dispute.

Discussion:
The Author's Comment accompanying this proposal is confusing. The Author's Comment suggests that the proposed revisions are simply a reorganization of existing Rule 10451.1, with additional language to require an employer to file a DOR in the event of a dispute. But existing Rule 10451.1(c)(2) does require an employer to file a DOR in the event of a dispute. More importantly, however, much of the proposed rule is already covered by Labor Code section 4622(c) and should be deleted here.

The proposed rule is not entirely consistent with the Labor Code §4622(c), which requires the defendant to file both a Petition and a DOR within 60 days of the objection but does not require

the defendant to pay the expense. If the intent of the proposed rule is to allow the defendant to issue payment instead of filing the DOR, it would appear that the proposed rule may not be authorized by the statute.

§10788 – Petition for Automatic Reassignment
Recommendation:
(a) An injured worker shall be entitled to one reassignment of a judge for trial or expedited hearing. If the injured worker has not exercised the right to automatic reassignment and one or more lien claimants have become parties and no testimony has been taken, the lien claimants shall be entitled to one reassignment of judge for a trial, which may be exercised by any of them. The defendants shall be entitled to one reassignment of judge for a trial or expedited hearing, which may be exercised by any of them. ~~The lien claimants shall be entitled to one reassignment of judge for a lien trial, which may be exercised by any of them.~~ This rule is not applicable to conference hearings. In no event shall any motion or petition for reassignment be entertained after the swearing of the first witness at a trial or expedited hearing.

Discussion:
Current rule 8 CCR §10453 allows a lien claimant to petition only if the injured worker has not petitioned. The proposed rule expands the ability of a lien claimant to petition for automatic reassignment. No clear explanation has been provided why a lien claimant should be able to independently disrupt a trial assignment, particularly where the trial judge has already adjudicated the underlying injury and/or approved a settlement of the case-in-chief. The lien claimant's rights are still derivative of the injured workers. [See: Barri v. Workers' Compensation Appeals Board (2018), 28 Cal.App.5th 428] The Institute recommends that the original practice be preserved.

§10790 – Interpreters
Discussion:
In the continuing absence of an Interpreter Fee Schedule, the Institute fears that deletion of the only regulatory guideline for payment of interpreter services is dangerous. We suggest that, at a minimum, language be retained providing that only those fees that are reasonably, actually, and necessarily incurred are reimbursable, with the burden on the provider to demonstrate those facts. A sunset provision could be included to account for the Fee Schedule when it is finalized.

§10832 – Notices of Intention and Orders after Notices of Intention
Recommendations:
(c) If an objection is filed within the time provided, the Workers' Compensation Appeals Board, in its discretion may:
(1) Sustain the objection;
(2) ~~Issue an order consistent with the notice of intention together with an opinion on decision; or~~
~~(3)~~ Set the matter for hearing.

Discussion:
The dual purposes of the due process requirements for notice and opportunity to be heard would be effectively thwarted if an order were permitted to be issued without a hearing. Additionally,

requiring that a hearing be held before an objection is overruled helps to ensure that a properly filed objection is actually seen and considered by the judge prior to rendering a decision.

§10940(a) – Filing and Service of Petitions for Reconsideration, Removal, Disqualification and Answers
Recommendations:
Petitions for reconsideration, removal, or disqualification and answers shall be filed in EAMS, ~~with any district office of the Workers' Compensation Appeals Board,~~ or with the district office having venue in accordance with Labor Code section 5501.5 unless otherwise provided. Petitions for reconsideration of decisions after reconsideration of the Appeals Board shall be filed with the office of the Appeals Board. Petitions filed in EAMS pursuant to this rule must comply with rules 10205.10-10205.14.

Discussion:
One of the promised benefits of the Electronic Adjudication Management System was that it would streamline and simplify filing requirements. While much of EAMS has delivered less than promised, the provision permitting appeals to be filed at any District Office has actually proven useful and convenient to parties who are already constrained by strict time deadlines. The provision should be restored.

§10995(b) – Reconsideration of Arbitrator's Decisions or Awards
Recommendations:
(b) A petition for reconsideration from any final order, decision or award filed by an arbitrator under the mandatory or voluntary arbitration provisions of Labor Code sections 5270 through 5275, and any answer, shall be filed in EAMS or with ~~the any district office having venue in accordance with Labor Code section 5501.5.~~ No duplicate copies of petitions shall filed with any other district office or with the Appeals Board.

Discussion:
One of the promised benefits of the Electronic Adjudication Management System was that it would streamline and simplify filing requirements. While much of EAMS has delivered less than promised, the provision permitting appeals to be filed at any District Office has actually proven useful and convenient to parties who are already constrained by strict time deadlines. The provision should be restored.

June 27, 2019
Henry Bruce, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly

increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.
The following terms should be preserved:

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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB address the specific issue. This “solution” is not a solution.

June 27, 2019
Adam Brooks

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This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

June 27, 2019
Comfort Zone Dental

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June 27, 2019
Meera Jani, DC

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June 27, 2019
Paul J. Marsh, DC
Arrowhead Evaluation Services, Inc.

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June 27, 2019
Jill Torres, Ph.D.

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June 27, 2019
James T. Plato, MPH DC

Regarding the DWC's proposed rule change that would prevent QMEs from filing ‘Petitions For The Determination Of Cost’ with the WCAB, such a change would have a devastating impact on QMEs and would only serve to put additional downward pressure on QME availability. It would only serve to incentivize more doctors from participating in the QME system and would continue to provide yet another reason for existing QMEs to withdraw from the system altogether.

As is stands, QMEs have little recourse to secure payment for their med-legal work in the face of frequent inappropriate disallowances, fee reductions and, not infrequently, blatant delays in payment beyond the the 60 days stipulated under LC4622. Yet the QME remains legally bound to continue providing re-evaluations, supplemental reports and deposition appearances in cases where such unjustified non-payments have occurred and remain unresolved. And now, if this proposed rule change is implemented, QMEs will have little to no recourse to have such disputes heard in a timely and effective manner, with the claims administrators being relieved of any threat of financial sanctions for ‘bad faith’, as is currently provided for under the Petition process.

Furthermore, this proposed rule change will in effect diminish insurance carriers' incentive and motivation to follow the current mandate under LC4622 with regard to both providing specific written objection or to comply with the 60 day time-frame for the payment of medical-legal expenses…a problem that QMEs face and must deal with on a routine basis with little if any help or support from the DWC.

Additionally, (and very importantly), this proposed rule change would be in direct violation of the 1976 ruling by the chairman of the WCAB and the DWC Admin. Dir., as follows:

In may of 1976, the Chairman of the Appeals Board and the Administrative Director jointly issued Policy & Procedure Manual Index No. 6.6.10, which made it clear that it is the policy of the Appeals Board that payment of medical-legal costs was not to wait for resolution of all issues and that upon a proper showing the appropriate order was to be issued by the workers' compensation judge. Additionally, "The Uniform Lien Procedures, Policy & Procedure Manual Index Number 6.8.1.1, effective 12/18/95, specifically cited Index No. 6.6.10 and stated that the Uniform Lien Procedures would not supersede that 1976 policy. The policy set forth in Index 6.6.10 remains in effect…" In other words, given that Labor Code Section 4625(a) says, in pertinent part: "All charges for medical legal expenses for which the employer is liable that are not in excess of those set forth in the Official Medical Legal Fee Schedule ... shall be paid promptly pursuant to Section 4622", disputes involving payment of a valid medical-legal expenses need not wait for the case-in-chief to be settled before resolution of same.

If anything, it would behoove both the DWC's QME system and existing pressure on the WCAB to resolve such med-legal payment disputes to set up a hearing system within the WCAB dedicated solely & exclusively to the hearing of such Petitions. And, if filed properly with adequate documentation, such Petitions, (as I have experienced myself), can frequently be resolved with a written order from the administrative hearing judge without actually scheduling a hearing when violations have been blatant and well documented.

It remains extremely puzzling and inexplicable why a medical-legal process that the Workers' Compensation system depends upon to resolve disputes between the parties in a timely manner in order to expedite and resolve claims would further burden and frustrate this process with a rule change that would further dis-incentivize QMEs from participation.

As the DWC is well aware, QMEs are already under significant scrutiny with regard to their reports and med-legal billing content, with review process consequences that have a serious and significant negative impact on QMEs whether ultimately exonerated of accusations by the claims administrators or not. But no where have we seen any attempt or proposed changes by the DWC that would compel claims administrators to follow the letter-of-the-law under LC4622, with seldom enforced consequences if they do not.

June 27, 2019
Jeffrey Hiner, DC

Hi, can you please not change the QME medical billing procedures. It is already difficult to get paid for reports by insurance companies that we have spent considerable amounts of time on.

June 27, 2019
Sandra Karlic Hiner, DC

Please don't change the QME medical billing procedures. It is already hard enough to get paid for reports by insurance companies that we have spent hours and hours on.

June 27, 2019
Carrie L. Forrest, Ph.D.

My name is Carrie L. Forrest , and I am a QME. I am writing to let you know I am strongly opposed to the proposed changes to Regulation 10451.1. These changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief. Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME.

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- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

Thank you for your consideration of these important issues.

June 27, 2019
Paul Aubin

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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If there is a specific issue affecting the WCAB with petitions for medical-legal costs then changes should be proposed that address that specific issue. This proposed “solution” represents sweeping changes with one apparent goal in mind: to further erode the QME's already flimsy ability to compel full and timely payment on a totally proper medical-legal bill. This is just the latest in a long line of recent changes to the CA WC system designed to benefit insurance companies and further weaken the injured workers leverage in their attempts to ensure a fair resolution to their case.

June 27, 2019
Norman Reichwald

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would create an unreasonable and and undue financial burden to the QME doctors who are wrongly denied payment. This diminishes the accountability of payers to comply with regulations and therefore promotes incentives for payers to underpay or deny payment for irrelevant reasons such as "Provider is not in MPN" or "Claim is denied" which do not apply to QME and AME bills.

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June 27, 2019
Michael Blott, DC

I am a QME and an instructor of QME courses.
It should be no surprise that the numbers of QMEs are falling.
I would have left long ago if I did not enjoy the niche way of helping injured workers.
Non-IBR petitions have been helpful but in every case of bringing one before the WCAB, I had to educate the Judge that was not aware of how a QME can use one. Hopefully that has changed since it has been approximately a year since my last hearing. (I represent myself to assist my knowledge in teaching my students) Of the over a dozen I have filed, never once did the carrier file a DOR on my objection of non payment.

In most of the cases that were the cause of my filing a Non-IBR Petition was failure to pay anything with out explanation. I would be interested in the investigation rate of the DEU audit unit regarding QME non-payment. (I have filed numerous referrals)

The proposed changes in the regulations holds onto the failed part of the last changes (carrier is to file DOR which they are never held accountable for not doing) and take away the good part (settling the QME denial prior to the end of case in chief)

June 27, 2019
Vahe Sukiasyan, Psy.D.

My name is Dr. Vahe Sukiasyan, Psy, D, QME. I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

June 27, 2019
Raul Marco

Please help the injured worker in getting what they deserve and need to get back to work. Stop insurance companies telling doctors what should do???????

June 26, 2019
Daniel Dunkelman, FACS

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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June 26, 2019
Jeffrey A. Hirsch, MD

Thank you for allowing me to comment on proposed changes.

I can tell you that after nearly 20 years as a QME in California, practicing medicine aimed at treating injured workers
and writing the associated reports has grown more and more difficult.

My staff has faced increasingly insurmountable obstacles in obtaining timely payment on far too many cases.

Rule changes making it more difficult for medical providers to obtain payments and address disputes will further impede
adequate medical care for injured workers. Cases, already moving too slowly, will slow down further.

My experience with many payors leads me to believe that many will take advantage of these rule changes (for instance compelling
QME's to wait for the case to be closed prior to seeking payment) to place more adverse financial pressure on physicians practicing in
this community.

Please do not make it yet more difficult for injured workers to obtain their benefits, in this case by placing more negative pressure on doctors and
other providers.

June 26, 2019
Kevin Li, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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June 26, 2019
Kari Tervo, Ph.D.

I have been a QME psychologist since 2014, and I am writing in opposition to the newly-proposed payment schedule changes.

The proposed changes (among others) eliminate the option to protest bill-pay refusals until the case settles--which could take years.

Are you trying to destroy any motivation for QME doctors to want to continue to perform QME evaluations?

What practitioner would shrug and say, "Okay, maybe I won't get paid for years then, if at all--let me go ahead and dedicate a significant portion of my schedule to doing QME evaluations." Not one! Just like everyone, doctors perform work for pay, and we reasonably have certain expectations about when, if, and how much we will be paid.

All this change does is motivate insurance companies to deny QME bills and to discourage qualified experts from wanting to sign up to assist with the important services that the DWC offers.

I understand that as a neutral state administrative agency, you must take into account the concerns of insurance companies. But, betraying any idea of neutrality or concern for applicants, this proposed change doesn't take into account the concerns of injured workers at all. If qualified practitioners won't sign up for work for which insurance companies would be highly-motivated to reject the billing, then injured workers will lose out on the evaluations they need.

Injured workers **and** insurance companies need neutral QME doctors to evaluate injury claims. And just like everyone else, QME doctors work for pay and need to have a reasonable expectation of when, if, and how much they will be paid. Please reject these changes--they're completely unrealistic.

June 26, 2019
Shawn Uraine, MD

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is

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Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME.

I will not be renewing my QME license next month.

June 26, 2019
David Rose, DC

It seems inherently incorrect to not have a judge decide on a QME bill. If there is no official forum for dispute resolution on a bill it will allow insurance companies to ride roughshod over the QME because they know the case has be settled first before the bill can be considered.The new proposed QME rule change will cause more qualified legitimate good QME's to exit the system.

June 26, 2019
Gennady Kolodenker, DPM

I am a QME and I am strongly opposed to the proposed changes to Regulation 10451.1. The proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as “Provider not in MPN” or “Claim is denied.” The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.
Further, this change would certainly result in more doctors leaving the QME system and discourage doctors from becoming QME. QME headcount is currently at an all-time low and continues to plummet. The system cannot afford to lose more QMEs and this misguided change to the regulations would worsen the unprecedented shortage of QMEs today.

The following terms should be preserved:

- Medical-Legal Providers should be allowed to file a DOR
- Defendants should be obligated to issue an EOR compliant with LC 4603.3.
- The WCAB can only defer the hearing when there is a threshold issue that would legally defeat the entire claim.
- A list of "Bad Faith" tactics should be in the regulation, including, but not limited to: failing to pay any uncontested portion of a bill; failing to make a good faith effort to

timely comply with applicable statutory or regulatory medical-legal timelines or procedures; contesting liability for the medical-legal provider's billing based on a dispute over injury, or injury to a particular body part, lack of authorization or not being in the MPN; or other reasons that are inapplicable to medical-legal evaluations.
- Providing a mechanism for determining the value of the bill - whether the judge decides or it goes to IBR.
- Rule indicating the medical-legal providers do not have to file a lien when there is a dispute.

This seems to be a solution in search of a problem. If there is a specific issue affecting the WCAB now with petitions for medical-legal costs then I recommend that the WCAB sharpen their pencil and address the specific issue. This “solution” is throwing the baby out with the bath water.

June 26, 2019
Kevin Deitel, MD

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Padra Gad Nourpavar, DO

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June 26, 2019
Joshua Kirz, Ph.D.

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June 26, 2019
Charles McDaniel, MD

I am a QME and I am opposed to the proposed changes to Regulation 10451.1.
Again the WCAB proposes changes that are not impartial, are biased against the worker, and preference the insurance companies by incentivizing the insurance company to prolong and delay resolution of claims.

As well, WCAB again undermines the QME’s that provide service to the WCAB by removing examples of insurer bad-faith in payment of billing.

If the WCAB continues to erode the Workers Compensation system by fostering a system that is hostile to the QME's then the outcome will be QME's that decline to renew, and a decline in the qualifications and quality of physicians who are willing to apply to be QME's.

More specifically, the proposed changes would take away my right to be heard on a non-IBR petition prior to resolution of the case in chief if the defense elects not to file a Declaration of Readiness to proceed. Such a change would embolden payors to underpay or deny medical-legal bills, a practice which is already rampant and unchecked. Carriers routinely deny legitimate QME and AME bills for bogus reasons such as "Provider not in MPN" or "Claim is denied." The only recourse providers have now is to file a non-IBR petition and DOR. Such bad-faith denials would undoubtedly increase if providers are robbed of their current right to be heard prior to resolution of the case in chief.

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This is obviously the WCAB pandering to special interests from the insurance company instead of remaining impartial.

June 26, 2019
John M. Warrington, Ph.D.

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Yehuda Gertel

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June 26, 2019
Arsalan Malik, MD

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June 26, 2019
Tigran Garabekyan, MD

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