The California Commission on Health and Safety and Workers' Compensation

RECOMMENDATIONS FOR IMPROVEMENT OF THE IMC's PROTECTION OF INJURED WORKERS AND REGULATION OF QMES

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Background.

The Legislature created the Industrial Medical Council in 1989, as part of a broad effort to contain rapidly rising medical-legal costs by limiting the number of medical-legal reports per case, establishing a medical-legal fee schedule, and by regulating the physicians who perform medical-legal evaluations. The IMC's principal mission is to certify, appoint, and regulate the work of Qualified Medical Examiners [QMEs] who, with some exceptions, are the only physicians other than treating doctors who are legally authorized to produce medical-legal reports admissible before the WCAB. These responsibilities require the IMC to act as a consumer protection agency for injured workers who are examined by QMEs.

The IMC plays an especially critical role in cases involving unrepresented applicants. When either party objects to findings of the primary treating physician, the injured worker must choose a QME from a three-member panel randomly generated by the IMC. No other medical-legal reports may be obtained in such cases.[1] In 2002, there were about 27,900 QME panels. There are currently 4,462 QMEs.

CHSWC Involvement

Sherry Smith, an injured worker and member of SEIU Local 707, became aware of the IMC's disciplinary role as part of her own case.

[1] For injuries on and after January 1, 2003, an unrepresented employee who retains an attorney after the panel QME examination is entitled to obtain the same medical-legal reports as an employee who had been represented before the dispute leading to the panel QME selection arose.

When she came to believe that QMEs whose licenses had been suspended or terminated by their licensing boards were still listed as QMEs, she began to research the issue further. She eventually made contact with the IMC staff and filed a Public Records Act request. Because she was dissatisfied by the response she received, Ms. Smith took the issue to her Union local. On July 30, 2001, John Morrison, the Local 707 President, sent the outline of a legislative proposal to Commissioner Allen Davenport.

Mr. Davenport brought the issue to the attention of the Commission in late 2001. Commission staff met with members of the IMC staff to gather information about its complaint-handling and disciplinary functions. At the February 2002, CHSWC meeting, the Commission decided to invite IMC staff to appear at the April meeting. Dr. Anne Searcy and David Kizer, then the staff attorney in charge of discipline matters, explained the IMC disciplinary process at the April meeting.

Ms. Smith and Chip Atkin addressed the Commission at its meeting of December 13, 2002. Dr. Susan McKenzie, the IMC Executive Director, and James Fisher, an IMC staff attorney, appeared on behalf of the IMC. The Commission directed staff to meet with Ms. Smith and IMC staff, and to report back with analysis and recommendations, pursuant to the Commission's mandate to conduct a continuing examination of the workers' compensation system and to make recommendations for administrative or legislative modifications which would improve the operation of the system. [Labor Code §77(a)].

In January 2003, CHSWC staff met with Mr. Fisher and Richard Starkeson, the IMC Counsel. On February 5, 2003, Dr. Searcy, Mr. Fisher, and CHSWC staff met with Ms. Smith and other members of Local 707 in Santa Rosa. The IMC staff has been very forthcoming in providing information. The meetings have been very constructive and have led to a better understanding of areas which could lead to an improvement in the IMC's protection of, and communication with, injured workers. While the IMC staff has been informed of our general recommendations, it is understood by all parties that only the IMC itself can make policy in these areas.

In formulating our recommendations, we have looked at the IMC primarily in its role as a consumer protection agency. We have organized our discussion under the general headings of discipline,

disclosure, quality control and assurance, and governance, although there is considerable overlap among these categories.

I. DISCIPLINE.

The IMC exercises its disciplinary authority over QMEs in four different contexts:

A. Where the physician's license has been terminated or suspended by the relevant licensing authority so as to preclude practice.

In this situation, the IMC must terminate from the QME list any physician whose license has been terminated. It must suspend the physician's privilege to serve as a QME when his or her license has been suspended by the relevant licensing authority. The IMC may take these actions without a hearing, pursuant to Labor Code section 139.2(k). The IMC is currently considering a change in its procedures in these cases to delegate authority to its Executive Director. Because time is of the essence in these most serious cases, this proposed change is an encouraging development.

B. Where the physician has been suspended or placed on probation by the relevant licensing authority.

In this situation, the IMC must file an accusation and provide the QME with an opportunity for a hearing, pursuant to section 139.2(l). However, subsection (m) provides that the IMC "shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board." While the IMC has some discretion to frame an appropriate remedy for the doctor's misconduct, it must, at a minimum, issue a suspension.[2]

C. Where the physician has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice, or of a crime of moral turpitude.

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[2] The IMC interprets section 139.2(m) as allowing it somewhat greater discretion than outlined in the text. The IMC probably does have discretion, as indicated in its Sanctions Guidelines, to place a QME on probation in these circumstances. In practice, it does not appear that the IMC ever imposes a lesser penalty than the licensing board.

In this situation, the IMC must terminate the physician from the QME list. Of course, the QME's license will probably also be revoked or terminated by the licensing board.

D. Where the physician has violated the IMC statute or regulations, as provided in section 139.2(k).

In these situations, the IMC has broad discretion with respect to the nature of the penalty: termination, suspension, or probation, and the conditions imposed with respect to probation or suspension. Any IMC action must adhere to the due process requirements in subsection (l) and the IMC sanction guidelines [8 CCR 65].

RECOMMENDATIONS:

The highest priority should be given to formalizing the relationship between the IMC and the licensing boards.[3] Although the IMC has been in existence since 1990, it still has no written agreement with the licensing boards concerning notification of disciplinary investigations and findings, and the sharing of relevant information. Communications between the IMC and the licensing boards appear to be ad hoc, informal, and dependent upon personal relationships. There is little institutional memory. Labor Code section 139.2 (l) mandates the IMC to report to the relevant licensing authority the name of any QME disciplined by it, but there is no corresponding statutory duty for the licensing boards to report to the IMC, even though the historical record strongly suggests that the vast majority of IMC disciplinary actions followed licensing board decisions.

Any agreement should call for immediate notification by the licensing board to the QME of filing of accusations and disciplinary actions. In addition, the IMC should formalize its ability to inspect and make copies of the central files of QMEs, pursuant to the provisions of Business and Professions Code section 800(c). The agreement should provide for cooperation between the licensing board and IMC staffs on disciplinary

[3] The IMC certifies QMEs licensed by the Medical Board of California, the Board of Chiropractic Examiners, the Board of Podiatric Medicine, the Osteopathic Medical Board, the State Board of Optometry, the Dental Board of California, and the Board of Psychology. With the exception of the Board of Chiropractic Examiners, all of these agencies operate under the umbrella of the Department of Consumer Affairs.

and disclosure matters. It should be noted that the IMC has referred some complaints against QMEs to the licensing boards.[4]

As a result of increasing public attention to physician discipline issues, the Medical Board's Discipline Coordination Unit has recently begun posting a monthly disciplinary "hotsheet" on its website.[5] The hotsheet includes all disciplinary decisions, recent accusations and voluntary resignations for M.D.s, podiatrists, psychologists, physician assistants and physical therapists. The IMC should emulate the Medical Board and issue its own disciplinary "hotsheet" for QMEs and post it prominently on its web site.

The IMC should act within 30 days of notification of licensing board terminations and suspensions to terminate or suspend QME status, without a hearing, where permitted, or to file accusations where a hearing is necessary.

With respect to its own disciplinary investigations and procedures, the IMC should post a complaint form on its internet web site. The IMC's statistical reporting of complaints and responsive actions needs to be improved. The current reporting gives almost no information or detail about the nature and category of complaints, the numbers of doctors receiving multiple complaints, or the nature of the "resolution" of complaints. The IMC should issue an annual report concerning the work of its disciplinary unit. Although the IMC is not staffed to conduct extensive disciplinary investigations, it does have a responsibility to exercise its disciplinary authority where QMEs have failed to comply with its rules concerning face-to-face time, evaluation guidelines, and statutory deadlines. It appears that the IMC has rarely, if ever, taken action against QMEs for these kinds of violations. This issue will be discussed further in the Quality Assurance and Control section.

II. DISCLOSURE.

Ms. Smith and her colleagues have questioned the adequacy of the IMC's disclosure of disciplinary information about QMEs. These

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[4] According to statistics supplied by the IMC, there have been 63 such referrals since 1997.

[5] The January 2003 issue is at http://www.medbd.ca.gov/01-03hotsheet.pdf.

questions mirror a debate about the appropriate level of disclosure by the Medical Board of California and other licensing authorities of information about discipline, criminal convictions, loss of hospital staff privileges and malpractice awards and settlements. Fortunately, the Legislature last year settled most of these issues in SB 1950 (Figueroa) (Chapter 1085 of the Statutes of 2002).

SB 1950 contains detailed provisions concerning the nature and extent of disclosure of information by the licensing boards, as well as the means of disclosure, and the length of time that various disciplinary actions must continue to be disclosed. (Business & Professions Code sections 803.1 and 2027.) Because most IMC discipline is secondary to disciplinary action taken by the licensing boards, it would constitute an unnecessary duplication of effort to require the IMC to post on its web site the same information that the licensing boards are required to post. The IMC does provide links to the search engines of all of the relevant licensing boards. The disclosure provisions of SB 1950 should also govern the IMC's policies on disclosure of information relating to disciplinary activities it initiates independent of the licensing boards.

With respect to unrepresented injured workers, simply posting information on a web site is obviously an insufficient method of disclosure. Understanding this, the IMC places an asterisk next to the name of any QME selected for a three-member panel who is on probation. The injured worker may request a new panel if he or she objects to the inclusion of the disciplined QME on the panel.

RECOMMENDATIONS:

For unrepresented injured workers, the QME process is yet another confusing part of the overly complex workers' compensation system. These injured workers often have no idea why they are being asked to select a doctor from a list of three names. They do not know the purpose of the examination, how to go about making an informed choice, what to expect from the doctor, what their rights are at the exam, if they object to the eventual report or rating, or how to find out more about the process.

We recommend that the IMC, in conjunction with DWC, develop a brief, easy-to-understand, pamphlet to be sent to unrepresented injured workers in the same envelope as the QME panel letter. The pamphlet should be similar in tone and presentation to the injured worker guides

previously developed by CHSWC. The pamphlet should, at a minimum, give an overview of the QME process; explain the reason(s) for the exam; provide phone numbers and internet addresses for obtaining additional information about the physicians and procedures; information about the QME's obligations, including maximum waiting times and minimum face-to face times; the right to have a friend or relative present at the exam; the right to consult with an I&A officer or an attorney; and the deadlines for submission of the report and making objections.

III. QUALITY ASSURANCE AND CONTROL.

Many of the concerns raised by Ms. Smith and her colleagues are really matters relating to the demeanor of QMEs during the examination, the quality and thoroughness of their reports, and their objectivity (or lack of objectivity). While the IMC has ample statutory and regulatory authority to monitor and regulate quality issues, it often must rely on people -- workers' compensation judges, in particular -- and agencies, such as the WCAB and the DWC Administrative Director, who are beyond its control.

Labor Code section 139.2(d)(2) provides that the IMC shall not reappoint a QME who has had more than five of his or her reports rejected, for failing to meet minimum standards established by the IMC or the WCAB, by a WCJ within a two-year period. No QME has ever had five reports rejected under this section. In fact, there are no reported cases arising under this provision, and the most senior attorneys at the WCAB report that they have never seen any such cases on reconsideration. For various reasons, this section has become a virtual dead letter. First, a WCJ can reject a report only if it is considered at a contested hearing. Only a small percentage of cases reach a contested hearing. Most are settled through a stipulated award or a compromise and release. The quality of the respective QME reports is an important settlement consideration. An attorney will not want to go trial if he must rely on a report that does not meet minimum standards. As a result, the really poor reports will rarely be considered by a WCJ at trial. Furthermore, judges are focused on deciding the issues framed by the parties. They will generally explain why they find one report to be superior to another, but will rarely think about explicitly rejecting a report for failing to meet minimum standards. While it would be useful

to remind WCJs of the provisions of section 139.2(d)(2), it cannot realistically be expected to be a significant source of QME quality assurance.

Labor Code section 4068(a) requires the WCAB to notify the Administrative Director when it determines that a treating physician's report "contains opinions that are the result of conjecture, are not supported by adequate evidence, or that indicate bias." According to the WCAB, no such determination has ever been made. Subsection (b) provides that if the Administrative Director "believes that any treating physician's reports show a pattern of unsupported opinions, he or she shall notify in writing the physician's applicable licensing body of his findings. If the treating physician is a medical evaluator, the administrative director shall also notify the Industrial Medical Council." It appears that this section has never been used by the WCAB or the Administrative Director. Nonetheless, the existence of the section demonstrates a Legislative interest in assuring the quality of medical reports used in the workers' compensation system.

The IMC has developed extensive sanction guidelines. [8 CCR 65.] They include provisions for discipline of QMEs who fail to comply with the Council's evaluation guidelines, face-to-face time standards, reporting deadlines, and other statutory and regulatory provisions. Labor Code section 139.2(k) vests the IMC with broad authority to impose discipline on QMEs who have violated any material statutory or administrative duty. More specifically, the statute permits the IMC to impose discipline for failing to comply with timeframe standards or the minimum standards established under the evaluation guidelines.

The IMC appears to have sufficient authority to ensure compliance with quality control standards, even without assistance from WCJs, the WCAB, and the AD. The IMC staff does conduct periodic reviews of medical-legal reports. When report review reveals QME deficiencies, the matter is referred to the Discipline Unit for investigation. While we recognize that the IMC has an extremely small discipline unit, a few well-publicized actions for egregious violations could have a salutary effect.

RECOMMENDATIONS:

The IMC knows quite a bit about the written reports of QMEs, but very little about what goes on during the examinations. Based on complaints

to the IMC, anecdotal reports from WCJs, injured workers, attorneys, and others, it appears that some QMEs are not complying with the minimum face-to-face timeframes, that full histories are not always taken, that injured workers are made to wait longer than an hour to see the doctor, and that QMEs do not always treat injured workers with respect. Because the IMC's oversight of these kinds of quality issues is almost exclusively complaint-driven, it is impossible to tell how pervasive these problems are.

The IMC could gather more statistically reliable information on these kinds of questions if it used injured workers as a resource. We recommend that the IMC design and develop a questionnaire for injured workers, which would be given to them by the QME at the time of the examination. The questionnaire would have to be returned to the IMC before the doctor's report is issued, in order to prevent the report's contents from affecting the responses. This kind of questionnaire has been used by Kaiser Permanente for many years. The responses would be very useful in determining where problem areas exist. Continuing education programs could be modified to address these issues. The responses could also be used by IMC staff to identify problem patterns with specific QMEs, who could then be counseled and monitored. The very existence of such a mechanism might well serve to put QMEs on better behavior.

At the present time, the IMC has no way to determine which QME is selected from a three-member panel. The questionnaire could help the IMC to learn more about whether some doctors are performing so many QME evaluations that it would be difficult or impossible for them to comply with the statutory requirement that at least one-third of their practice is devoted to treatment. Some QMEs who are associated with medical-legal evaluation companies perform QME exams at many locations throughout the state.[6] While there is nothing inherently improper about being available at so many offices, it does call into question the ability of such doctors to maintain a substantial treatment practice. These QMEs will also be "randomly" selected for more panels than the average physician, because of their availability at so many dispersed locations.

The questionnaire could also help the IMC and the broader workers' compensation system to understand how unrepresented injured workers

[6] One QME lists 28 separate office locations.

go about selecting a panel QME, how well they understand the QME process, and whether injured workers perceive the process to be fair and efficient.

Ms. Smith and her colleagues have raised questions concerning "biased" QMEs. While actual bias undoubtedly exists, it is extremely difficult to define and prove. Much of what passes for bias is no more than an honest difference of opinion among medical experts, or an unconscious tendency to be more "liberal" or "conservative" than another doctor. The most effective protection against real or perceived bias is the injured worker's ability to obtain legal representation and obtain a QME report from a doctor of his or her choice. If the system is working properly, reports from credible, competent, and fair doctors will carry more weight in settlement negotiations and in formal trials than those from less fair, credible, and competent doctors. Because evidence of actual bias is so subjective and so difficult to obtain, we make no formal recommendation on this issue.

IMC staff and injured workers have reported that defendants will sometimes order applicants to submit to examinations with non-QME physicians pursuant to Labor Code section 4050. Section 4050 has been in existence, in nearly the same form, since the beginnings of the California workers' compensation system in 1917. It provides that "whenever the right to compensation under this division exists in favor of an employee, he shall, upon the written request of his employer, submit at reasonable intervals to examination by a practicing physician…" There is no requirement that such a physician be a QME.

Since the 1989 reform legislation went into effect, medical-legal examinations have been regulated by the provisions of Labor Code sections 4060-4062. These provisions regulate the number, nature, timing, content, and procedures for obtaining admissible medical-legal evidence. With the exception of treating physician reports, all admissible medical-legal examinations must be conducted by QMEs or AMEs. Reports obtained pursuant to section 4050 are not admissible.

Because section 4050 examinations and reports are not part of the QME process, they fall outside of the IMC's primary jurisdiction and are essentially unregulated. Defendants seem to use section 4050 for several different purposes. They may require an applicant to submit to a section 4050 examination during the initial AOE/COE investigation period. This procedure should never be permitted, because the section

applies only to admitted injury cases. Section 4050 examinations are also sometimes used as a "back door" approach to admit otherwise inadmissible evidence. The defendant will obtain a section 4050 report and later submit it, along with other medical records, to a QME or AME. Even though the report itself is inadmissible, the QME or AME will read and consider it.

We recommend that section 4050 be amended to clarify that it is limited by the provisions of sections 4061 and 4062. This appears to be consistent with Legislative intent and will ensure that there are no unregulated examination procedures. If, in extremely unusual situations, such as the unavailability or lack of a QME in a particular specialty, the parties can always petition a WCJ for permission to use a non-QME physician. WCJs already possess ample authority to develop the record as circumstances require.

IV. GOVERNANCE.

The IMC is comprised exclusively of medical professionals. It consists of eleven doctors of medicine, two osteopaths, two chiropractors, one physical therapist, one psychologist, one podiatrist, one acupuncturist, and one medical economist. There are no public members.

The IMC has done an excellent job of preparing education and training materials for physicians, as well as evaluation and treatment guidelines. It has not done as good a job when it comes to communicating with, and understanding the needs of, injured workers. The IMC's highest priority should be the protection of the safety and legal rights of injured workers. Because the IMC receives little non-professional public input at its meetings, it does not have the benefit of hearing the perspectives and concerns of its most important constituency.

RECOMMENDATION:

The Council should create an advisory committee comprised of injured workers and other members of the public to advise it on matters relating to communication with injured workers and on other issues not requiring medical expertise.

CONCLUSION.

We are convinced that the IMC is dedicated to protecting injured workers in the QME process. Many of the specific problems in disciplinary procedures have been addressed by the IMC. Further improvements to the disciplinary system are in the works and appear to be a high priority for the Council. While disciplinary issues are extremely important, they apply to only a small percentage of QMEs. Our investigation has led us to the conclusion that communication between the IMC and injured workers and additional attention to quality assurance and control problems are of equal or greater importance. We also believe that the public needs to be represented before the IMC through an advisory committee to ensure that it hears more diverse views on an ongoing basis.