Qualified Medical Evaluator Regulations	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
General Comment	Regarding unrepresented cases, commenter opines that there needs to be a specific telephone number at the DWC for unrepresented employees who have questions or are unclear on the process.	Julie Armstrong, RN Psy.d, QME April 3, 2015 Written Comment	A phone number is listed on the top of the first page.	None.
	Commenter opines that there is a need for unbiased information for unrepresented employees. More than 35-40% of her QME evaluations take place on individuals with education only to 6th grade (or less.) These workers are intimidated by the process overall, at a time when they may be scared about their job, or injured and therefore more vulnerable. In many of her evaluations, she spends upwards of 30 minutes simply answering questions about the process up to the QME as well as about the sequence of events after my appointment. Clearly many employees engage in the process without adequate information about the process.		This comment is unrelated to the proposed regulations and therefore beyond the scope of the regulatory process	None.
	Commenter opines that the information number should be printed in **LARGE AND OBVIOUS TYPEFACE** on all forms for the		The information is listed on the top of the first page.	None.

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	unrepresented worker.			
General Comment	Commenter states that the current QME process is not only broken but fraudulent in its implementation. The current rules allow for the medical outfit from Fresno and the CLMS group in the Valley to dominate the panels to the point that he has not seen a local doctor on a panel in almost a year. Commenter opines that allowing these enterprises to dominate what is supposed to be a random sampling is intentional on the part of the DWC. Commenter states that this is outrageous and somebody needs to pay the price for it. Commenter states that there is an issue of separate treatment by represented individuals. Unrepresented applicants get to pick the best doctor from a panel while represented applicants must take the worst doctor from the panel. Commenter opines that this process is a violation of his client's right to due process in that because he hires an attorney he is treated differently. Commenter states that there can be no rational basis, at least a legal one, for such a rule.	Robert Kelley, Esq. April 3, 2015 Written Comment	This comment is unrelated to the proposed regulations and therefore beyond the scope of the regulatory process. This comment is unrelated to the proposed regulations and therefore beyond the scope of the regulatory process.	None. None.

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	Commenter is waiting for the right case to take this up. Commenter states that when he has raised this in his cases the other side tends to agree with him and that they resolve the case by the use of alternate methods. Commenter hopes that someday someone will not cave and he can then fight this out. Commenter is waiting for the day that the Board has to state that somehow that this rule is legal and does not violate his client's due process rights. Commenter suggests that the imbeciles that concocted this rule retract it immediately and take his other suggestions seriously.		This comment is unrelated to the proposed regulations and therefore beyond the scope of the regulatory process. This comment is unrelated to the proposed regulations and therefore beyond the scope of the regulatory process.	None. None.
100, 104, 105, 106	Commenter objects to the elimination of "PSN Psychology- Clinical Neuropsychology" as a specialty, as applied to Title 8, California Code of Regulations, Sections 100, 104, 105, and 106. Commenter notes that the	Delia M. Silva, Board Certified in Clinical Neuropsychology QME April 7, 2015	The licensing board is the California Board of Psychology which does not recognize subspecialties. The Administrative Director under Labor Code section 139.2(a)	None.

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	rationale indicated is that the California Medical Board does not recognize Clinical Neuropsychology as a specialty. Commenter is a neuropsychologist who performs QMEs in both psychology and neuropsychology, and is adamantly opposed to this proposed change. Commenter states that a neuropsychologist is a clinical psychologist by graduate school training and licensure, and has taken the steps to undergo highly specialized training in brain-behavior relationships that is not offered to most clinical psychologists. In order for a psychologist to be considered competent to practice as a neuropsychologist, it is now required that they undergo a two-year postdoctoral training program in which they gain specialized knowledge on neurological and medical principles. Commenter states that at the present time, the title, "neuropsychologist" is not protected in the majority of states, including California. That means that	Written Comment	has the authority to decide which specialties to recognize as part of the QME process; the Administrative Director chose to recognize only those specialty boards recognized by the respective physician licensing boards. The California Board of Psychology has jurisdiction to recognize specialty areas of practice and it does not recognize neuropsychology boards. In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange	None. None.

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	any licensed psychologist is able to state that they are a "neuropsychologist," however, this does not indicate competence in this subspecialty by any means. In order to have recognized distinction over general psychologists, many trained neuropsychologists are now seeking voluntary board certification in clinical neuropsychology through the American Board of Professional Psychology (ABPP) or the American Board of Professional Neuropsychology (ABN). Both boards require a rigorous peer-review process to ensure competence in the practice of neuropsychology. The following is a link that provides a comprehensive description of the training requirements to become a neuropsychologist: http://theaacn.org/position_papers/Houston_Conference.pdf Commenter opines that eliminating "Clinical Neuropsychology" as a QME designation would pose a grave danger to claimants. All competent neuropsychologists who are currently designated under the "Clinical		for diagnostic tests with a neuropsychologist. This will give injured workers wider access to a wider geographic area. In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will	None.

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	Neuropsychology" subspecialty would be lumped into the general "Psychology" specialty, and there would be no distinction over which QMEs are able to provide competent evaluations for neurological or complex medical cases. Commenter states that a neuropsychologist is uniquely prepared to address cognitive functioning and appropriately attribute causation of any cognitive deficits or psychiatric conditions while taking into account neurological, medical, psychosocial, and psychological factors. Neuropsychologists are often better equipped to answer these questions than other medical specialties. Commenter often sees reports by other medical doctors, including neurologists, who inaccurately rate the severity of a traumatic brain injury (TBI) because they have relied on subjective reports rather than using the objective standards for grading a TBI. This results in erroneous causation, disability ratings, and treatment recommendations that often harms the patient and costs the insurance carrier more money. Commenter states that if		give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	None.

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	neuropsychology were to be eliminated as a QME subspecialty, there would be increased errors such as this by psychologists who do not have the knowledge about TBI and other neuropsychological conditions. Commenter states that in addition to having specialized knowledge about neurological and medical conditions, neuropsychologists offer a wider range of cognitive testing over generalist psychologists. Their evaluations also include increased measures of effort testing and performance validity, which allow them to objectively assess a person's response style and identify malingering. Most of these tests are exclusively offered by neuropsychologists, which allow their evaluations to have greater measures of objectivity about a person's motivational approach over any other medical specialty as well as psychologists. Commenter opines that the elimination of "Clinical Neuropsychology" as a QME		In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. In the event that a psychologist is unable to perform the necessary evaluation, the	None. None.

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	subspecialty would result in a vast disservice to the public when choosing a QME evaluator. Commenter states that not all psychologists are competent to perform neuropsychological evaluations and doing so can cause harm to the patient and that the ramifications of misdiagnosis can have costly consequences in providing uninformed treatment recommendations or "second opinion" evaluations. Commenter notes that if a psychologist is designated from a QME panel to perform a neuropsychological evaluation and informs the parties that they do not have competency in this specialty, this will delay the process of QME selection until a random panel that includes a neuropsychologist appears. This would ultimately lead to greater inefficiency and potential worsening of claimants' conditions.		psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers wider access to a wider geographic area.	
100, 104, 105, 106	Commenter opines that eliminating	Patricia L. Hastings,		None.

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	neuropsychology as a distinct QME specialty is a grave mistake and will lead to unnecessary increased litigation. Commenter predicts challenges to PQME reports on a substantial evidence basis becoming routine if this change is implemented. Commenter states that the goal of all recent reform legislation has been to render medical evaluations more objective and to promote evidence-based medicine. Commenter opines that allowing psychologists to evaluate claims of TBI runs exactly counter to that goal. Psychology is a "soft," quasi-medical discipline; neuropsychology is its "hard" science, evidence-based relative.	Esq. April 4, 2015 Written Comment	In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	

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100, 104, 105, 106	Commenter is distressed by the proposal to eliminate what he opines is the very valuable subspecialty of Clinical Neuropsychology and merge it with the existing designation of Psychology. Commenter states that they are not the same specialties, although there is some overlap; not unlike the overlap between "pulmonary medicine" and "internal medicine." Commenter represents injured workers with brain injuries and it is his experience that psychologists are not qualified and do not have the specialized training necessary to assess the effects of traumatic brain and head injuries. There is a specialized battery of neuropsychological diagnostic testing that is administered and scored, in addition to their clinical experiences, necessary to assess the impact of a brain injury that a psychologist is not qualified to administer or interpret. Commenter opines that there is no logical reason to eliminate the specialty of "Clinical Neuropsychology." Commenter opines that doing so will do nothing but confuse the process by which	Jeff Denicholas, Esq. April 4, 2015 Written Comment	In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	None.

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	substantial medical evidence is procured to the detriment of those injured workers with brain injuries. Orthopedics is broken down into subspecialties that include surgeons, knees, spine, hands, ankles, among others. When searching for the proper specialist to evaluate a case he has to cull through the subspecialists to secure the proper specialist to evaluate the case. Commenter states that merging "Clinical Neuropsychology" with "Psychology" will not make the process simpler, it will make it more difficult.			
100, 104, 105, 106	Commenter opines that the elimination of the "clinical neuropsychology" designation a terrible choice, and should not be done. Commenter notes that neuropsychology is that branch of psychology which tests for, and analyzes, damage and injury to the brain resulting from injury or disease, and is highly specialized. Commenter has been a defense attorney since 1990; however her is	Richard Berryhill, Esq. Schmit Law Office April 8, 2015 Written Comment	In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	None. None. None.

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	highly aware of the necessity for this specialty to definitively establish the existence or non-existence of physical damage or loss of brain function, as opposed to mental disorders. Commenter states that neuropsychologists such as Dr. Claude Munday, or Dr. Thomas Hardey, are completely unique in their method and function and cannot be replaced. Dr. Hardey, for example, is a consultant to our state universities, colleges, and professional sports teams and is a member of a committee on head injuries. This is distinctly NOT the function of a psychologist, but must be determined by a neuropsychologist. Commenter has practiced extensively in personal injury cases as a plaintiff's attorney before devoting his practice to workers' compensation defense. Commenter states that no one but neuropsychologist's opinions would have been acceptable evidence to substantiate brain injury in civil litigation, because no other specialty can diagnose physical injury, damage, or loss of brain function.		See comment above. See comment above.	None. None.

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	Commenter requests that the Division NOT eliminate the “clinical neuropsychology” designation.		See comment above.	None.
100, 104, 105, 106	Commenter is opposed to the deletion of the "PSN Psychology - Clinical Neuropsychology" as a specialty code. It is proposed that the QMEs listed in this specialty code will be merged into the existing code "PSY-Psychology." Commenter states that neuropsychology is an essential specialty that is required to evaluate head injury cases. Commenter opines that there is no valid reason to discontinue their participation in the process. Neuropsychology is a specialized form of medicine and it cannot be rolled into any other specialty. Neuropsychologists deal	Bernardo De La Torre, Esq., President California Applicants’ Attorneys Association May 22, 2015 Written Comment	In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	None. None.

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	with very serious brain injuries with life-long consequences. The training and expertise of this specialty is required to conduct testing to determine the extent of cognitive deficits in brain injury cases. Commenter notes that neuropsychologists must also evaluate the impact of chemical exposures or drug impacts on the brain not to mention trauma or multiple traumas. Regular psychologists don't have the expertise to do this. Neuropsychology is not simply a crossover of neurology and psychology, or a combination of the two. Neuropsychologists specialize in addressing head injuries and cognitive deficits. Commenter states that if neuropsychologists are removed from the QME list, there would be no specialty to evaluate head injuries, and if they are rolled into the psychology specialty, then any panel would include psychologists who do not have the training or expertise to address head injuries. Injured workers would have no way of knowing if the doctor on the specialty list is a psychologist		In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	None.

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	or specially trained neuro psychologist if this change is adopted. Commenter states that the rationale in the Initial Statement of Reasons is misinformed when stating that this change is required by Labor Code section 139.2 as the California Medical Board does not recognize Neuropsychology as a specialty. Psychologists are licensed by the California Board of Psychology under the Department of Consumer Affairs and have nothing to do with the California Medical Board. Section 139.2 (b)(3) which requires that specialists be certified by a board recognized by the Medical Board (note it is the Board that must be recognized, not the specialty) applies to physicians with MD and DO degrees, and not psychologists. Psychologists fall under Labor Code section 139.2(b)(5), which only requires that they be "board certified in clinical psychology by a board recognized by the administrative director." The American Board of Clinical Neuropsychology is one of the boards governed by the American		The licensing board is the California Board of Psychology which does not recognize subspecialties.	None.

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	Board of Professional Psychology, and there is no basis for the Administrative Director to not recognize it. Commenter notes that there is language in the AMA Guides, Chapter 13-3 f , page 325 that specifically references neuropsychiatric tests for evaluating cerebral impairments, which neither neurologists, psychologists, or psychiatrists have any training or expertise to perform. Neuropsychology is a recognized specialty for evaluating brain injuries and is endorsed by the AMA as reflected in the Guides. Commenter opines that both insurance carriers and injured workers benefit from the continued opportunity to obtain competent reports to evaluate a claim. Eliminating neuropsychology as a specialty for QME evaluations will be an obstacle to achieving this goal. Commenter is concerned with the elimination of the specialty MMO Orthopaedic Surgery – Oncology and MMO Radiology-Oncology from Sections 100, 104, 105, and 106 of these proposed regulations. The Initial		In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology. MMO – Orthopedic Surgery – Oncology and MMO Radiology – Oncology are only being eliminated from Sections 100 and 104. Those specialties were eliminated	None. None.

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	Statement of Reasons states that "these specialties are no longer offered to the public. The deletion of these specialties is a clarifying change." Commenter asks what are injured workers with cancer now supposed to do when seeking to obtain a competent report to evaluate their claim. Commenter opines that if they select an MMO Internal Medicine – Medical Oncology specialty, that doesn't necessarily mean that physician will have surgical or diagnostic expertise to evaluate their medical condition. Commenter opines that eliminating these specialties for QME evaluations will be an obstacle to achieving the goal of all parties to obtain competent reports.		previously in Sections 105 and 106. This change is being made on the QME application and reapplication forms to be consistent.	

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30(a), 105	Commenter supports the proposed changes for unrepresented cases in section 30, subdivision (a), as generally favorable. Unrepresented injured workers no longer are required to provide documentation of a written objection letter to obtain a panel QME. However, if the requesting party is the claims administrator, the claims administrator is required to attach a written objection letter to the new QME Form 105 sent to the Medical Unit, under section 30, subdivision (a), paragraph (2), which is appropriate.	Bernardo De La Torre, Esq., President California Applicants' Attorneys Association May 22, 2015 Written Comment	No response necessary.	None.
	Commenter supports the online panel QME process as a method to expedite QME panel requests and save costs; however, he strongly believes that the online panel QME process should just be for represented cases. Commenter supports that the QME form 105 can still be submitted by mail on unrepresented cases.		No response necessary.	None.
	Commenters states that the new QME Form 105 for unrepresented injured workers has simple, easy to understand instructions, which should		Agreed, however, this comment is beyond the scope of this rulemaking. This issue will be addressed in the future.	None.

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	simplify the filing process. Commenter states that a Spanish version of this form must be made available to comply with Labor Code section 124(b) which states that "Forms and notices required to be given to employees by the division shall be in English and Spanish." Commenter would like to see a Spanish version of QME Form 105 before these regulations become final.			
30(b)(3), 106	With regard to represented cases, commenter recommends that section 30, subdivision (b), paragraph (3) be revised to not require service of "supporting documentation" on the opposing party, if it has previously been served. Commenter opines that if the online QME eForm 106 references the supporting documentation filed, this should be sufficient. Commenter recommends that the language <u>"but not previously served</u>" be added after "…<u>supporting documentation that was submitted online</u>…" in paragraph (3). Commenter opines that it would be helpful and more efficient if the online	Bernardo De La Torre, Esq., President California Applicants' Attorneys Association May 22, 2015 Written Comment	As this is an automated system, this will ensure that the opposing side is served with and can verify all documents relied upon in requesting a panel list. Agreed in part. The regulations require that UAN be provided	None. None.

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	QME eForm 106, was set up to auto populate information for the case from EAMS, or in the alternative allow a scanned version of the form to be submitted electronically from information in the applicants' attorney's or claims administrator's database. This will save valuable time for both the claims administrator and applicants' attorney, who otherwise would have to type in case and address information on every submission.		which will auto populate information.	
31.1(a)	Commenter supports the addition of Section 31.1, new subdivision (a), to these regulations. Commenter opines that allowing for any disputes regarding the validity of the panel QME selection list or appropriateness of the specialty designation to be resolved at the WCAB will further the goal of eliminating or minimizing delays in the QME panel process. This will also insure that the administrative burden of reviewing these disputes will not be placed on the Medical Unit.	Bernardo De La Torre, Esq., President California Applicants' Attorneys Association May 22, 2015 Written Comment	No response necessary.	None.
General Comment	Commenter appreciates the effort by the Division to create an online system that will make the panel request process more efficient and effective	Michael McClain General Counsel Stacy L. Jones	No response necessary.	None.

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	and eliminate the backlog. The paper process has proven to be very cumbersome and has caused unfortunate delays in obtaining medical legal opinions that are essential to resolving benefit delivery issues. Online requests can be processed instantly – a necessity as time frames decrease and speed in determining issues becomes ever more important. The fact that panels can be computer generated and communicated immediately will certainly streamline the medical legal process. The prompt resolution of disputes will make benefit delivery more efficient and injured workers will not have to suffer unnecessary procedural delays.	Senior Research Associate California Workers' Compensation Institute (CWCI) May 22, 2015 Written Comment		
30(b)	Commenter states that this section requires the immediate use of the electronic filing process. Commenter opines that in the development of electronic systems, there are always potential pitfalls, bottlenecks from a high volume of initial requests, and	Michael McClain General Counsel Stacy L. Jones Senior Research Associate	Allowing a paper process along with an online process will cause overlap and confusion in the process. The online system will be tested and fully operational at the time of operation.	None.

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	technical glitches. Commenter opines that until the electronic system for requesting panel QMEs is fully tested and functional, the requesting party should have the option of filing a paper form or using the online process. This initial period could be as short as 90 days or as long as 180 days but there should be some period of time where both systems overlap.	California Workers' Compensation Institute (CWCI) May 22, 2015 Written Comment		
30(a) and (b)	Commenter opines that these sections could be revised after the transition period to permit, unrepresented injured workers the option of filing electronically.	Michael McClain General Counsel Stacy L. Jones Senior Research Associate California Workers' Compensation Institute (CWCI) May 22, 2015 Written Comment	Agreed, however, this is beyond the scope of this rulemaking. This issue will be addressed in the future.	None.
30(b)(5)	Commenter notes that if technical problems arise, the requesting party should contact the Medical Unit.	Michael McClain General Counsel	Contact information will be provided in the online system.	None.

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	Commenter opines that it would be beneficial if the regulation stated the contact or provided phone number or e-mail address for this purpose.	Stacy L. Jones Senior Research Associate California Workers' Compensation Institute (CWCI) May 22, 2015 Written Comment		
100, 104, 105, 106	Commenter has great CONCERN over the proposed regulations to abolish the Clinical Neuropsychologist designation from the Qualified Medical Evaluator (QME) process. Commenter states that for over two decades, there have been distinct categories for clinical psychologists and neuropsychologists within the California Workers' Compensation system. Commenter opines that the merger of categories will be harmful for workers, practitioners, and businesses. Commenter states that when a worker suffers a traumatic brain injury or concussion, it is clinically indicated that the individual be sent to see a clinical neuropsychologist. This is an individual with a general license	Amanda Levy Director of Government Affairs California Psychological Association May 22, 2015 Written Comment	The licensing board is the California Board of Psychology which does not recognize subspecialties. The Administrative Director under Labor Code section 139.2(a) has the authority to decide which specialties to recognize as part of the QME process; the Administrative Director chose to recognize only those specialty boards recognized by the respective physician licensing boards. The California Board of Psychology has jurisdiction to recognize specialty areas of practice and it does not recognize neuropsychology boards.	None. None.

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	issued by the Board of Psychology and who has expertise in the neuropsychology subspecialty. The National Academy of Neuropsychology defines a neuropsychologist as "a professional within the field of psychology with special expertise in the applied science of brain-behavior relationships. Clinical neuropsychologists use this knowledge in the assessment, diagnosis, treatment, and/or rehabilitation of patients across the lifespan with neurological, medical, neurodevelopmental and psychiatric conditions, as well as other cognitive and learning disorders. Nationally, one is recognized as a clinical neuropsychologist by being a psychologist who is certified in clinical neuropsychology by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or a licensee who has completed an internship or its equivalent in a clinically relevant area of professional psychology, and has at least two years of experience and specialized training, at least one year		In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers wider access to a wider geographic area.	

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	of which is at the post-doctoral level in the study and practice of clinical neuropsychology and related neurosciences under the supervision of a clinical neuropsychologist. Commenter states that while all practitioners are licensed by the Board of Psychology, there is a variance in the work that a psychologist does versus a neuropsychologist and it is appropriate to recognize that difference. A psychologist cannot treat outside their scope of practice and scope of competence. Therefore, workers will be turned away by a psychologist who cannot conduct a full neuropsychological evaluation. Commenter states that if these regulations move forward as is, the random QME panel of three psychologists might not include any neuropsychologist, and there is a very slim chance a panel would consist of three neuropsychologists from which to choose. The injured worker would have to wait for a referral to a neuropsychologist from one of the QME psychologists or would have to have a new panel created in hopes of		See response above.	None.

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	there being a neuropsychologist on the panel. This process delays evaluation and is bad for workers and practitioners alike.			
30(b)(3)	Commenter states that this section appears to indicate that a panel would be generated immediately upon receipt of a request. The party requesting the panel would receive the panel immediately after submitting their request online. Then, the requesting party is required to serve the generated panel on the opposing party within one (1) working day. Commenter states that this is a problem because it gives the requesting party up to 10 extra days to consider the panel. For example, if a party requests a panel on a Friday before a long weekend, the requesting party would have until the following Monday to serve the panel. If the mail takes 5 days to get to the opposing party, the opposing party may not get the panel until a week later, on the following Monday. This means the requesting party will have seen the panel 10 days before the	Yeabin Bernal Joseph M. Roberts Law Office of Robin Jacobs May 22, 2015 Written and Oral Comments	Agree.	Amend section 30(b) to allow each party 10 days from service of the panel to strike a doctor.

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	opposing party. Commenter opines that this creates problems in at least two ways. First, it creates confusion in strike deadlines. Per Labor Code 4062.2(b), parties are required to strike panel doctors "within 10 days of assignment of the panel by the administrative director." If the requesting party gets the panel up to 10 days in advance of their opposing party, the strike deadline would have run by the time the opposing party receives the panel. Unless there are rules created to prevent this confusion, many panel strikes will need to be reviewed by the WCAB to determine the timeliness of panel strike. Second, this arrangement will give an unfair advantage to the requesting party because the requesting party may get up to 10 more days to review the panel. That party will have more time to research the doctors and make their decisions more carefully, while the other party will have a guaranteed late start. This is not equitable.			

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30(b)(4) and 31.1	Commenter opines that this new subsection 30(b)(4) contains confusing language. There is no acceptance time specified for requests submitted on a Saturday, Sunday, holiday, and Monday through Friday between 5pm and 12am. Commenter states that adding the acceptance time, as the new regulations have done in cases of requests submitted between 12am and 8am Monday through Friday, would resolve this issue. Commenter opines that it would be reasonable to include in the new regulations that all panel requests made on a Saturday, Sunday, holiday, and Monday through Friday between 5pm and 12am will be deemed to have been submitted at 8am on the next business day. This issue appears to be simple to solve. Commenter states that a problem exists because the new rules do not contemplate what actions will be taken if the Medical Unit receives more than one panel request for different specialties at the same time. Previously, section 31.1 addressed this issue. However, subdivisions (a)(1)-(3) and (b) of section 31.1 have been	Yeabin Bernal Joseph M. Roberts Law Office of Robin Jacobs May 22, 2015 Written and Oral Comments	Agree. Agree in part.	Section 30(b)(4) is amended and renumbered to 30(b)(2) and show the request time. Section 30(b)(4) is amended and renumbered as 30(b)(3) and states that after issuance of a panel, any subsequent request will be a duplicate request.

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	deleted under the new regulations. The Initial Statement of Reasons published by the Division indicates that the subdivisions will be deleted because "parties will be unable to make simultaneous requests." Commenter states that this is not true.			The system will not allow simultaneous requests. Once a panel is generated in a case, regardless of the type of specialty requested, it will be considered a duplicate request and rejected.
	Assuming all panel requests made on a Saturday, Sunday, holiday, and Monday through Friday between 5pm and 12am will be considered to have been submitted at 8am on the next business day, there will be many instances where two panel requests will be deemed submitted exactly at the same time. Since subdivisions (a)(1)-(3) and (b) of section 31.1 have been deleted, there are no rules regarding what decision the Medical Unit will make, based on what guidelines. Parties will need guidance on how the Medical Unit will proceed if two requests are deemed received at the exact same time.		Agree in part.	Section 30(b)(4) is amended and renumbered as 30(b)(2) and shows that the submission dates are for determining the timeliness of requests only pursuant to Labor Code section 4062.2. The panel list is generated instantaneously in real time, any subsequent requests, although deemed to have been made on the same day, will be

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				considered a duplicate. Only one party that submits the request first will be able to generate the list.
31.1(a) and (b)	Commenter states that due to the deletion of 31.1 (a)(1)-(3) and (b), parties are now required to refer to the proposed 31.1(a) and (b) for controversies regarding panel validity and appropriate specialty. Commenter opines that there is a potential that the new regulations are not sufficiently clear to meet the requirements under the Administrative Procedure Act. The new subsection (a) reads: "Disputes regarding the validity of panel requests may be resolved by a Workers' Compensation Administrative Law Judge." Since Workers' Compensation Judges are vested with judicial authority to review cases or controversies in Workers' Compensation matters, commenter opines that a more accurate way to state the power of Workers' Compensation Judges may be to use the word *shall* instead of	Yeabin Bernal Joseph M. Roberts Law Office of Robin Jacobs May 22, 2015 Written and Oral Comments	Agree. Agree. See above response.	Section 31.1(a) deletes "may" and adds "shall." Section 31.1(b) is amended to add that either party may appeal the Medical Director's decision with a judge. See above action.

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	may. The regulation would thus read: "[d]isputes regarding the validity of panel requests *shall* be resolved by a Workers' Compensation Administrative Law Judge."			
	Section 31.1(b) provides "[d]isputes regarding the appropriateness of the specialty designated shall be resolved pursuant to section 31.5(a)(10) of Title 8 of the California Code of Regulations." Commenter states that this is a partial continuation of current regulations; however, the Initial Statement of Reasons does not state why section 31.5(a)(10) was singled out as the controlling regulation in panel specialty disputes. For example, there is no explanation as to why section 31.5(a)(9) would not be just as relevant and appropriate.		Section 31.1(b)(9) provides for a replacement QME or replacement panel where the dispute does not involve the appropriateness of the specialty selected. Based upon the nature of the injury, an injured worker may not want to be seen by a female QME and may seek a replacement panel pursuant to Section 31.1(b)(9).	None.
	Commenter states that the choice of the word *shall* in section 31.1(b) creates an interesting contrast with the word *may* in 31.1(a). When read together, commenter opines that the two sections are susceptible to a misinterpretation that ultimately results in the limitation of the powers		Agree.	Section 31.1(a) deletes "may" and adds "shall." Section 31.1(b) is amended to add that either party may appeal the Medical Director's decision with a judge.

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	of the Workers Compensation Judges. One could interpret these regulations to mean that while Workers' Compensation Judges are able to rule on panel validity issues, panel specialty issues fall under the exclusive domain of the Medical Director. In order to address this issue, there needs to be guidelines regarding the appeal of the decision made by the Medical Director. Under section 31.5(a)(10), the Medical Director determines the panel specialty. While the power of the Medical Director to determine some panel issues has been present in past regulations, the Workers' Compensation Judges have always had the power to review the decisions of the Medical Director regarding panel specialty. This power is the exercise of an essential judicial function by Workers' Compensation Judges. Considering the amendment of existing regulations, commenter states the need to clearly indicate the Workers' Compensation Judges' power to review the decisions made by the Medical Director regarding panel specialty. If this is not done,			

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	commenter opines that there is a potential for this power by the Workers' Compensation Judges to be divested, much like in the IMR-Dubon conundrum, causing unnecessary litigation and delays.			
30(b)(3)	Commenter states that this section does not clearly indicate when the Panel QME list and Declaration of Service must be served upon the opposing party. To ensure clarity, commenter recommends that the DWC modify the text as follows (changes indicated by strike-out and underline: "Print and serve. . .within 1(one) working day ~~of~~ after generating the QME panel list".	Robyn Stryd Claims Operations Manager State Compensation Insurance Fund May 22, 2015 Written Comment	Agree. See response above.	Section 3(b)(1)(C) is amended to replace "of" with "after." See action above.
31.5	Commenter supports the transition to online QME panel requests for represented cases. However, the proposed regulations do not address disputes over the specialty of the QME. In order to reduce disputes, commenter requests that the following text be added to section 31.5: "In the event a party in a represented	Robyn Stryd Claims Operations Manager State Compensation Insurance Fund May 22, 2015 Written Comment	Pursuant to Labor Code section 4062.2, the requesting party has the legal right to designate the specialty of the medical evaluator. Any party disputing the specialty designated can seek a replacement panel under Section 31.5 utilizing Form 31.5.	None.

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	case wishes to request a QME panel pursuant to Labor Code section 4062.2 in a specialty other than the specialty of the treating physician, the party shall submit with the panel request any relevant documentation supporting the reason for requesting a different specialty. The panel shall be issued in the specialty of the treating physician unless the Medical Director is persuaded by supporting documentation provided by the requestor that explains the medical basis for the requested specialty." Commenter recommends that the DWC promulgate a form to dispute the appropriateness of the designated specialty under § 31.5(a)(10).		Form 31.5 can be utilized to see a replacement panel in a different specialty.	None.
105	Commenter notes that the changes to QME form 105 were designed to make it more user-friendly for the unrepresented injured worker, but there was no effective date in either the form or the proposed regulations. Commenter recommends that the DWC specify the effective date of the revised QME form 105 in the regulations.	Robyn Stryd Claims Operations Manager State Compensation Insurance Fund May 22, 2015 Written Comment	Agree.	The form is amended to add a revision date of September 2015.

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106	Commenter notes that QME form 106 is used to request a QME panel for represented injured workers and is to be used to submit request electronically. Section 30(b) states the form is to be used for dates of injury on or after January 1, 2005 but the draft form states it is for dates of injury prior to January 1, 2005. Additionally, the title of the revised QME Form 106 has been amended to include the new language "<u>for injuries occurring prior to January 1, 2005</u>".	Robyn Stryd Claims Operations Manager State Compensation Insurance Fund May 22, 2015 Written Comment	Form 106 will not be submitted electronically. The regulations state that for injuries after January 1, 2005, parties utilize the website. For injuries prior to that date, the Form 106 is used.	None.
	Commenter recommends that the instructions for mailing be updated on the revised Form 106 to coincide with the changes in the regulations.		There are no instructions on the Form 106. A separate instruction sheet outside the rulemaking will be updated.	None.
	Commenter recommends that the DWC indicate the effective date of the revised QME form 106 and clarify for what dates of injury the form should be used. Upon clarification of date of injury, DWC should specify when the form is to be mailed, when it is to be submitted electronically, and how disputes for either type of submission will be handled by the Medical Director. Given the changes to the		Agree in part. For all dates of injury after January 1, 2005, the parties will utilize an online system to generate a panel. Form 106 will not be submitted electronically. Form 106 will be utilized for injuries occurring before January 1, 2005 and by agreement. The parties will go on a website to submit a panel request. There	Form 106 is amended to reflect a revision date of September 2015.

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	form and that it will be electronically submitted for represented cases, commenter states that the DWC should allow a grace period from the effective date of the form(s) of 90 to 120 days or more. Allowing for a grace period will give employers and claims administrators time to update electronic systems to include both revised QME forms 105 and 106.		is no paper form that needs to be submitted electronically.	
100, 104, 105, 106	Commenter states that the current manual method of fulfillment of panel requests is expensive and time consuming. The proposed system is a big step in the direction of efficiency. Commenter notes that within these regulations is a proposal to abolish the QME category of "clinical neuropsychologist" and to transfer all currently recognized neuropsychologists into the same category used for regular psychologists. Commenter acknowledges that the state has	Stephen J. Cattolica Director of Government Relations California Society of Industrial Medicine and Surgery (CSIMS) May 22, 2015 Written and Oral Comment	No response necessary. The licensing board is the California Board of Psychology which does not recognize subspecialties. The Administrative Director under Labor Code section 139.2(a) has the authority to decide which specialties to recognize as part of the QME process;	None. None.

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	recognized neuropsychology for decades, but that the Division's proposal is technically correct given a strict reading of Labor Code Section 139.2. Commenter would like to point out that there is a significant difference between the services provided by neuropsychologists as compared to psychologists. It's critical to permit the continued distinction between these two specialties. Commenter opines that merging them into one category of "Psychologist" will be detrimental to both injured workers and their employers/insurers. Commenter opines that despite the impending electronic methodology, it will increase the workload of the DWC due to increased requests for QME panel consultations. Commenter states that since 1993, the State of California has appointed neuropsychologists to serve QMEs in workers' compensation cases. Neuropsychologists are licensed psychologists who have taken additional training enabling them to specialize in the assessment and		the Administrative Director chose to recognize only those specialty boards recognized by the respective physician licensing boards. The California Board of Psychology has jurisdiction to recognize specialty areas of practice and it does not recognize neuropsychology boards. In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers wider access to a wider geographic area. See response above.	None. None.

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	evaluation of brain trauma and injuries resulting from oxygen deprivation, tumor or cumulative concussions. They function m a medical area significantly different than general psychologists. Commenter stats that there is a vast difference between what psychologists do and what neuropsychologists do. Psychologists in the work comp setting typically evaluate, diagnose, and treat behavior and mental processes. On the other hand, according to the National Academy of Neuropsychology, "A clinical neuropsychologist is a professional within the field of psychology with special expertise in the applied science of brain-behavior relationships. Clinical neuropsychologists use this knowledge in the assessment, diagnosis, treatment, and/or rehabilitation of patients across the lifespan with neurological, medical, neurodevelopmental and psychiatric conditions, as well as other cognitive and learning disorders. The clinical		See response above. See response above.	None. None.

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	neuropsychologist uses psychological, neurological, cognitive, behavioral, and physiological principles, techniques and tests to evaluate patients' neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning. The clinical neuropsychologist uses this information and information provided by other medical/healthcare providers to identify and diagnose neurobehavioral disorders, and plan and implement intervention strategies." Commenter notes that statistics provided by the DWC's Workers' Compensation Information System (WCIS) in June of 2014 indicate that from 2000 through 2013, there were 39,203 brain injuries reported - an average of 2800 brain injuries per year. Over that same period, 24,821 concussion injuries were reported. These numbers are not statistically large in the scope of the hundreds of thousands of workers compensation claims reported each year. However,		See response above.	None.

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	they are rarely single-diagnosis claims and represent some of the most complicated and costly injuries possible. For the workers and their families, those costs go far beyond the hard costs of medical care, temporary and permanent disability. Commenter states that it is clear that when an injured worker suffers a traumatic brain injury, he/she needs to be evaluated by a neuropsychologist, not a general psychologist. Commenter opines that if the DWC abolishes the QME designation for neuropsychologists and folds them into the category of "general psychologists," there is a high probability that these critically injured workers will never receive a random QME panel of three neuropsychologists. This is not a good outcome for the injured worker or the employer who is responsible for paying the claim costs. Commenter states that a possible alternative would be for the worker to obtain representation - hire a lawyer – so that an Agreed Medical Evaluator		See response above. See response above.	None. None.

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	could be chosen. It is doubtful that employers want to advocate for this "alternative."			
	Commenter states that the real effect of reclassification can be explained with some relatively simple mathematics. According to a DWC spokesperson[1], there are approximately 450 psychologist QMEs in California and 157 neuropsychologists. Therefore, if these two specialties were combined, neuropsychologists would account for approximately 25.9% of the new pool. Yet, to injured workers, claims administrators and the Division, they would be indistinguishable from one another.		See response above.	None.
	Commenter notes that in 2014, the DWC created 633 neuropsychology panels. At the same time, it created 8,436 psychology panels. In essence, there were 13 times more psychology panels than neuropsychology panels, but only neuropsychologists specialize in traumatic brain injuries.		See response above.	None.

[1] Workcompcentral.com, "Legislation Seeks to Head off DWC Effort to Remove Neuropsychology QMEs" April 27, 2015

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	Commenter opines that if neuropsychologists are merged with psychologists, the chance that an injured worker who needs a neuropsychological evaluation receiving a panel with three appropriate specialists will drop from the current 100% to 1 in 66. That is, there will be no better than a 1.5% chance that an injured worker with a brain injury will receive a panel of three physicians trained in neuropsychology. Given the fundamentals of the QME search process, the statistical probability of receiving a panel of this specialty type does not improve with repeated attempts.		See response above.	None.
	Commenter opines that because QME panels are generated using the residential address of the injured worker at the center of each search, a second, third, fourth or virtually any subsequently generated panel could produce the same three general psychologists unless the DWC intervenes and by intervening, violate the requirement that the process be		See response above.	None.

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	random. Commenter states that DWC intervention would be in vain simply because the Division would have no way of distinguishing these especially skilled physicians from their general psychologist peers. Comment opines that repeated attempts to generate a useful panel will be expensive for employers because the DWC may have to create a series of random QME panels until it happens to get one that just includes neuropsychologists. This delay will negate the efficiency of the new electronic request system. Additionally, the employer will pay additional Temporary Disability benefits in some cases and delays will certainly have a detrimental effect on the medical condition of these severely injured workers as they wait and wait.		See response above.	None.
	Commenter states that in order to provide the Division with the required statutory authority to prevent the abolition of the QME Clinical Neuropsychologist specialty category, an urgency bill, co-sponsored by		This comment is beyond the scope of this rulemaking.	None.

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	CSIMS and the California Psychology Association was recently introduced by Assembly member Devin Mathis (R-Visalia) and co-authored by Ken Cooley (D - Rancho Cordova). It is anticipated that this bi-partisan legislation may move successfully through the legislative process without undue delays. Since the legislative process is not yet complete, commenter requests that the Division thoughtfully consider the negative repercussions of the proposed regulatory change that abolishes the very useful and medically critical designation of Neuropsychologist.			
100, 104, 105, 106	Commenter opposes the proposal to eliminate the specialty designation of neuropsychology. Commenter states that clinical neuropsychologist is a	Eric Freitag Neuropsychologist and QME California	Disagree. The California Board of Psychology, the licensing board for psychologists, does not	None.

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	professional within the field of psychology with special expertise in the applied science of brain and behavior and how it affects one's functioning. Neuropsychologists evaluate a patient or an injured worker who has a known or suspected brain injury or brain disease and evaluate how their brain functions and how that might impact their day-to-day behavior and ability to function. Neuropsychologists obtain advanced training in both the pre-doctoral and post-doctoral level and use this knowledge in the assessment, diagnosis, and treatment of patients with neurological disorders or injuries. Clinical neuropsychology is a specialty recognized by the American Psychological Association. Commenter states that the activities of a neuropsychologist, whether that be evaluation, testing, treatment, diagnostic formulations, differ significantly from the approaches and techniques used by a general psychologist. Commenter states that a psychologist without the proper training and specialization in neuropsychology would not be able to	Psychological Association May 22, 2015 Oral Comment	recognize subspecialties. The Administrative Director under Labor Code section 139.2(a) has the authority to decide which specialties to recognize as part of the QME process; the Administrative Director chose to recognize only those specialty boards recognized by the respective physician licensing boards. The California Board of Psychology has jurisdiction to recognize specialty areas of practice and it does not recognize neuropsychology boards. In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist.	

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	competently administer a neuropsychological test battery. Commenter opines that the proposed regulatory actions ultimately place the injured worker at risk for either a delay in adjudication of their claim, or, potentially more seriously, obtaining an evaluation from a non-competent provider. Commenter supposes that a worker has sustained a traumatic brain injury and this worker obtains a Panel QME from a psychologist with no expertise in brain injury or no expertise in neuropsychological evaluation. Ethics would actually require that the psychologist decline the evaluation, which would certainly delay the worker's claim process. However, commenter states that there is a possibility that a psychologist may perform the evaluation and come up with conclusions that were erroneous that would impact the worker's claim and potentially also impact their future health care. Commenter states that organizations are working with Assemblymen Mathis and Cooley in support of AB 1542. This bill would		The California Board of Psychology, the licensing board for psychologists, does not recognize subspecialties. The Administrative Director under Labor Code section 139.2(a) has the authority to decide which specialties to recognize as part of the QME process; the Administrative Director chose to recognize only those specialty boards recognized by the respective physician licensing boards. The California Board of Psychology has jurisdiction to recognize specialty areas of practice and it does not recognize neuropsychology boards. In the event that a psychologist is unable to perform the necessary evaluation, the psychologist QME can arrange for diagnostic tests with a neuropsychologist. This will give injured workers wider	None.

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	provide a legislative solution to this regulatory issue. Commenter requests that the Division delay in making any rule changes at this point to allow the legislative process to unfold.		access to a wider geographic area. According to the DWC database, in 2013, of the 120,000 panels requested, only 381 were requested in neuropsychology.	
	Commenter's biggest concern with these proposed regulatory changes is the change in specialties that is being proposed. Neuropsychology. Neuropsychology is a very important specialty and the only one that's competent to evaluate closed-head trauma. It's not the same as a psychologist or psychiatrist and throwing it into the mix is going to lead to QME panels that do not have competent physicians to evaluate head trauma cases. Commenter has handled cases of closed-head trauma where the treating psychologist or psychiatrist felt the person had severe brain damage and would probably never be able to work again. Commenter got them to visit a neuropsychologist who did extensive testing and determined that there was no brain damage, per se,	Mark Gearheart Board of Governors California Applicants' Attorneys Association May 22, 2015 Oral Comment	See response above.	None.

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	but the problem was psychological and the person needed a specific type of treatment involving mental retraining and they would be fine. Commenter states that these injured workers need a lot of reassurance, but there wasn't brain damage. Commenter cannot imagine what's going to happen if this specialty's eliminated. Commenter states that the rationale in the Statement of Reasons is misinformed. The change it says is required by Labor Code Section 139.2 because the California Medical Board does not recognize neuropsychology as a specialty. However, psychologists are not licensed by the medical board, they're licensed by the California Board of Psychology under the Department of Consumer Affairs. This has nothing to do with the medical board. And labor -- pardon me, Labor Code Section 16 139.2(b) (5) only requires that the QME in psychology be Board-certified in clinical psychology by a Board recognized by the Administrative Director. The American Board of Clinical Psychology is one of the boards		See response above.	None.

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	governed by the American Board of Professional Psychology, so the legal rationale is incorrect. And we did -- C.A.A.A. submitted written comments electronically that include this argument on these citations, but we think that's a real problem. And, in fact, I think the changes in the medical 25 specialties are really a solution in search of a problem. Commenter does not know what problem this is supposed to solve. It just creates one. It doesn't solve any problems. And the same could be said of the oncology changes. I don't really think there is a problem. Commenter is unsure what's being solved. The Statement of Reasons simply says, We're not going to offer these specialties anymore. It doesn't say why. So one's left to wonder, is there no reason or perhaps there have been secret discussions with certain interested parties prior to the regulatory process without all stakeholders being involved and someone's got a hidden agenda? Commenter states that there's no basis for it. Commenter believes that the changes will deprive both employers and employees in many cases of			

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	having someone who's competent to evaluate the injury in the list of QMEs. Commenter opines that the ultimate solution is to get rid of the Schwarzenegger-era QME system, which is absolutely unworkable, defective, and causes poor-quality evidence, delays and increased frictional costs, but I realize that's statutory, so we'll move on. Commenter hopes that someday the Legislature and the Governor will come to their senses and get rid of that. It's a bad system, but these changes will make it worse. Commenter states that he and his organization supports the online QME process. Commenter opines that the QME process is flawed, it doesn't work well for anybody, but the online process is a good idea and he commends DWC and appreciates the effort that's gone into this. It's a great idea and he supports it. Commenter does thing that there's a couple of problems and he would like to call attention to them. One is this idea that		This comment is beyond the scope of this rulemaking. As this is an automated system, this will ensure that the opposing side is served with and can verify all documents relied upon in requesting a panel list. The Medical Unit also needs this information if there are technical issues the user is experiencing.	None. None.

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	the party requesting the panel should attach supporting documentation like the objection letter and all these things. Commenter opines that this suggestions to him that the DWC has not completely gotten away from the concept of the Medical Unit screening these things, which is the problem. Commenter states that the Medical Unit's not competent to screen these things. He just got another one last week where he had submitted the panel request on the 17th day after the objection letter and the Medical Unit rejected it because we requested it too early. The Medical Unit's doing a remarkably poor job with the 12 panel QMEs. Commenter opines that the problem is that the Division either has people who aren't qualified or competent or overloaded screening these things. This shouldn't happen. If somebody wants a panel, give them a panel. If there is a dispute, go to the Board. Commenter questions submitting documentation electronically to the Medical Unit that has already been sent to the other side? Are they going		As this is an automated system, this will ensure that the opposing side is served with and can verify all	None.

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	to screen these? If they're going to screen them what's the point of having an online process? It won't speed anything up. The point of an online process is to eliminate the human errors. Give us a panel. If the other party has an objection, go to the Board.		documents relied upon in requesting a panel list. The Medical Unit also needs this information if there are technical issues the user is experiencing.	
	Commenter recommends that language be added about supporting documents. If there's some supporting document that hasn't been previously served, that should be attached. But normally these will all have been served on the other side. Commenter opines that if the Division is going to get away from having bureaucracy impede the process with human screening, then why do the document need to be attached?		See response above.	None.
	Commenter does not know why the administration continues to violate Labor Code Section 124(b) which requires that all forms of notices given to the employee by the Division shall be in English and Spanish. Commenter states that the ongoing discrimination against Spanish-		Agreed, however, this is beyond the scope of this rulemaking and will be addressed in the future.	None.

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	speaking people is unacceptable, illegal, and inexcusable.			