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1(c)(c)	Commenter recommends the following revised language: (cc) "Request for factual correction" means a request by an unrepresented injured worker or a claims administrator, *or their representative*, to a panel QME: 1) to change a statement or assertion of fact contained in a comprehensive medical-legal evaluation that is capable of verification from written records submitted to a panel QME pursuant to section 35 of title 8 of the California Code of Regulations. ***2) to address specific issues completely*** ***3) to follow regulatory procedures for reporting established by the administrative director.*** Commenter strongly urges the Division to take note of authorizing statute Labor Code section 4061 subsections (d)(1) The statute states that the parties may each request one supplemental report "seeking correction of factual errors in the report." Commenter believes that the	Julianne Broyles California Association of Joint Powers Authority June 17, 2013 Written Comment	Rejected. This comment was previously submitted by Julianne Broyles on April 4, 2013 and was rejected.	None

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	Request for Factual Correction process should support the correction OR clarification of factual errors regarding an issue that pertains to any/all benefits provided under workers' compensation. Commenter opines that the purpose of the reform of this statute by SB 863 was to allow the parties to obtain a **complete and accurate** report from the QME, on which all determinations of workers' compensation benefits are made. If this medical opinion fails to address all issues completely and accurately, an injured worker's benefits are then delayed and employer costs increase –both results are contrary to the intent of the stakeholders involved in the reforms discussions. Commenter notes that corrections or additional reports are permitted in every section of this rulemaking package, with the exception of Regulation 37. Commenter does not understand why, in this critical area alone, corrected or updated medical information is barred. If this section is			

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	left unchanged, it begs that question of why bother seeking the permanent disability rating if the request will be rejected as incomplete. Commenter opines that it makes no sense to be required to use a defective report when simple communication, as authorized by statute, could clarify relevant issues. Commenter states that parties should be able to append medical reports or medical evaluations not previously sent to these report in order to cure a defective QME report in the most expeditious means available. This means the injured employee obtains benefits faster and reduces cost of the claim paid for by the employer.			
1(s)	Commenter opines that if the administrative director (AD) will not allow incomplete medical legal reports to be corrected with a supplemental report prior to the permanent disability rating, then the regulations should impose a realistic consequence for QMEs who fail to address all relevant issues, file incomplete reports, or fail to meet the regulatory and procedural requirements relating to medical legal evaluations.	Michael McClain General Counsel California Workers' Compensation Institute (CWCI) June 18, 2013 Written Comment	Rejected. See the response to Michael McClain's comment of April 4, 2013.	None

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	Commenter states that the recommendation that the failure to address all relevant issues or to file a complete report should be considered a factual error that should be corrected by a supplemental report before the QME report is referred to DEU for rating appears to have been rejected. Commenter states that this problem still remains and the rationale for requiring correction prior to the rating is still valid. Commenter opines that the AD should investigate other means to incentivize or penalize medical legal evaluators for the failure to meet their statutory responsibilities. Title 8, section 10606 defines the reporting physician's obligation to address all relevant medical and legal issues. A QME report that fails to do so is incomplete and legally incompetent. A medical legal evaluation that omits an opinion regarding apportionment, fails to address relevant issues, or violates pertinent regulations does not meet the requirements of the QME's statutory role and only delays the resolution of the claim and the payment of appropriate			

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	benefits to injured workers. If the AD believes that a defective report cannot be remedied before the DEU rates it, commenter opines that there should be some significant consequence for issuing an incomplete report, such as reducing the evaluator's reimbursement, tracking the number of defective reports for consideration in renewing the physician's QME status, or auditing the QME's work product.			
1(t)	Commenter states that the following last sentence of this subsection should be eliminated: **This opinion is not binding in any proceeding concerning an injured worker's need for medical treatment.** Commenter opines that this sentence relating to scope of PQME or AME opinions regarding future medical care should be eliminated. It is not contained in any statute. IMR is now (07/01/2013) the dispute resolution process for valid, timely UR denials to medical treatment requests. However, there already exist many cases where the PQME or AME opinion	Bret Graham President Latino Comp June 14, 2013 Written Comment	The phrase is being stricken because it was the intent to strike the sentence after the 45 day comment period. The term "future medical care" is used in Labor Code section 4061 and is a term that needs to be defined. This rule does not impact requests for future medical care in cases where an award of future medical care has already been made. As the commentator points out disputes about appropriate treatment in cases with future medical care awards are no longer resolved through the QME/AME process, but by the IMR process. Therefore, the	The sentence is being stricken.

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	ALREADY resolved "future medical care" dispute before applicability of IMR process. Commenter opines that it is a waste of medical, financial and judicial resources to "re-litigate" those already resolved disputes through the new IRM system. Additionally, Commenter states that it may certainly be the case where the PQME or AME opinion is the ONLY evidence or reporting on a treatment request and then it would, in effect, be binding.		entitlement to medical treatment will not litigate any past issues using IMR.	
1(t)	Commenter opines that it is unclear whether the last sentence of this subdivision (beginning "This opinion is not binding . . . .") is to be deleted. In the Notice of 15 Day Changes, pages 3 - 4, the description of this subdivision suggests that the last sentence will be deleted. In addition, the Notice includes a recitation of the entire modified subdivision that excludes the last sentence. However, the Text version of the proposed subdivision includes this sentence. Commenter strongly recommends that the definition of "Future Medical Care" in this subdivision be amended.	Mark Gerlach California Applicants' Attorneys Association June 18, 2013 Written Comment	Rejected. See the responses to the comments of Julianne Broyles, California Association of Joint Powers Authorities, April 4, 2013, Written Comment; Mark Gerlach, California Applicants' Attorneys Association, April 4, 2013, Written Comment; Mark Gearheart, California Applicants' Attorneys Association, April 4, 2013, Oral Comment. The comment also misunderstands the nature of the disputes resolved by QME. Labor Code section	None.

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	This subdivision defines future medical care as limited to treatment after the injured worker has reached maximum medical improvement or a permanent and stationary status, and references CCR §10606 regarding physicians' reports as evidence. Commenter opines that the problem with this definition is two fold: It would appear to require physicians to submit reports that are not substantial evidence, and it is inconsistent with the statute. The first of these problems arises because an employee is not permanent and stationary until all reasonable healing modalities have been attempted and all reasonable diagnostic testing has been completed. *City of Glendale v. WCAB* (*Forrest*) (1982) 47 Cal. Comp. Cases 168 (Writ denied), *Wyland Entertainment v. WCAB* (*Norton*) (1975) 40 Cal. Comp. Cases 617(Writ denied). When the possibility of improvement by additional medical treatment has become remote, the injured worker is permanent and stationary. *General Foundry Service v. WCAB* (*Jackson*)		4061 which is designed to resolve a dispute after the primary treating physician has found an injured worker is P & S "concerning the existence or extent of permanent impairment and limitations *or the need for future medical care.*" (Emphasis supplied) The definition of future medical care fits the dispute that needs to be resolved in the newly amended 4061, whether the injured worker is entitled to an award of medical treatment. All of the cases cited by the commentator predate the current medical dispute resolution system using the QME process implemented by the Margolin-Greene Workers Compensation Reform Act in 1989 and as modified by subsequent reform legislation. The comment and the cases cited in the comment raise a different issue: what is the scope of an AME or QMEs	

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	(1986) 42 Cal. 3d 331, 51 Cal. Comp. Cases 375; *Braewood Convalescent Hospital v. WCAB* (*Bolton*) (1983) 34 Cal. 3d 159, 48 Cal. Comp. Cases 566. The California Supreme Court explained in *Jackson* that permanent and stationary status is a question of fact for the Trier of Fact; that is, the Workers' Compensation Judge. In order to make this determination, the WCJ must have substantial evidence. The WCJ is required to state the evidence relied upon and specify in detail the reasons for his or her opinions. *LeVesque v. WCAB,* 35 Cal. Comp. Cases 16. If the rules prohibit physicians from discussing what diagnostic studies or treatment is needed for the patient to become permanent and stationary, their report will not be substantial evidence. It is essential that evaluating physicians review not only past treatment, but specifically discuss whether there is further treatment that should be provided for the injured employee to become permanent and stationary. Barring the evaluating physician from discussing these issues means the		ability to comment on the medical treatment prior to an injured worker being P & S or MMI? The cases cited by the commentator are not situations covered by Labor code section 4061. In the *Braewood Convalescent* case the issue was whether a weight reduction program was reasonable and necessary to cure and relieve the injured worker's injuries is now a medical treatment issue. In *Norton,* the appeals board held that injured worker was entitled to an award of both "continuing temporary disability and further medical care" because the worker was recovering from the effects of surgery, but what was not at issues was the nature of the medical treatment received by the worker. Finally, in *Forrest,* the issue apparently was whether the injured worker needed a myelogram to diagnose the nature of the worker's condition. Under the	

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	report will not constitute the substantial medical evidence per *LeVesque* that the WCAB may rely on for a decision, creating a system where the state requires employers to pay for evaluations that are useless. The end result would leave the dispute resolution system in disarray; *increasing* litigation, employers' costs, and delays for injured workers. Commenter opines that the proposal to limit medical doctors from evaluating a case is completely unnecessary to the goal of resolving specific treatment disputes through independent medical review, which we believe is the intent of this provision. Instead of this blanket prohibition, commenter recommends that the rule simply indicate that the opinion of the evaluating physician is not binding. Combined with the clear statutory rules for resolving disputes over medical necessity, this language would achieve the goal. Commenter opines that unnecessarily restricting the scope of an evaluator's exercise of his or her expertise will only result in a system that mandates the production		current dispute resolution system, the need for the myeloram would be resolved through IMR. To the extent that the cited cases establish a legal principal that if continuing medical treatment is medically necessary to cure or relieve the injured worker from the effects of the injury the need for the medical case would defer a finding of P & S status or TD as a matter of law until the treatment has been provided. Treatment. *(See Cal. Code of Regs., tit. 8 § 9785(a) (6).)* Depending on the issue, a trier of fact may have to look to evaluations from QMEs, AMEs or IMR decisions for substantial evidence on an issue. It is also simply not the case as the commentator strongly suggests that substantial medical evidence on all issues	

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	of reports that are not substantial evidence. In order to assure minimal delay in resolving disputes and delivering benefits, commenter opines that these rules must not prohibit QMEs from addressing, as necessary, all medical issues relating on an ancillary basis to any other allowed issue, including but not limited to temporary disability, MMI status and permanent disability. Commenter strongly urges that these proposed rules be amended to provide simply that the AME or QME shall not provide an opinion on a medical treatment issue that is currently the subject of an active UR/IMR dispute resolution process. This amended language would comply with the statute, meet the legislative goals, and allow medical experts to generate competent opinions regarding permanent and stationary status, temporary disability, et cetera.		must flow from a single source. The legislature has expressly removed AMEs and QMEs from resolving disputes concerning the nature and extent of medical treatment. Section 1(f) of SB 863 expresses the Legislative finding the IMR process "will be more expeditious, more economical, and more scientifically sound than the existing function of medical necessity determinations performed by qualified medical evaluators appointed pursuant to Section 139.2 of the Labor Code. The existing process of appointing qualified medical evaluators to examine patients and resolve treatment disputes is costly and time consuming, and it prolongs disputes and causes delays in medical treatment for injured workers. Additionally, the process of selection of qualified medical evaluators can bias the outcomes." (Labor Code §§ 4061(Removing the	

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			term “continuing medical care” and replacing it with “future medical care” and adding language stating the section does not apply to medical disputes under Labor Code sections 4610 and employee disputes under sections 4616.2 and 4616.4.concerning MPNs ; 4062 (a); 4610.5. (Disputes over medical necessity of treatment recommended by the primary treater resolved through UR /IMR process.) The direct conflict with the legislative intent outlined above is expressed by the commentator as "[i]t is essential that evaluating physicians review not only past treatment, *but specifically discuss whether there is further treatment that should be provided for the injured employee to become permanent and stationary*." (Emphasis supplied) The problem is not whether *past medical treatment* should be described or discussed by the	

			AME or QME, but whether QME or AME should express any opinion about the nature of the contemporaneous medical treatment provided to the injured worker. The legislature has said no because disputes over any need medical treatment, at any time, are consigned exclusively to the UR/IMR process. (Labor Code §§ 4062; 4610.5.) Obviously, a QME should also not provide opinions about issues, like medical treatment, that are not disputed by the parties. *(Cal. Code of Regs., tit. 8, § 9793 (b) (4) (Contested claim means a disputed medical fact.)*	
1(t)	Commenter recommends the following revised language: **Subsection (t): Future Medical Care:** (t) "Future medical care" means medical treatment as defined in Labor	Julianne Broyles California Association of Joint Powers Authority June 17, 2013 Written Comment	Rejected. The identical comment was already made April 4, 2013, by the same commentator and rejected in the 45 day comment period.	None

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	Code section 4600 ~~that is reasonably required to cure or relieve an injured worker of the effects of the industrial injury after an injured worker has reached maximum medical improvement or permanent and stationary status including a description of the type of the medical treatment which might be necessary in the future. This opinion is not binding in any proceeding concerning an injured worker's need for medical treatment~~ ***which might be necessary in the future after maximum medical improvement status. The AME/QME opinion shall only be considered on the issue of future medical care which might be needed and shall not be considered on any past, current or continuing care treatment recommendations.*** Commenter agrees with the modification to insert "as described in section 10606(d) of title 8 of the California Code of Regulations" at the end of the first sentence of the subdivision.			

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13(b)	Commenter is of the opinion that the proposed language in this new subsection is inconsistent with subdivision (a) of Regulation 13, Labor Code Section 139.2(b) (3) and the DWC's own QME Form 104. Labor Code Section 139.2(b)(3) provides that medical doctors (MDs) and doctors of osteopathy (DOs) must meet one of four qualifications to be qualified medical evaluators (QMEs). Subdivision (3) of Labor Code Section 139.2(b) reads, as follows: *(3) Is a medical doctor or doctor of osteopathy and meets one of the following requirements:* *(A) Is board certified in a specialty by a board recognized by the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California.* *(B) Has successfully completed a residency training program accredited by the American College of Graduate*	Carlyle Brakensiek Legislative Advocate Advocal June 7, 2013 Written Comment	Rejected. The requirement in subdivision (b) for a QME to provide written documentation of their compliance with the provisions of subdivision (a) of the same section is not inconsistent. The form 104 is not inconsistent because all QMEs are required to have a specialty when they are appointed. (Lab. Code § 139.2.) Section 13 provides guidance with respect to the recognition of specialties. That section states "[a] physician's specialty (ies) is one for which the physician is board certified or, one for which a medical doctor or doctor of osteopathy has completed a postgraduate specialty training as defined in Section 11(a) (2) (A) or held an appointment as a QME in that specialty on June 30, 2000, pursuant to Labor Code Section 139.2." The rule does not contemplate chiropractic specialties. In SB 863, the	None

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	Medical Education or the osteopathic equivalent. *(C) Was an active qualified medical evaluator on June 30, 2000.* *(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.* When Section 139.2 was added to the Labor Code in 1989 (AB 276 (Margolin - Ch. 892, Stats. 1989)), it initially required all QMEs to be either board certified or board eligible. The Legislature soon discovered, however, that some physicians who had been practicing occupational medicine competently for many years in various specialties were neither board certified nor board eligible. In some cases, physicians had practiced in specialties before certification even existed for their		legislature eliminated a 300 hour post graduate specialty track for chiropractor's to qualify as QMEs.	

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	particular specialty. Accordingly, beginning in 1990 and subsequently, the Legislature amended Section 139.2 to recognize these practical realities. The Industrial Medical Council (IMC) supported these changes and the current version of Labor Code Section 139.2(b)(3) quoted above reflects that recognition. Commenter notes that both the current and proposed Regulation 13 do not provide any guidance for recognizing chiropractic specialties. In view of Regulation 311.1 (Title 5, California Code of Regulations) adopted by the Board of Chiropractic Examiners, commenter recommends that the Administrative Director consider further modifying Regulation 13(b) to cover chiropractic specialties. Commenter suggests the following revised language: *(b) All requests by a physician to add or remove a medical specialty shall be in writing.* (1) *A ~~physician~~ <u>medical doctor or doctor of osteopathy</u> seeking to add or*			

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	change specialties shall include the documentation specified in subdivision (a) that establishes ~~the physician is board certified in the specialty recognized by the Administrative Director that the physician wishes to add~~ one of the following: *(A) board certification;* *(B) completion of an accredited residency training program,;* *(C) appointment as an active qualified medical evaluator on June 30, 2000;* *(D) proof of qualifications equivalent to board certification.* *(2) A doctor of chiropractic seeking to add or change specialties shall include the documentation specified in subdivision (a) that establishes that he or she is certified by a board recognized by the Board of Chiropractic Examiners pursuant to Regulation 311.1, Title 16, California Code of Regulations.* *The failure to provide proof of certification documentation of one the foregoing shall be grounds to deny the*			

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	request.			
13(b)	Commenter states that for Orthopaedic Surgery, the process to become board certified takes several years including passing a written test (Part I) and then passing an oral test (Part II). Part II requires that a surgeon practice for 2 years. Commenter opines that practicing Orthopaedic surgeons who are board eligible should be allowed to be QMEs. Commenter states that for Orthopaedic Surgery subspecialties such as Hand or Spine, there are no board certifications within Orthopedic Surgery. There are certificates of added qualification but not all Hand surgeons or Spine surgeons possess these. General Orthopaedic surgeons operate on the hand and spine as part of their orthopedic practice and thus should be able to do QMEs in Hand and Spine as it is in the practice scope of General Orthopedics. Commenter opines that restricting QMEs for Hand and Spine to only fellowship-trained surgeons would severely limit the number of available Orthopedic Surgeons to do QMEs in the state.	James Chen, MD June 5, 2013 Written Comment	Rejected. The comment appears related to the addition of 13(b) which would require written documentation of the QME's qualifications to be listed in a particular specialty. The commenter misunderstands the rule. Under section 13 of the current rule, which is being renumbered to section 13(a), a QME's specialty is determined, except for one circumstance not applicable here, by the QME's education and training. Rule 13 categorizes a QME's specialty as one where the physician has completed a postgraduate training program approved by the AGCME, i.e. a residency program, *(Cal. Code of Regs., tit. 8, §§ 11(a)(2)(A); 13)*, one for which the physician is board certified or the physician's licensing board must recognize the designated specialty board. *(Cal. Code of Regs., tit. 8, §13.)* The AD has	None.

	Commenter requests that the Division take this into consideration on the proposed regulations as the requirement for Board Certification is quite onerous for Orthopedic Surgery and in particular there are no Board Certifications for Hand Surgery or Spine Surgery.		administratively grouped medical doctor specialists who meet the qualification cited above into the specialties of "spine" and "hand" for the convenience of injured workers and other workers compensation professionals. These groupings are composed of orthopedists that have either completed a residency program or are board certified in orthopedics. The commenter erroneously believes the completion of a residency to be listed in the specialty is insufficient to be listed in the hand or spine specialties.	
26 (d)	Commenter recommends the addition of a "subsection d" with the following language: **(d) If a QME moves to a new office location that is within 3 miles of the QME's previous office, the QME may transfer scheduled QME evaluation to the new office upon 30 days advance notice to all parties.** Commenter opines that this would	Peter R. Osinoff Theresa Taing Bonne, Bridges, Mueller, O'Keefe and Nichols June 18, 2013 Written Comment	Rejected. The concept of good cause encompasses the type of issues described in the comment. Termination of a lease is also an issue of good cause. If accepted, the remainder of the suggestions would subvert the intent of the rule which is to create stability about where examinations will take place. The regulations provide a framework for	None

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	give a QME the flexibility to make smart business decisions, like moving down the street to reduce overhead, without slowing a claimant's access to benefits.		QME's to craft their lease arrangements.	
26(b)(1) and (2)	Commenter opines that although this section states that good cause is not limited to the circumstances described in subsections 1-3, commenter recommends that additional examples of good cause be provided for guidance that will predictably be needed. Commenter suggests that following revisions and the addition of a fourth (4) subsection: (1) natural disasters, ~~**or other**~~ community catastrophes, **or habitability issues** that interrupt the operation of the evaluator's business **or may adversely affect the proper evaluation, health, and welfare of claimants;** (2) for an office location defined in Section 26(a), the expiration of a written lease agreement of not less than 12 months duration, **or the termination or material change by the lessor of a written lease agreement of**	Peter R. Osinoff Theresa Taing Bonne, Bridges, Mueller, O'Keefe and Nichols June 18, 2013 Written Comment	See responses to comment to rule 26(d).	None

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	any length that adversely affects the performance of evaluations; **(4) at any time after a QME has moved to an office that has been designated as a temporary office, the QME may move to an office location with a lease agreement of not less than 12 months duration, or to a property owned by the QME, without maintaining the temporary office for 180 days.**			
30(a)	Commenter states that the revised language of this subdivision includes a requirement that the party requesting a QME panel shall attach a written objection indicating the identity of the primary treating physician, the date of the physician's report that is subject to objection and a description of the medical determination that requires a comprehensive report. Not only does the commenter believe that this change is not authorized by the governing statute, he believes the adoption of this rule would seriously impair the rights of many injured workers. Subdivision (a) specifically applies to	Mark Gerlach California Applicants' Attorneys Association June 18, 2013 Written Comment	Rejected. Labor Code sections 4061 and 4062 require an objection to a determination of the treating physician before requesting a QME. See Stephen J. Cattolica Director, Government Relations AdvoCal, April 4, 2013, Written Comment in the 45 day comment period. In addition the following cases require there be an objection to a determination of the treating doctor before the QME process is invoked State Comp. Insurance Fund v. Workers' Comp. Appeals Bd. (2008 44 Cal. 4th 230; J.C. Penney Co.	None.

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	unrepresented cases. Because unrepresented employees are not served with medical reports, commenter opines that this new requirement will result in most affected employees being unable to ever request a panel. Nothing in the statute requires such specificity in requesting a panel QME. Requiring an unrepresented injured worker to specify the specific report objected to, when they almost never have any medical reports, will only put these workers at an even greater disadvantage than they already are. Commenter has previously commented on why he believes that this same requirement should not apply in represented cases, and finds the reasons are even more compelling in the case of unrepresented injured workers. Commenter strongly urges that this requirement be eliminated for both unrepresented and represented employees, deleting the appropriate language in subdivisions (a)(1) and (b)(1).		v. Workers' Comp. Appeals Bd. (Edwards) (2009) 175 Cal.App.4th 818; Tenet/Centinela Hospital Medical Center v. Workers' Comp. Appeals Bd. (Rushing) (2000) 80 Cal.App.4th 1041; County of Santa Barbara v. Workers' Comp. Appeals Bd. (1999) 64 Cal.Comp.Cases 907 (writ denied); and, San Diego Gas & Elec. v. Workers' Comp. Appeals Bd. (1997) 62 Cal.Comp.Cases 384 (writ denied).	

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30(b)(1)	Commenter recommends the following revised language: (1) identify the disputed issue attach a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical ~~dispute~~ determination that requires a comprehensive medical/legal report to be resolved or attach a request for an examination to determine the compensability under Labor Code section 4060; Commenter opines that the phrase should parallel the language in section 30(a) (1).	Michael McClain General Counsel California Workers' Compensation Institute (CWCI) June 18, 2013 Written Comment	Accepted	Subdivision (b)(1) was changed.
30(c)(2)	Commenter notes that this proposed regulation provides that the Medical Director may "revoke" a panel if the Medical Director is "satisfied" that the panel was issued by mistake, misrepresentation of fact, or if the parties have agreed to use an AME. Commenter recommends that this provision be deleted. If the parties agree to use an AME,	Mark Gerlach California Applicants' Attorneys Association June 18, 2013 Written Comment	Rejected. The purpose of this section is to manage panels issued by mistake and to clarify for the parties which panel was correctly issued. For example, Labor Code section 4062.2 (f) now requires in represented cases "[a] panel shall not be requested pursuant to subdivision (b) on any issue that has been agreed to be	None.

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	there is no reason to revoke the panel; the parties simply go to the AME. That is already happening in some cases. Commenter opines that there is a problem with having the Medical Director revoke panels for alleged mistake or misrepresentation when the Medical Director is "satisfied". What does "satisfied" mean? What is the legal standard? What is the procedure for a party to request revocation based on mistake or misrepresentation? What are the procedural rules? Are there any time limits? If there are disputed facts, how is the Medical Director going to give the parties due process (notice and an opportunity to be heard)? What rules of evidence apply regarding testimony and documentary evidence regarding the possible mistake or misrepresentation? Commenter opines that the Medical Director is not equipped to handle these types of disputes; such issues are currently handled at the Appeals Board. Commenter states that it is not even clear that the Medical Director has authority to conduct such		submitted to or has been submitted to an agreed medical evaluator unless the agreement has been canceled by mutual written consent." If a panel gets issued and the parties subsequently agree to an AME the panel can be revoked to clarify the record in the matters. In some cases parties may ask for and receive duplicate panels; in these situations one of the panels should be rescinded. In some cases, after the issuance of a panel, it comes to the attention of the Unit that the information presented in support of the issuance of the panel is wrong or misleading the panel can be revoked. The issuance of a panel is not an adversarial process and due process is not relevant because decisions concerning the issuance of panels are appealed under Labor Code section 5300(f). Finally, the current	

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	inquiries, and he believes that the Medical Director has neither the expertise nor the resources to do so. Commenter opines that if the Medical Director is going to take on this responsibility, not only should the authority be statutory, but the Medical Director needs to promulgate rules of procedure and evidence and provide the parties due process. The Workers' Compensation Appeals Board currently hears numerous disputes regarding alleged improperly issued panels, and it is well equipped to do so. Commenter opines that there is no reason that the Medical Director should become involved in this process and recommends that this provision be deleted.		QME regulations allow the revision or replacement of panels under certain circumstances. *(Cal. Code of Regs., tit. 8, § 31.5.)*	
31.7(b)	Commenter states that additional specialty QME's may be issued by DWC – Medical Unit for "good cause" which is now limited to three situations 31.7(b): (1) written agreement (which will rarely if ever occur); (2) acupuncturist (rare); or (3) WCALJ Order. The prior additional "good cause" was if the PQME or AME so advised in his/her reporting.	Bret Graham President Latino Comp June 14, 2013 Written Comment	Rejected. See the comment to rules 31.7(2) and 35.5(c) (1). The need for the additional QME is because there is an issue or issues outside the expertise of the QME. The appeals board has long recognized that one QME may not be able to address all of the medial disputes contained in	None.

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	Commenter opines that the whole point of the changes in SB 863 was to let the medical experts make medical decisions. Commenter states that in this instance, the proposed Regulation 31.7(b) (2) change removes from the medical experts (PQME or AME) the ability to explain what the limits of their scope of practice or expertise are and delegates that solely to the non-medical experts, the WCALJ's. Further, this means that in each case where additionally specialty QME's are needed, there will need to be an expedited hearing before a WCALJ. Commenter opines that this will create a massive increase in the number of hearings. Commenter opines that the DIR – Medical Unit should have faith in its own QME's that they are able to determine whether or not they are able to determine medical issues. If a QME (or AME) states in a report that a second (or more) specialty QME is needed as that area is outside the QME (or AME) expertise commenter feels that is more than sufficient for the DWC – Medical Unit to issue a second or additional panel(s). Why would the parties need to have a		the claim forms filed by the injured worker and the injured worker is entitled to additional panel examinations to resolve the issues. (*Gubbins v. Metropolitan Insurance Co.* (1997) 5.) This procedure insures that either the parties agree that a dispute exists that needs resolution and what the appropriate specialty is needed for the additional panel. If the parties cannot agree a WCJ can resolve the issues. Eliminating the ability of a QME or AME to recommend the issuance of a QME panel was deemed appropriate because many of the requests under the current rule had to do with medical treatment that was never in dispute between the parties.	

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	WCALJ, in addition, determine that issue to constitute "good cause" with the inherent delay and waste of scarce judicial resources? Commenter states that Regulation 31.7(b) should be returned to its original language.			
31.7(b)	Commenter states that that changes proposed in subdivision (b) include deletion of current paragraph (2). Paragraph (2) states that a recommendation by an AME or QME that a new evaluator in another specialty is needed to evaluate one or more remaining disputed conditions, injuries, or issues that are outside of the evaluator's areas of clinical competence is good cause to issue an additional QME panel. According to the Initial Statement of Reasons, this paragraph is being deleted "to reflect that in represented cases, parties no longer need to attempt to agree upon an AME to obtain a subsequent panel." Commenter states that it is correct that the statutory requirement to attempt to agree upon an AME has been repealed. Commenter opines	Mark Gerlach California Applicants' Attorneys Association June 18, 2013 Written Comment	Rejected. See the response to Nagar Matian, Esq., April 4, 2013, Oral Comment	None.

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	that the statutory change does not require, or in any manner justify, the deletion of the entirety of paragraph (2). The fact that represented parties no longer need to attempt to agree on an AME has no bearing on the fact that the AME or QME has stated that there are disputed issues outside of that evaluator's expertise and that another evaluator in a different specialty is needed to resolve the disputed issue(s). Commenter opines that elimination of this paragraph will only add significant delays and costs to the system. Commenter opines that the only amendment to this paragraph required by the statutory change in SB 863 is the deletion of the final clause, "and either the injured worker is unrepresented or the parties in a represented case have been unable to select an Agreed Medical Evaluator for that purpose." Commenter recommends that this paragraph be retained, amended only to delete this unnecessary last clause.			
31.7(b)(2) and (b)(3)	Commenter recommends that this subsection be deleted.	Julianne Broyles California	Rejected. See the comment to Julianne Broyles	None

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter opines that the regulatory section should be amended to delete the second reason listed to obtain and additional QME panel as it pertains to an acupuncturist QME needing a different specialty to evaluate disability. Commenter states that effective, July 1, 2013, acupuncture as a viable QME specialty is not likely to occur, making this section unnecessary and confusing. Commenter is concerned that it is too easy to obtain multiple QME panels. Commenter notes that multiple panels are very expensive and add additional costs for employers. Multiple panels also delays claim resolution. Commenter opines that the Division should require an identified good cause as the basis for an additional panel and language be added to allow for the other party to object to any order issued if those factors are not met. For that reason, commenter recommends that language be added to allow a party to object to an Order issuing a QME Panel. Alternatively, delete 31.7(b) (3).	Association of Joint Powers Authority June 17, 2013 Written Comment	California Association of Joint Powers Authorities April 4, 2013 Written Comment in the 45 day comments and the comment to Bret Graham President Latino Comp June 14, 2013 Written Comment in this 15 day comment.	

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
32(a)	Commenter suggests the following revised language: ***Consultations*** **~~Acupuncture Referrals~~** ***~~In any case where an acupuncturist has been selected by the injured worker from a three-member panel and an issue of disability is in dispute, the acupuncturist shall, notify the parties to the examination that another specialty is required to determine disability and refer the parties to the Medical Unit to request and additional panel pursuant to section 31.7(b) (2). request a consult from a QME defined under section 1(z) to evaluate the disability issue(s). The acupuncturist shall evaluate all other issues as required for a complete evaluation. If requested by the QME acupuncturist to obtain a QME to provide the consulting evaluation the Medical Director shall issue a panel within fifteen (15) days of the request in the specialty selected by the QME acupuncturist.~~*** (a) ***~~(b) Except as provided in subdivision 32(a) above~~, n*** No QME	Julianne Broyles California Association of Joint Powers Authority June 17, 2013 Written Comment	Rejected. See comment to Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment in the 45 day comment period.	None

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	may obtain a consultation for the purpose of obtaining an opinion regarding permanent disability and apportionment consistent with the requirements of Labor Code sections 4660 through 4664 and the AMA Guides . Commenter opines that all references in Section 32 to acupuncturists should be eliminated. An acupuncturist is not now able to address disability issues. Per Regulation 35(g) (2), effective July 1, 2013, they cannot opine on disputed medical treatment issues. Therefore, as of July 1, 2013 there is no functional need to retain acupuncture as a QME specialty.			
34(b)	Commenter states that the proposed language requires the initial exam to be at the address listed on the Panel selection form. Former language allowed the injured worker, "for his or her convenience" to change the exam location to another location of the same QME so long as that address was on the PQME database. This ability to change allowed for less travel distance and quicker appointments for the injured worker – after all the whole	Bret Graham President Latino Comp June 14, 2013 Written Comment	Rejected. This issue of appointment movement for the initial exam has been an enforcement problem for the AD. This rule simplifies the process of scheduling appointments by requiring the initial appointment to the location on the panel. Any subsequent appointments maybe scheduled at any available location. A QME	None

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	point is to allow prompt resolution of disputes without having to go to the WCALJ – all still under the supervision of the DWC – Medical Unit program. Commenter opines that in many instances this ability to change locations avoided having a PQME be unable to timely schedule the exam and have to go through the process of issuing a replacement panel. Commenter opines that with the limitation to 10 QME offices, inevitably, there will be more and more cases where the QME cannot see the injured worker at a convenient location or within the time limits. Commenter opines that the proposed change limits that option and will result in additional delays and hardship for the injured workers. There is no tangible benefit to this change. Commenter requests that Regulation 34(b) be returned to its original language.		should manage their evaluation calendar using the tools available in section 33 of the QME regulations.	
35(a)	Commenter would like clarity on Regulation 35(a)(3)(4)(5) in light of Regulation 35(b)(1) and Labor Code	Peggy Thill Claims Operation Manager	This is not a comment on the regulations. Labor Code section 4062.3 (b) specifies	None

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	section 4062.3(f) which provide for simultaneous service of letters to the agreed medical examiner and to opposing counsel. Is an "advocacy letter" to an agreed medical examiner subject to the 20 day service rule, or may it be sent simultaneously to the AME and the opposing party? Commenter recommends the following revised language: (3) A letter outlining the issues that the ~~evaluator~~ panel qualified medical evaluator is requested to address in the evaluation, which shall be served on the opposing party no less than 20 days in advance of the evaluation; (4) …required by Labor Code section 4610 ~~;~~ . A letter outlining the issues that the agreed medical evaluator is requested to address in the evaluation, which shall be served on the opposing party simultaneously (after prior agreement by the parties regarding the content of the letter, per Labor Code section 4062.3(c)); (5) For evaluations ~~N~~non-medical records…	State Compensation Insurance Fund June 14, 2013 Written Comment	that the 20 day requirement applies only to QMEs.	

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35.5(c)(2)	Commenter suggests the following revised language: (c)(2) If the evaluator declares the injured worker permanent and stationary for ~~*all conditions*~~ *the body part evaluated* and ~~*that*~~ the *evaluator finds* injury has caused permanent partial disability, the evaluator shall complete the Physician's ~~Return-to-Work & Voucher~~ Report *Report of Permanent and Stationary Status and Work Capacity* (DWC-AD Form 10133.36) and *simultaneously* serve it on the claims administrator *and the employee* together with the medical report. Commenter opines that without this addition one party or the other could be disadvantaged by receiving the documents late, with inadequate time within which to take necessary action.	Steven Suchil Assistant Vice President/Counsel American Insurance Association June 18, 2013 Written Comment	Rejected. Service of the documents in this section does not imply an evaluator may serve documents at different times. Serving documents at different times may constitute ex-parte contact under Labor Code section 4062.3.	None.
35.5(g)(2)	Commenter opines that this subsection is not compatible with the law per LC 4061, 4062, 4610 and especially 4610.5(a) (1), (2). Commenter opines that 35.5(g) (1) at least correctly explains that for medical disputes not subject to IMR the current	Bret Graham President LatinoComp June 14, 2013 Written Comment	Rejected. The commenter has not read section 35.5 (g) (1) that addresses the pre-07/01/2013 medical treatment issues. After 07/01/2013, UR and IMR are required to resolve the necessity of	None.

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	AME/PQME process is to be followed. Commenter opines that the proposed subsection overreaches and fails to consider that many of the medical disputes which are REQUIRED to be resolved under the current AME/PQME system have been submitted to AME's or PQME's whose evaluations will take place AFTER 07/01/2013. Under the proposed language, these disputes would not be resolved by the AME/PQME and also could not be resolved by the IMR process as it is inapplicable to those pre-07/01/2013 UR denials. Thus, there would be no resolution for all of those hundreds of thousands of disputes! Commenter states that this subsection also ignores LC 4062 and the limits of LC 4061. In short, it assumes that ALL medical treatment issues or disputes will be the subject of a UR denial and subject to the IMR process. Commenter opines that this is simply not the case and not what is happening currently nor is it what was intended by the Legislature in its changes to LC 4061, 4062, 4610 and		medical treatment disputes. See the comment to 1 (t) in response to Mark Gerlach California Applicants' Attorneys Association June 18, 2013 Written Comment.	

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	4610.5 et. seq. LC 4061 evaluations are when the injured workers has reached MMI/P&S status and there would, thus, be no current medical treatment disputes. LC 4062 evaluations, in contrast are by definition, when the injured worker has NOT reached MMI/P&S. Commenter states that it would be most appropriate for the 4062 AME/QME to opine on medical treatment -- current, ongoing and future. Commenter states that this subsection should conform to the language of LC 4062 and carve out those UR denial disputes (subject to IMR) from those matters on which the AME/QME may resolve medical treatment disputes. Commenter opines that the solution to this problem is to change the language to conform to the letter and intent of the statutes, as follows: (2) *(A)* For *all other evaluations* ~~any evaluation performed on or after July 1, 2013,~~ *pursuant to Labor Code Section 4061*, and regardless of the date of injury, an Agreed Medical			

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	Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue, but shall provide an opinion about whether the injured worker will need future medical care to cure or relieve the effects of an industrial injury. *(B) For all other evaluations pursuant to Labor Code Section 4062, and regardless of the date of injury, an Agreed Medical Evaluator or Qualified Medical Evaluator shall not provide an opinion on any disputed medical treatment issue which is the subject of a LC 4610 and 4610.5 et seq. dispute resolution process.*			
36(c)(1)	Commenter suggests the following revised language: (c)(1)The documents listed above shall be simultaneously served on the local DEU office, at the same time as serving the report~~, QME Form 111, DWC-AD Form 100 (DEU) and DWC-AD Form 101 (DEU)~~ on the claims administrator, ~~*or if none the employer*~~, and on the unrepresented employee within the time frames	Steven Suchil Assistant Vice President/Counsel American Insurance Association June 18, 2013 Written Comment	Rejected. This language was not changed in the 15 day comment period.	None.

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	specified in section 38 of Title 8 of the California Code or Regulations, unless section 36.5 of Title 8 of the California Code of Regulations applies. Commenter recommends this deletion because every possible type of employer is included in the definition of Claims Administrator found in Section 1, new subsection (i).			
37	Commenter recommends revising this section to allow supplemental reports to be requested by written letter and requests the elimination of Form 37. Commenter recommends the following revised language: (a) An unrepresented employee, or the claims administrator may request the factual correction of a comprehensive medical-legal report within 30 days of the receipt of a comprehensive medical report from a panel Qualified Medical Evaluator. (b) A request for factual correction ***using the form in section 37(f) of title 8 of the California Code of Regulations*** shall be served on the	Julianne Broyles California Association of Joint Powers Authority June 17, 2013 Written Comment	Rejected, see the response to Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment during the 45 day comment period about rules 37(b) – (f). .	None

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	panel Qualified Medical Evaluator who examined the injured worker, the party who did not file the request and the Disability Evaluation Unit office where the comprehensive medical-legal report was served. If the request for factual correction is served by the claims administrator, the injured worker shall have five (5) days after the service of the request for factual correction to respond to the corrections mentioned in the request. The injured workers' response shall be served on the panel Qualified Medical Evaluator and the claims administrator. (c) If the request for factual correction is filed *made* by the injured worker the panel Qualified Medical Evaluator shall have ten days after service of the request to review the corrections requested~~. *in the form and determine if factual corrections are necessary to*~~ ***and*** ensure the factual accuracy of the comprehensive medical-legal report. If the request for factual correction is filed made by the claims administrator or by both parties, the time to review the request for correction shall be			

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	extended to 15 days after the service of the request for correction. (d) At the end of the period for the panel QME to review the request for factual correction in subdivision (c), the panel QME shall file a supplemental report with the DEU office where the original comprehensive medical-legal report was filed. ***~~indicating whether the factual correction of the comprehensive medical-legal report is necessary to ensure the factual accuracy of the report and, where factual corrections are necessary, if the factual changes change the opinions of the panel QME stated in the report.~~*** ***~~(e) In no event shall a party file any documents with the panel QME other than the form indicating the facts that should be corrected; nor shall the panel QME review any documents not previously filed with the panel QME pursuant to Section 35 of these rules.~~*** ***~~(f) Request for Factual Correction of~~***			

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	~~***a Unrepresented Panel QME report form. [Form 37]***~~ ~~***NOTE: Form referred to above are available at no charge by downloading from the web at http://www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900. [QME Form 37]***~~ Refer to argument made by commenter in Section 1(c)(c).			
37(a)	Commenter references that the Notice of 15 Day Changes (page 6) states that this subdivision is being amended "in order to clarify that a factual correction may only be requested if the QME finds permanent disability." Commenter opines that this statement is incorrect. Subdivision (d) of Labor Code §4061 provides that either the employee or the employer may request one supplemental report seeking correction of factual errors "[w]ithin 30 days of receipt of a report from a qualified medical evaluator . . . ." Commenter opines that there is no requirement in the statute that such a request may be made only if the QME finds permanent disability. There can	Mark Gerlach California Applicants' Attorneys Association June 18, 2013 Written Comment	Rejected. The factual correction section is tied to a report of the QME that is filed with the DEU pursuant to Labor Code section 4061(f).	None.

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	be numerous circumstances where the QME finds no impairment, but the report is factually incorrect - for example, the report incorrectly states that applicant reported no complaints, or that the applicant had a prior injury that was responsible. Commenter opines that the statute permits the worker to request a supplemental report to correct such an error.			
37(b)	Commenter suggests the following revised language: (b) A request for factual correction using the form in section 37(f) of title 8 of the California Code of Regulations shall be <u>simultaneously</u> served on the panel Qualified Medical Evaluator who examined the injured worker, the party who did not file the request and the Disability Evaluation Unit office where the comprehensive medical-legal report was served. Commenter opines that without this addition that "the party who did not file the request and the Disability Evaluation Unit office" could receive notice long after the form is served on the QME.	Steven Suchil Assistant Vice President/Counsel American Insurance Association June 18, 2013 Written Comment	Rejected. Service of the documents in this section does not mean serving documents at different times.	None.

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DWC Form 104	Commenter states that the list of specialty codes the QMEs use on Form 104 to identify their specialty/specialties, that the three-letter specialty code "MMO" is used for three separate and district medical specialties: Internal Medicine – Medical Oncology; Orthopedic Surgery – Oncology, and Radiology – Oncology. Commenter opines that this overlap results in the assignment of QME panels containing physicians who may not be appropriate for an injured workers' condition. For example, commenters was informed of an injured worker with bone cancer who was given a panel of three internist which he feels that a more appropriate specialty would have been a panel of orthopedic surgeons who specialize in oncology.	Carlyle Brakensiek Legislative Advocate Advocal June 13, 2013 Written Comment Robert Weinmann June 14, 2013 Written Comment	Rejected. Substantive changes to the list of QME specialties are beyond the scope of this rulemaking.	None.
DWC QME Form 100 and 104	Commenter is concerned that the Division intends to recognize orthopedic fellowships as specialties and require fellowship certification to practice as a qualified medical evaluator ("QME") in the hand and spine subspecialties of orthopedic surgery. Commenter opines that this action would violate the authorizing	Steve Ounjian Vice President California Medical Legal Specialists, LLC June 18, 2013 Written Comment	Rejected. The changes in the form to reduce the allotted lines for fellowship information from two to one and removing the previous language concerning fellowships was done to clarify that fellowships are not the equivalent of residency	None

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	statutes and create a shortage of QMEs available to evaluate hand and spine cases. Commenter states that the administrative director's authority to recognize medical doctor specialties derives from Labor Code Sections 139.2(a), 139.2(b)(3), and 12. Commenter states that in all cases, the administrative director has authority to recognize specialties and not subspecialties. The Accreditation Council for Graduate Medical Education defines them as follows: • **Specialty Program:** A structured educational experience in a field of medical practice following completion of medical school and, in some cases, prerequisite basic clinical education designed to conform to the Program Requirements of a particular specialty; also known as 'core' programs. • **Subspecialty Program:** A structured educational experience following completion of a prerequisite		training. There is no cited authority supporting the assertion the authorizing statutes prohibit the recognition of subspecialties, indeed the current group of QME specialties already recognize subspecialties as recognized by the Medical Board.	

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	specialty program in GME designed to conform to the Program Requirements of a particular subspecialty. Commenter states that "fellowship" is synonymous with "subspecialty" and "residency" is synonymous with "specialty". • **Fellowship:** see "subspecialty program" • **Residency:** A program accredited to provide a structured educational experience designed to conform to the Program Requirements of a particular specialty. Commenter opines that a requirement of certification in hand and spine subspecialties as specialties will create a shortage of QMEs available to evaluate hand and spine cases of orthopedic surgery. Based on the above considerations, commenter urges the division to amend the proposed regulations so as to recognize specialties only.			

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DWC QME Form 100 and 104	Commenter states that her organization has received complaints from orthopaedic surgeons who are requesting to be listed under the core – orthopaedic surgeon QME category - as well as another orthopaedic specialty category on Forms 100 and 104 – spine, hand and/or oncology. It is commenters understanding that the Division automatically lists a QME under their core specialty category upon demonstration that they meet the qualifications. However, if the QME wants to be listed under a subspecialty category under their core specialty, (e.g., for Orthopaedic Surgeons - spine, hand, or oncology), their request must be reviewed by the Medical Director. Even though this system could result in some delays, commenter supports this process. Commenter believes that it is in everyone's best interest to try and match the injured worker with the most qualified QME for their particular injury. This starts with the correct placement of the QME on the panel list under the categories where they have the most expertise.	Lesley Anderson, M.D., Chair Workers' Compensation Committee California Orthopaedic Association June 12, 2013 Written Comment	Rejected. This comment is beyond the scope of this rulemaking. There is, however, no rule or policy that automatically lists QMEs in specialties they have not chosen.	None

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	After review, commenter notes that the regulations do not provide guidance to the Medical Director as to how to evaluate whether the QME qualifies to be listed in a subspecialty category. Commenter offers the following recommendation to the Division. Commenter believes that it is reasonable that the QME demonstrate one of the following in order to be listed in a subspecialty category: - Have a Certificate of Added Qualification (CAQ) in the subspecialty area - Demonstrate Fellowship training in the subspecialty area - Certify under penalty of perjury that at least 50% of their treatment practice is in the subspecialty area Commenter opines that meeting one of these criteria will help ensure that injured workers are evaluated by the most qualified QMEs.			
DWC QME Form 100 and 104	Commenter strongly supports the Division's decision to only recognize those Boards that are nationally recognized by the American Board of	Lesley Anderson, M.D., Chair Workers' Compensation	Rejected. This comment is beyond the scope of this rulemaking.	None

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	Medical Specialties (ABMS). This will ensure uniformity of high standards and transparency for injured workers. Commenter opines the many other organizations, including licensure boards, attempt to create Boards when the profession does not have nationally-recognized boards, but none of these boards have the same rigor and high standards as required by the ABMS. Commenter urges the Division not to add these additional Boards to the DWC Forms 100 or 104 as you will be establishing vastly different "board" standards for QMEs. Ultimately it will be confusing and misleading to injured workers.	Committee California Orthopaedic Association June 12, 2013 Written Comment		
DWC QME Form 100 and 104	Commenter states that the regulations call for QMEs to meet certain requirements to demonstrate that the QME applicant has a strong knowledge base in a specific area of medicine. Commenter believes that it is important that a physician with a strong knowledge of the treatment under dispute is evaluating the specific circumstances of the case. Commenter supports the intent of the regulations	Lisa Folberg, Vice President Medical & Regulatory Policy California Medical Association June 13, 2013 Written Comment	Rejected. This is not a comment about a regulation that is being proposed or amended and is beyond the scope of this rulemaking.	None

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	but requests that the regulations be amended to more fully capture that intent. Commenter opines that a physician does not require board certification in order to practice in a given specialty or sub-specialty. Some physicians may have years of practice experience in a given subspecialty without being board certified. The regulation does provide that physicians who are not board certified may be deemed to be qualified by the Administrative Director and the Medical Board or Osteopathic Medical Board. Commenter believes that these regulations would be improved by specifying the criteria for being deemed to have sufficient specialty expertise to be appointed as a QME. These criteria should include: • Practicing at least half-time within the sub-specialty; • Completing at least two-thirds of CME credits required for licensure within the sub-specialty; or • Recent experience as an			

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	expert medical reviewer in the sub-specialty in California. Commenter opines that QME appointments should also consider the ability of applicants to maintain a high level of confidentiality, provide objective unbiased evaluations, and to articulate and document their findings. Commenter believes that creating a flexible yet well-defined process for selecting QMEs will further the state's goal of developing a robust workers' compensation process.			
DWC QME Form 100; 104; 105a and 106a	Commenter notes that "Orthopaedic Surgery – Oncology" has been added to the list of orthopaedic subspecialties. Commenter recommends that the category "Orthopaedic Surgery (other than Spine or Hand) be amended to say: "Orthopaedic Surgery (other than Spine, Hand, or Oncology)."	Lesley Anderson, M.D., Chair Workers' Compensation Committee California Orthopaedic Association June 12, 2013 Written Comment	Rejected. The MMO category of orthopedic surgery has not been added; the category has existed since at least 2009.	None