

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
1(cc)	<p>Commenter recommends the following language:</p> <p>“Request for factual correction” means <u>a request</u>:</p> <ol style="list-style-type: none"> 1) a request by an unrepresented injured worker or a claims administrator to a panel QME to change an incorrect statement or assertion of fact contained in a comprehensive medical-legal evaluation to a statement or assertion of fact that is capable of capable verification from written records submitted to a panel QME pursuant to section 35 of title 8 of the California Code of Regulations- 2) <u>to address specific issues completely</u> 3) <u>to follow regulatory procedures for reporting established by the administrative director.</u> <p>Commenter states that Labor Code section 4061(d) (1), the statutory basis for this regulation, simply states that the parties may request a supplemental report “seeking correction of factual</p>	<p>Michael McClain General Counsel April 4, 2013 Written Comment</p>	<p>Rejected. The suggestion is beyond the scope of the authorizing statute. The legislature in enacting Labor Code section 4061(d) (1), added a new procedure to the unrepresented QME process without eliminating other review processes. (<i>Mountain Lion Foundation v. Fish and Game Com.</i> (1997) 16 Cal. 4th 105, 129.) The examples in the comment raise legal issues not factual issues. Other mechanisms in sections 10162(c) (apportionment review) and 10164 (summary rating recon) of the regulations address the issues raised by the commentator. In addition, notwithstanding, the summary rating process, the parties can always ask the QME to issue a supplemental report to address previously unaddressed legal issues or to review newly acquired medical records.</p>	<p>None</p>

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	<p>errors in the report.” The legislative policy underlying this procedure is to allow the parties to obtain a useful, complete, and accurate report from the QME. 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. Commenter opines that if that failure can be corrected by a supplemental report, then that is the preferred method.</p> <p>Commenter opines that the allowance to correct factual errors by supplemental report must also apply to the evaluator’s failure to address and/or properly articulate an opinion on the issue of apportionment. Permitting a report to be evaluated for permanent disability when a significant issue is simply misstated or not adequately addressed is a waste of the division’s resources, compels unnecessary litigation, and incurs an inexcusable delay. When a significant issue is overlooked, a supplemental report can cure that quickly.</p> <p>Commenter states that the recommended</p>			

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	revisions also comport with section 4061(f).			
1(cc)	<p>Commenter recommends the following revised language:</p> <p>(cc) “Request for factual correction” means a request by an unrepresented injured worker or a claims administrator to a panel QME:</p> <p>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.</p> <p>2) to address specific issues completely</p> <p>3) to follow regulatory procedures for reporting established by the administrative director.</p> <p>Commenter states that Labor Code section 4061(d) (1), the statutory basis for this regulation, simply states that the parties may request a supplemental report “seeking correction of factual errors in the report.” The purpose of this procedure is to allow the parties to obtain a complete and accurate report</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. The suggestion is beyond the scope of the authorizing statute. See the response above.</p>	<p>None</p>

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	from the QME, on which determinations of workers' compensation benefits are made. Commenter opines that if this medical opinion fails to address all issues completely and accurately, an injured worker's benefits are delayed.			
1(cc)	<p>Commenter states that SB 863 amended Labor Code Section 4061 (d) making it clearly applicable only to an unrepresented injured worker. Commenter states that the Division's current definition, while being much clearer on this point does not directly link a request from the claims administrator to only unrepresented injured worker cases. Commenter opines that the current definition could be read to allow a claims administrator to make a request for factual correction to any panel QME. Commenter suggests the following revised language:</p> <p>(cc) "Request for factual correction" means a request by an unrepresented injured worker or <u>the unrepresented injured worker's claims administrator to the panel QME to change</u> "</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p>	<p>Rejected. Statutorily, pursuant to Labor Code section 4061(d) the request for factual correction only applies in the case of an unrepresented injured worker who has been found permanent & stationary (P &S) or has reached the stage of maximum medical improvement (MMI); therefore the procedure does not apply to medical reports not finding the injured worker P& S or MMI.</p>	None
1(t)	<p>Commenter recommends the following revised language:</p>	<p>Julianne Broyles California Association of Joint</p>	<p>Rejected. The purpose of the definition is to provide a definition for the term "future</p>	None

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	<p>“Future medical care” means medical treatment as defined in Labor 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 <u>which might be necessary in the future after maximum medical improvement status. The AME/OME 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.</u></p> <p>Commenter opines that the definition of Future Medical Care should use the entire text of Labor Code §4600 or none of the text within the proposed regulatory definition. Employers are concerned that by using only selected</p>	<p>Powers Authorities April 4, 2013 Written Comment</p>	<p>medical care” which was not previously defined. The definition, contrary to the comment, includes medical treatment as defined in Labor Code section 4600. The Independent Medical Review (IMR) program is designed to resolve medial disputes at the time the issue arises and to remove the QME/AME process of determining whether an injured worker needs a particular type of medical treatment. (Labor Code § 4610.5 et. seq.) This suggestion appears to return QMEs and AMEs into the medical treatment dispute resolution process, which is against the intent of the legislature.</p>	

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	portions of Labor Code §4600 as proposed, an inaccurate and misleading definition of Future Medical Care is created. Commenter recommends that additional language be added to comport and align the regulations with current statutes limiting the AME/QME opinion to future medical care and not to dispute medical treatment recommendations.			
100	Commenter recommends adding a field for the National Provider (NPI) Number.	Steven Suchil Assistant Vice President – Counsel American Insurance Association April 4, 2013 Written Comment	Rejected. There is no rationale provided for the suggestion. The request for and the provision of the California license number of the applicant is sufficient for the DWC’s needs.	None
11(d)	<p>Commenter requests the following addition:</p> <p><i><u>(5) For injuries after January 1, 2014, the QME cannot be a reviewer in an independent medical review organization.</u></i></p> <p>Commenter states that Labor Code section 139.5(d) (4) (D) precludes a QME from also participating in the independent medical review organization.</p>	Michael McClain General Counsel April 4, 2013 Written Comment	Rejected. The statute is clear and needs no additional clarification, a regulation would be redundant.	None

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11.5	<p>Commenter states that the first paragraph of this section makes reference to subdivision 1 (q). Section 1 was re-numbered and the correct section is (p).</p> <p>Commenter recommends correcting the citation in Section 11.5 from 1(q) to 1(p).</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	Accepted.	The citation was corrected.
11.5(h)(i)(1)	<p>Commenter states that within the discussion of course content, he believes it is important to assist accredited providers with guidance as to the weight or emphasis that should be put on "old" cases, post-2005 cases and the most recent cases. Commenter opines that the background, history and evolution of medical-legal reporting is important for all QME candidates. However, new candidates are not likely to deal with older dates of injury and instructional time must be used efficiently. Commenter requests the Division's guidance in this regard.</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p>	<p>Rejected. Based on information received from the DEU about 30% of their ratings are 2005 cases or earlier. Therefore there is a need for QME candidates to be familiar with an array of concepts which are applicable to a wide range of dates of injury.</p>	None
26	<p>Commenter recommends the addition of three more conditions of good cause as follows:</p> <p><u>(4) distasteful circumstances like</u></p>	<p>Bruce P. Hector, M.D. Medical Director & Quality Assurance Officer</p>	<p>Rejected. A move necessitated by real estate habitability problems can be considered good cause under the rule. The commenter wrongly reads</p>	None

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	<p><u>inadequately maintained property, bad odors (§41(a) (1), construction noise, failure of the landlord to maintain a safe environment or office unsuitable to the type of examinations necessary.</u></p> <p><u>(5) Physicians are permitted to substitute one office for another within the restricted 180 day period within the same geographic area shall provide under penalty of perjury they attest to the stated reasons.</u></p> <p><u>(6) during the 30 - 60 day transition period from one substituted office to the next, the physician is allowed to transfer QME Panel appointments scheduled for the old office to the new one upon proper notification to all parties (30 day advance notice) as long as the new office is within a radius of 5 miles.</u></p> <p>Commenter has no objection to limiting evaluating offices to 10 or allowing location substitution twice per reappointment year. Commenter opines that this regulation appears absent language that would prevent a</p>	<p>PMG & Exam Works March 20, 2013 Written Comment April 4, 2013 Oral Comment</p>	<p>examples in the rule to be limitations rather than illustrations of good cause. A change of address with the same geographic area would defeat the purpose of the rule which is to provide locational stability for QME appointments by limiting the number of office changes. The final suggestion is rejected because it would be hard to implement and the number of “active QME offices” would exceed the 10 office limit because, for example, ten old offices (those that will be closed) would be used for examinations only, while 10 other locations would be used for issuing new panels and scheduling new appointments. After the first evaluation current law allows QMEs to perform additional evaluations of an injured worker at any available office.</p>	

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	<p>QME from adding offices if he/she has less than 10, yet DWC Medical Unit is informing QME's they may not add offices up to the limit of 10 for an undisclosed period of time in apparent contradiction to the regulation. Often new or seasoned evaluators initiate their QME service with limited locations, expanding as they master the necessary skills and/or as their practice activities permit. Commenter suggests that this regulation be altered to allow a QME at any time to add office locations up to a total of 10.</p> <p>Commenter opines that limiting reasons for relocation to natural or community disasters or lease termination seems rather onerous and places a special burden on the QME, staff and claimants to tolerate distasteful circumstances like inadequately maintained property, bad odors (in compliance with Regulation §41(a) (1), construction noise, failure of the landlord to maintain a safe environment or office unsuitable to the type of examinations necessary. Commenter recommends that</p>			

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	<p>physicians be permitted to substitute one office for another within the same geographic area within any 180 day period providing that under penalty of perjury they attest to any of the stated reasons.</p> <p>Commenter requests that during the 30 - 60 day transition period from one office to the next, the physician be allowed to transfer QME Panel appointments scheduled for the old office to the new one upon proper notification to all parties as long as the new office is within a reasonable radius, he suggests 5 miles.</p> <p>Commenter opines that this will prevent the need for the party(s) to apply for a new panel on cases scheduled prior to the office closure date but to provide completed exams after that date, avoiding potential doctor shopping and harm to claimants.</p> <p>Commenter recommends allowing the original evaluating physician to perform re-evaluation in a new location or an office closest to where the original evaluation took place.</p>			

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26(c)	<p>Commenter opines that this sub-section attempts to prevent very short term use and frequent shifting of office locations by QMEs. Commenter agrees with this principal, but points out that disasters and catastrophes can include a capricious land lord's decision to cancel a lease on short notice as well as family or health issues that may arise that would prevent 30 day advance notice to the Division. Commenter suggests that notice of less than thirty days be permitted based on a written petition to the Administrative Director, outlining the cause of the short notice.</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p> <p>Carlyle Brakensiek CSIMS & CSPM&R April 4, 2013 Oral Comment</p>	<p>Rejected. The concept of good cause is flexible enough to allow for office movement resulting from disasters or other catastrophic events.</p>	None
30(a) and (b)	<p>Commenter states that references to these forms should be 105a and 106a.</p>	<p>Michael McClain General Counsel April 4, 2013 Written Comment</p>	<p>Rejected. The references are correct because the 105a and 106a will become the 105 and the 106 when these regulations are adopted.</p>	None
30(a)(1) and (b)	<p>These subdivisions state that among other information, the party requesting a QME panel shall, "... attach a written objection indicating the date of primary treating physician's report that is the subject of the objection...."</p> <p>Commenter suggests that this new language inappropriately narrows the criteria for objections to only those that are based solely on a treating physician's report. Commenter does</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p>	<p>Rejected. The changes requiring more documentation of the dispute between the parties is necessary to determine if the dispute should be resolved in the QME process or the IMR process. These changes clarify the nature of the showing by a party to meet the substantive legal requirements of Labor</p>	None

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	<p>not recall any provision within SB 863 that is the source of such a restriction. Bona fide medical disputes may be based on a number of issues not contained in any physician's report whether treating or consulting. Commenter opines that the language of Section 30 (a) (1) & (b) should be expanded.</p>		<p>Code sections 4061 and 4062 a panel is issued. Contrary to the commentator's view, the legislature requires a party to object to a determination of a primary treating physician to entitle the party to the issuance of a panel of qualified medical evaluators. Labor Code sections 4061 (b) and (c) that apply to represented and unrepresented panel require an objection to made before a QME may be requested. Labor Code section 4061 (b) states in full: <i>"If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in Section 4062.2."</i> (emphasis supplied)</p> <p>Labor Code section 4061 (c)</p>	

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			<p>states in full: <i>“If either the employee or employer objects to a medical determination made by the treating physician concerning the existence or extent of permanent impairment and limitations or the need for future medical care, and if the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. Either party may request a comprehensive medical evaluation to determine permanent disability or the need for future medical care, and the evaluation shall be obtained only by the procedure provided in Section 4062.1.”</i> (emphasis added)</p> <p>The language in Labor Code section 4062(a) also requires an objection to be made and states in full: <i>“If either the employee or employer objects</i></p>	

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			<p><i>to a medical determination made by the treating physician concerning any medical issues not covered by Section 4060 or 4061 and not subject to Section 4610, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney.”</i></p> <p>A request for a compensability examination only requires a party declare a need for medical evaluation to determine compensability of a claim. (Lab. Code § 4060.)</p> <p>This difference is reflected in rule 30. Compensability examinations are not available “apply where injury to any part or parts of the body is accepted as compensable by the employer.” (Lab. Code § 4060 (a).)</p>	
30(b)(1)	Commenter requests that the word “medical” prior to “dispute” be	Michael McClain General Counsel	Rejected. The term “medical dispute” is restricted to the	None

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	<p>deleted.</p> <p>Commenter states that SB 863 created an independent medical review process (Labor Code section 139.5) intended to address all medical treatment issues arising under section 4600. The sole medical issue to be addressed by the medical legal physician is whether the injured worker may require additional medical care in the future. Commenter opines that the phrase “medical dispute” in this regulation is too broad despite the limitations contained in subdivision 35.5(g) (2).</p>	<p>April 4, 2013 Written Comment</p>	<p>medical disputes identified by the legislature as being subject to the QME process, not the dispute subject to the IMR process. <i>(See the prior comment re medical disputes under Labor Code §§4060, 4061 and 4062.)</i></p>	
30(d)(3) and (4)	<p>Commenter questions why the Division proposes to delete § 30 (d) (3) and § 30 (d) 4). Commenter opines that the Division is seeking to narrow the circumstances under which a QME panel can be requested.</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p>	<p>Rejected, the circumstance for requesting a QME is statutory. See the comment to the commentator’s comment to 30(a) (1) and (b) for a more in depth discussion of the issue.</p>	None
30(e)	<p>Commenter states that this subsection newly allows that for unrepresented employees a QME panel can be issued based on the geographic location of the employer’s place of business. The Panel QME request form 105 does not request the address of the employer. Commenter recommends adding a space on Form 105 in the Employer</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. The form 105 has two spaces to put an in state zip code to be used for an injured worker who lives out of state.</p>	None

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	section for the employer address where the employee worked (not the corporate address).			
30(e)	<p>Commenter opines that providing the employer's place of business as an alternate location for determining the geographic area to choose a QME panel is unnecessary. Commenter opines that the Division falls far short of clarifying a number of key questions and overloads the outcome heavily in favor of the employer before any discussion begins. For example:</p> <p>(1) How can the employee ever prevail in his/her attempt to come to an agreement regarding the location?</p> <p>(2) The circumstances when business address alternative can or should be used,</p> <p>(3) Which employer location is to be used if the employer has more than one,</p> <p>(4) Who makes the decision which location is used and</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written and Oral Comment</p>	<p>Accepted. If an injured worker either does not currently or never resided in the state a rule is necessary to cover the issue. The parties can always agree to the zip code used to create a panel. If the parties cannot agree to a zip code, the zip code of the injured worker's prior residence is used. If the injured worker never lived in the state the default is the geographic location of the place of business where the injured worker was employed.</p>	<p>Added the phrases "if the employee never resided in the state" and "where the employee was employer" to clarify how to apply the rule.</p>

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	<p>(5) Why an alternative should be used at all.</p> <p>Commenter predicts the lack of clarity will, itself become an issue for litigation.</p>			
31.3(e)	<p>Commenter states that the QME unable to schedule a panel evaluation within 90 days may not be unavailable, but rather may be in high demand. Commenter opines that a report to the Division under the circumstances described in this subdivision must be submitted with an appropriate notation regarding the exact conditions under which the appointment could not be scheduled within the 90 day limit. Commenter opines that the Division should not waste resources investigating QMEs who may not be able to comply due to their expertise and existing workload.</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p>	<p>Rejected. Popularity is not a substitute for prompt evaluations. The 90 day outer limit is one quarter of a year and is a reasonable time for a QME to schedule an examination.</p>	None
31.7	<p>Commenter states that the text of this section lists four definitions of “good cause” for which a QME panel in a different specialty can be requested. However, the related Form 31.7 “Additional Panel Request-8 Cal Code of Regulations section 31.7” only lists two of the four on the form itself.</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. The form lists only two reasons for requesting an additional panel because the third method for receiving an additional panel is a judge order if the parties cannot agree to the need for a panel or cannot agree on the specialty.</p>	None

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	<p>Commenter suggests adding the reason stated in 31.7(b)(3) which is an Order from a WCALJ; add reason stated in 31.7(b)(4) which pertains to an agreement on the requested specialty between parties and an I & A Officer in unrepresented cases. Commenter opines that by making these changes, the Form 31.7 will be consistent with the section 31.7.</p>		<p>Judges have their own orders to handle this issue. The last method is after a consultation with an information and assistance officer (I &A) who is charged with conducting a meet and confer with the parties concerning the need for an additional panel. There is a separate panel request form given to I & A officers to accomplish this task.</p>	
31.7(2)	<p>Commenter recommends that this subsection be deleted.</p> <p>Commenter believes that the regulations should be amended to delete the second reason listed to obtain an additional QME panel as it pertains to an acupuncturist QME needing a different specialty to evaluate disability. Commenter believes that effective, July 1, 2013, acupuncture as a viable QME specialty is not likely to occur, making this section unnecessary.</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. Taking the suggested action would read acupuncturists out of the QME program. (<i>See Lab. Code § 139.2.</i>) Although the legislature precludes acupuncturists from providing opinions on disability issues acupuncturists may provide opinions on all other issues including AOE/COE issues and whether the worker is P & S.</p>	None
31.7(2)	<p>Commenter requests that the stricken language be restored.</p> <p>Commenter opines that the</p>	<p>Nagar Matian, Esq. April 4, 2013 Oral Comment</p>	<p>Rejected. Many panel requests under this section have to do with medical treatment issues that are now subject to IMR.</p>	None

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	<p>elimination of this section eases the process for obtaining a new panel QME; however, when dealing with cases that are litigated for multiple injuries, there is an opportunity for applicants’ attorneys or the employee to seek numerous panel QMEs. Commenter states that the process for obtaining a Panel QME can take anywhere from four to six months, drawing out litigation. Commenter believes that the original Panel QME physician should decide based upon their own experience whether or not additional panel QMEs are necessary.</p>		<p>Where there appears to be a need for additional examinations in different specialties the parties can agree on the need for the panel and the specialty. Utilizing the form provided the agreed to additional panel requests are filed quickly. Where the process is not used the parties are subject to the delays of the regular request process. As stated above, disputes about the need for an examination or the specialty should be resolved before a WJC before a panel is requested.</p>	
32(a)	<p>Commenter recommends the following revision:</p> <p><i>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</i></p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. See the prior response to Broyles comment to rule 31.7 (2)</p>	<p>None</p>

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	<p><i>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.</i></p> <p>(a) <i>(b) Except as provided in subdivision 32(a) above,</i> No QME 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 .</p> <p>Commenter opines that references in Section 32 to acupuncturists should be eliminated. Commenter states that an acupuncturist is not now able to address disability issues. Per Regulation 35(g) (2), effective July 1, 2013, they cannot opine on disputed</p>			

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	medical treatment issues. Commenter states that as of July 1, 2013 there is no functional need to retain acupuncture as a QME specialty.			
33(a)	Commenter states that notice to the Division should always be provided by a QME who cannot schedule evaluations in a timely manner. Commenter opines that, as with § 26, some accommodation must be made for a circumstances when notice cannot be provided 30 days prior to a period of "unavailability."	Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment	Rejected. (See Cal. Code of Regs., tit. 8, § 33(a) (Good cause exception for providing the administrative director less than 30 day notice of unavailability).)	None
34(h)	Commenter opines that this existing subdivision is of no consequence without a penalty for violating its provisions. Commenter requests that the Division add mandatory reimbursement, payable to the QME or AME, equal to one hour at the applicable rate (AME or QME) except 1.5 hours for Psychiatrists and Psychologists.	Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written and Oral Comment	Rejected. Reimbursement for a cancelled QME appointment as a medical-legal expense is within the discretion of the Appeals Board to award.	None
35(a)(3)	Commenter notes that there are no changes in the proposed language. Commenter states that the division has not provided any direction to the parties on the submission of medical records to the AME or QME. Subsection (3) recognizes a letter	Michael Weiser April 2, 2013 Written Comment	Rejected. Labor Code section 4062.3(b) provides a timeframe for providing medical reports to QME's prior to the examination. The section reads in relevant part "Information that a party	None

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	<p>outlining the issues that the evaluator is requested to address in the evaluation. This is to be served on the “opposing party” no less than 20 days in advance of the evaluation. Commenter states that it says nothing of serving the AME or QME. The AME or the QME is not an opposing party.</p> <p>Commenter states that the result is that the division leaves the option open to examiners and the attorney to serve the medical records on the physician at any time and in any manner that they please. Commenter questions how the division does not recognize this. The division provides no direction to the parties that would serve to provide a meaningful evidentiary record to the one person who is supposed to have it, the reviewing physician. As a result, if the physician receives the record at all, it is often late and the physician is precluded from undergoing any meaningful review of the medical record and cover letters prior to the clinical examination. The failure to address this issue causes problems</p>		<p>proposes to provide to the qualified medical evaluator selected from a panel shall be served on the opposing party <i>20 days before the information is provided to the evaluator.</i> (Emphasis added)</p>	

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	<p>with very people who tasked with providing an analysis of the evidence. In areas of civil and criminal procedure, adequate notice is required so the parties may review and prepare a response. Supporting documents and arguments must be provided in advance. Why is it that the parties are permitted to ignore matters of adequate service in the medical legal process?</p> <p>Commenter requests that the division make the process better by amending the language in CCR section 35 (a) (3) to read “which shall be served on the opposing party AND THE AME OR QME PHYSICIAN no less than 20 days in advance of the evaluation.</p>			
35(b)(1)	<p>Commenter requests that the following sentence be included:</p> <p><u><i>Similar communications of a non-substantive nature shall be allowed regarding the QME physician or physician staff.</i></u></p> <p>Commenter opines that section 4062.3(f) refers specifically to agreed medical evaluators and that the</p>	<p>Michael McClain General Counsel April 4, 2013 Written Comment</p>	<p>Rejected. The suggestion goes beyond the scope of the statute.</p>	<p>None</p>

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	<p>underlying policy issue is the same for QMEs and the regulations should reflect that. When the District Court of Appeal reviewed the question of ex parte communications with the medical legal evaluators, it carved out a slight and sensible exception from the strict, literal reading of section 4062.3 (<u>Alvarez v. WCAB</u> (2010) 75 CCC 817). Section 4062.3(f) reiterates that rationale but does not specifically include all medical legal evaluators. Subdivision (k) states that the WCAB retains jurisdiction to determine disputes arising from objections and ex parte communications. The rationale in <u>Alvarez</u> is part of the Board’s jurisprudence in regard to ex parte communication. Commenter opines that the administrative director should rationalize the dictates of section 4062.3 and add QMEs to this exception.</p>			
35.5(c)(1)	<p>Commenter recommends the following modifications:</p> <p>The evaluator shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee’s appointment with the medical evaluator</p>	<p>Michael McClain General Counsel April 4, 2013 Written Comment</p>	<p>Rejected. The reason for the clinical competence exception is to account for disputes that range across medical specialties and scopes of practice. The appeals board has long recognized that one QME may not be able to address all</p>	<p>None</p>

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	<p>that are issues within the evaluator’s scope of practice and areas of clinical competence. The reporting evaluator shall attempt to address each question raised by each party in the issue cover letter sent to the evaluator as provided in subdivision 35(a) (3).</p> <p>Commenter states that “clinical competence” is so subjective and open that it cannot be defined and therefore serves no useful purpose. Commenter opines that it should be dropped.</p> <p>Commenter states that AMEs and QMEs are qualified medical legal professionals who must have sufficient experience within the workers' compensation system to address any and all medical legal issues. Commenter opines that if the medical legal evaluators cannot provide an adequate response to an issue raised by a party, then they must explain why they cannot adequately address the question. Commenter opines that an “attempt” to respond might encourage guessing and prevent the explanation for their inability to answer, which is the more important</p>		<p>of the medial disputes contained in the claim forms filed by the injured worker. (<i>Gubbins v. Metropolitan Insurance Co.</i> (1997) 62 Cal. Comp. Cas. 946.) The Administrative Director maintains rules for acquiring additional panels that appear at section 31.7 of these regulations. (<i>Cal. Code of Regs., tit. 8, § 31.7.</i>)</p>	

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	information.			
35.5(c)(2)	<p>This subdivision stipulates that the evaluator must "declare the injured worker permanent and stationary for all conditions" (emph. added). Commenter opines that there will be a number of situations when an injured worker is P & S for an orthopedic injury (sprained ankle for instance) but not for another, compensable consequence (i.e. a gait derangement). Commenter question if the injured worker is eligible for the voucher based on any injury that causes permanent partial disability? Commenter recommends that "all" be replaced with "any accepted"</p>	<p>Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment</p>	Accepted	The subdivision was changed to reflect this issue and others.
35.5(g)(2)	<p>This paragraph states that for any evaluation on or after July 1, 2013, the QME or AME shall not provide an opinion on any disputed medical treatment issues, but shall provide an opinion about whether the injured worker will need future medical care. Commenter recognizes that this is an attempt to comply with the new statutory requirements in SB 863. Commenter opines that the rule as proposed appears to be inconsistent with both the existing and the</p>	<p>Mark Gerlach California Applicants' Attorneys Association April 4, 2013 Written Comment</p> <p>Mark Gearheart California Applicants' Attorneys Association</p>	Rejected. As of this writing, section 10606 of the Appeals Board's rules and this rule are in harmony. The purported inconsistency centers on the distinction between providing an <i>opinion</i> about medical treatment and providing a <i>history</i> of past and current treatment. This rule prohibits QMEs from providing opinions concerning the current need for medical	None

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	<p>proposed amended WCAB rule in section 10606. The proposed WCAB rule states that in order to be substantial evidence, a QME or AME report must, among other things, discuss past, continuing and future medical care. The rule also provides that the report of an AME or QME is admissible for the purpose of making a general award of future medical, assessing the adequacy of a Compromise and Release, or determining disputed lien claims.</p> <p>Commenter states that the problem created by proposed section 35.5(g) (2) is that it appears to require evaluators to do incomplete reports that will not constitute substantial evidence at the Appeals Board. AMEs and QMEs will need to discuss past, current and future medical treatment in order to address periods of temporary disability, whether the patient is at maximum medical improvement, and whether the patient needs a future medical award. The conundrum is how to reconcile this legitimate need for information with the statutory prohibition of using</p>	<p>April 4, 2013 Oral Comment</p>	<p>treatment, but it clearly allows for <i>providing a history</i> of past and current treatment for purposes of discussing resolving issues under Labor Code sections 4060, 4061 and 4062, except where the issue is in dispute between the parties and an opinion on the issues is not prohibited by the statute. The Administrative Director defines “continuing medical treatment” as “occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.”(<i>Cal. Code of Regs., tit. 8, § 9785 (a)(6).</i>) The Appeals Board’s current proposed version of 10606, while listing the potential content of a QME and AME medical evaluation, also limits the admissibility these reports to:</p> <ol style="list-style-type: none"> 1. The making of a general award of future medical care; 2. Assessing the adequacy of a compromise and release agreement as required by 	

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	<p>AMEs and QMEs to resolve specific treatment disputes.</p> <p>Commenter believes that these conflicting policies can be harmonized by amending the language in paragraph (2) to indicate that the AME or QME is not to provide an opinion on a medical treatment issue that is currently the subject of an active UR/IMR dispute resolution process. Furthermore, in order to conform to the WCAB rule, paragraph (2) can be amended to provide that AMEs and QMEs shall discuss past, current and future treatment as required to address temporary disability, maximum medical improvement, permanent disability and future medical needs.</p>		<p>board rule 10882;or 3. Determining disputed lien claims or claims of costs. (Published at Cal. Reg. Notice Resister 13, No. 11-z, p. 422 and text available at http://www.dir.ca.gov/wcab/rulemaking/wcab_rulemaking_proposed.html)</p> <p>The suggested “harmonizing language” would leave the door open for allowing QMEs or AMEs to comment and critique the current, or continuing medical treatment being provided as defined in rule 9785 (a) (6) that is either in dispute or has been in dispute or which is not in dispute. This contradicts the legislatures intent to bar QMEs and AMEs from providing opinion about “continuing medical care” when the legislature supplanted with the term “future medical care” that the QMEs and AMEs may provide and opinion about. The amendment to Labor Code</p>	

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			section 4061 and the creation of IMR removes “medical treatment disputes” from the types of medical disputes about which QMEs and AMEs may provide an opinion. Of course an AME or QME should not provide an opinion about an issue, nor should they be paid for, that is not in dispute between the parties.	
35.5(g)(2)	<p>Commenter recommends that for evaluations performed on or after 7/1/13 and regardless of date of injury, the QME or AME is only to comment on future medical care to cure and relieve the effects of an industrial injury. This section does not include the rest of the clarifying language in LC 4600(b).</p> <p>Commenter recommends that this section be amended to include the rest of the clarifying language in 4600 (b). Commenter opines that the comments by the evaluator on future care should include an analysis of current prescriptions and the need to continue them. For those where the evaluator determines a change is needed, the</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 4, 2013 Written Comment</p>	<p>Rejected. The first comment misunderstands that a citation to Labor Code section 4600 includes all of the statute including subdivision (b).</p> <p>The second comment concerning the scope of a QMEs opinion on medical care is contrary to the IMR provisions in SB 863. (Lab. Code §§ 4061, 4062 (a), 4610.) In the example, the question of whether an injured worker will need continuing prescriptions is either not an issue in dispute between the parties or if it is in dispute is within the purview of IMR. Under Labor Code</p>	None

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	analysis should include what changes in type and/or dosage are appropriate as well as an estimate as to the length of time that the employee will need to continue using the prescriptions.		section 4061 the scope of the QME or the AME opinion is about whether there is a “need for future medical care” and not the scope of what the need will be in the future. (See <i>Braewood Convalescent Hospital v. WCAB (Bolton)</i> (1983) 34 Cal. 3d 159 as an example of how an injured worker’s need for medical care may change over time.)	
35.5(g)(2)	Commenter states that this subdivision is in conflict with existing and proposed CCR Title 8, Section 10606, regarding key components required for a physician report to meet the standard of substantial medical evidence. This conflict must be resolved before this rulemaking is concluded. Commenter opines that dropping the requirement to report on medical treatment issues from Section 10606 may seem expeditious, but he requests that serious consideration be given to the value of each component currently listed in Section 10606 and their contribution, as a whole, to the definition of substantial medical	Stephen J. Cattolica Director, Government Relations AdvoCal April 4, 2013 Written Comment	Rejected. See previous comment. Rule 10606 is not a talisman that can overrule the intent of the legislature. Nor is section 10606 an inflexible standard; compliance with content of the regulation is based on the medical dispute that needs to be resolved and states “reports should include <i>where applicable</i> ” the items listed in the rule. (<i>Cal. Code of Regs., tit. 8, § 10606.</i>) In SB 863, the legislature eliminated the ability of AME’s and QMEs to resolve medical treatment disputes that were	None

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	evidence. Commenter does not believe it to be appropriate, nor does he believe it was intent of the Legislature, to change the definition of substantial medical evidence.		previously submitted to them pursuant to Labor Code section 4062 in certain circumstance, thus, the [medical] “treatment indicated” prong of 10606 is no longer applicable to AME and QME reports. (<i>Cal. Code of Regs., tit. 8, § 10606 (j).</i>) Thus, the rules here 35.5(g) (1) and 35.5(g) (2) proves 10606’s flexibility. Reports that are covered under rule 35.5(g) (1), would include a discussion of indicated medical treatment needed by the injured worker while reports falling under 35.5(g) (2) would not because of the changes to Labor Code section 4061.	
37	Commenter recommends that a Claim Number or Division of Workers' Compensation Case number should be provided on this form. Commenter opines that the lack of such information will inevitably lead to delays for the Claims Administrator and the Division.	Steven Suchil Assistant Vice President – Counsel American Insurance Association April 4, 2013 Written Comment	Rejected. The use of a claim number was considered, but rejected because the form will be filed with the DEU after the issuance of a panel which has a panel number on the form which is unique.	None
37	Commenter requests that this section and the required form be stricken.	Debra Russell Schools Insurance Authority	Rejected. A form is used because once the medical report is filed with the DEU	None

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	<p>Commenter opines that this section will lead to a delay of benefits to the injured worker, increase costs and promote additional litigation. Commenter believes that it is more expeditious to contact the evaluator directly to request additional information when clarification is needed.</p>	<p>April 4, 2013 Oral Testimony</p>	<p>the rating process is triggered in the Electronic Adjudication Management System (EAMS). The form is required to be filed with DEU in order to stop the rating process stop the DEU rating process as required by Labor Code section 4061(d).</p>	
<p>37 (f) - QME Form 37</p>	<p>Commenter states that this form is too restrictive and should be eliminated or made optional.</p> <p>Commenter states that the purpose of a medical legal evaluation is to ascertain the extent of the worker’s injuries, assess the need for future medical care, and determine the permanent impairment. To prepare an accurate report, the medical legal evaluator must be provided with all of the pertinent information regarding the applicant’s medical condition whenever it is available. Labor Code section 4061(d) (1) expressly provides the unrepresented employee and the employer the opportunity to request a supplemental report seeking the correction of factual errors in the QME’s opinion.</p>	<p>Michael McClain General Counsel April 4, 2013 Written Comment</p>	<p>Rejected. See comments to 1(cc) the prior comment to Russell about section 37.</p>	<p>None</p>

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	<p>Labor Code section 5704 similarly supports the opportunity for the parties to provide explanatory or rebuttal evidence after the receipt of a medical legal evaluation. The refusal to allow rebuttal evidence at any given stage of the proceeding may be an abuse of discretion. Edgar v WCAB (1966) 31 CCC 376.</p> <p>Commenter states that the underlying purpose of section 4061(d)(1) is to ensure that the information contained in the medical legal evaluation is correct and that time is not wasted appealing permanent disability ratings or judicial decisions based on erroneous facts. Commenter opines that Form 37 is too circumscribed and, therefore, does not comport with the statute. This is particularly so with regard to the instruction precluding the attachment of any additional, relevant medical information.</p>			
37(a)	Commenter state that there is no instruction sheet describing how Form 37 is to be completed. It is not indicated who will assist the employee	Peggy Thill Claims Operations Manager State Compensation	Accepted	An instruction will be issued that explains how to complete the form, but it is not part

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	<p>with completing the form.</p> <p>Commenter recommends that an English/Spanish instruction sheet including a FAQ should be attached to the form. Should additional questions arise, the employee may contact an I&A Officer.</p>	<p>Insurance Fund April 4, 2013 Written Comment</p>		<p>of this rulemaking.</p>
37(a) and (b)	<p>Commenter states that there is no clarification as to how the employee obtains Form 37. Is it provided by the claims administrator, the QME or is the employee expected to download it from the DWC website?</p> <p>Commenter recommends that Form 37 be provided by the QME to all parties along with the copy of the evaluation. The form should be available in English/Spanish.</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 4, 2013 Written Comment</p>	Accepted.	<p>The instructions that will accompany the form 105 will discuss the acquisition and use of the form 37, but it will not be part of the form.</p>
37(b)	<p>This subdivision establishes rules regarding a request for a factual correction of a report by a Qualified Medical Evaluator. The proposed rule provides that if a request for a factual correction is served by the claims administrator, the employee has five days to respond to the corrections mentioned in the request. Commenter understands the need to expedite this</p>	<p>Mark Gerlach California Applicants’ Attorneys Association April 4, 2013 Written Comment</p>	<p>Rejected. Labor Code section 4061(d) provides the summary rating process be delayed by 30 days to allow for the possible filing of the request for factual correction. Adding an additional time beyond the five days already in the regulation will just delay the process even further.</p>	None

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	<p>process but states that it must be understood that this process is applicable only for unrepresented workers. Commenter opines that many workers will be unable to meet this short deadline. In some cases there may be a language problem, and it may take the employee time to find someone to assist in reading the request and to help prepare a response. In other situations the employee may need to speak with an I&A officer about the document, and it may not be possible for this individual to get to the Board within 5 days, particularly when the employee resides in a rural area. Commenter suggests that this time limit be amended to at least fourteen days.</p>			
37(b)	<p>Commenter recommends the following revision:</p> <p>"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</p>	<p>Steven Suchil Assistant Vice President – Counsel American Insurance Association April 4, 2013 Written Comment</p>	<p>Rejected. Labor Code section 4061 (d) provides that the form must be filed with the DEU and served on the parties within 30 days of the receipt of the report.</p>	<p>None</p>

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	where the comprehensive medical-legal report was served."			
37(b)	<p>Commenter states that this subsection gives the injured worker 5 days to respond to a Request for Factual Correction served by a claims administrator. If the Request for Factual Correction is served by the injured worker, the regulation is silent as to the claims administrator's time frame to respond.</p> <p>Commenter recommends addition the following text to Section 37, subsection (b): The claims administrator shall have five (5) days after receipt of the Request for Factual Correction served by the injured worker to respond to the corrections mentioned in the request.</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. Labor Code 4061(d) (1) allows for a response by the injured worker to a request made by the employer, but not the reverse.</p>	None
37(b) – (f)	<p>Commenter recommends the following revision:</p> <p>(b) A request for factual correction <i>using the form in section 37(f) of title 8 of the California Code of Regulations</i> shall be 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</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. A form is used because once the medical report is filed with the DEU the rating process moves forward in EAMS. The form is required to be filed with DEU in order to stop the rating process stop the DEU rating process as required by Labor Code section 4061(d).</p>	None

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	<p>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.</p> <p>(c) If the request for factual correction is filed <i>made</i> by the injured worker the panel Qualified Medical Evaluator shall have ten days after service of the request to review the corrections requested. <i>in the form and determine if factual corrections are necessary to</i> <i>and and</i> 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 extended to 15 days after the service of the request for correction.</p> <p>(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</p>			

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	<p>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.</p> <p>(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.</p> <p>(f) Request for Factual Correction of a Unrepresented Panel QME report form. [Form 37]</p> <p>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]</p> <p>Commenter states that Labor Code section 4061, subsection (d) (1), which</p>			

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	<p>provides the statutory basis for this regulation, simply states that the parties may request a supplemental report “seeking correction of factual errors in the report.” The purpose of this procedure is to allow the parties to obtain a complete and accurate report from the QME, on which determinations of workers’ compensation benefits are made. Commenter opines that if this medical opinion fails to address all issues completely and accurately, an injured worker’s benefits are delayed. It is in the best interests of the injured worker to cure a defective QME report in the most expeditious means available. If the report can be corrected by a supplemental report, then that is the preferred method.</p> <p>Commenter opines that the regulatory requirement to complete Form 37 in order to request correction of an inaccurate or incomplete QME report does not expedite this process. Commenter is concerned that Form 37 unnecessarily limits access to information the QME may need to issue a corrected report. Commenter opines that any regulation that requires an evaluator to issue an opinion on a</p>			

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	<p>less than complete, or worse, an inaccurate record, is illogical.</p> <p>Commenter opines that this section as currently written will create additional delays in the payment of benefits, compel unnecessary litigation and waste scarce resources.</p>			
37(c)	<p>Commenter opines that when the employee receives a copy of Form 37, he/she may have questions about its purpose. It is not indicated who will assist the employee with any questions that may arise.</p> <p>Commenter recommends that I&A Officers at the appropriate WCAB should be available to assist the employee.</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 4, 2013 Written Comment</p>	<p>Rejected. Instructions that will accompany the 105 form will discuss the use of the Form 37. All of the instructions that accompany virtually all documents sent to unrepresented injured workers indicate that Information and Assistance officers are available to answer questions from injured workers.</p>	None
37(f)	<p>Commenter notes the top left hand corner of this form, “Person Requesting Correction (required) _____”. Commenter opines that this blank space is ambiguous. It raises the question of who should be listed on this line. Is the claims administrator a person or a party? Who has legal standing to request a Factual Correction?</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013 Written Comment</p>	<p>Rejected. Labor Code section 4061 (d) allows only the injured worker and the claims administrator to request a factual correction. The form in its electronic form has directions about using the drop down menu to select injured worker or the claims administrator.</p>	None

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	<p>Commenter recommends that this area of Form 37 be clarified by revising to: “Party Requesting Correction (required) with two checkboxes, one each for Employee and Claims Administrator. These are the two parties named in section 37 (a) that may request a factual correction.</p>			
38(b)	<p>Commenter recommends the following revision:</p> <p>(b) If an evaluator fails to prepare and serve the initial or follow-up comprehensive medical-legal evaluation report within thirty (30) days and the evaluator has failed to obtain approval from the Medical Director for an extension of time pursuant to this section, <u>a joint letter from both parties shall be sent to the physician indicating that if the report is not submitted within 10 working days from the receipt of the joint letter the report may be disallowed and the employee or the employer may request a QME replacement pursuant to section 31.5 of Title 8 of the California Code of Regulations. Neither the employee nor the employer shall have any liability for</u></p>	<p>Bruce P. Hector, M.D. Medical Director & Quality Assurance Officer PMG & Exam Works March 20, 2013 Written Comment April 4, 2013 Oral Comment</p>	<p>Rejected. Beyond the scope of the Administrative Director’s authority. (See Labor Code § 4062.5.)</p>	<p>None</p>

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	<p>payment for the medical evaluation which was not completed within the timeframes required under this section unless the employee and the employer each waive the right to a new evaluation and elect to accept the original evaluation, in writing or by signing and returning to the Medical Director either QME Form 113 (Notice of Denial of Request For Time Extension) or QME Form 116 (Notice of Late QME/AME Report - No Extension Requested) (See, 8 Cal. Code Regs. §§ 113 and 116).</p> <p>Commenter opines that one of the most difficult tasks for QME’s and AME’s is completing reports on a timely basis. Commenter opines that the problem stems from clinical practice responsibilities that must take precedence over report completion since lives are often in the balance and after the emergency is addressed, the physician is too tired to complete his dictation, even when he has the best of intentions. The due date can slip by before the evaluator knows it. For doctors, like most people, “the squeaky wheel gets the oil”. Further,</p>			

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	<p>when reports are nearing deadlines, one party or the other who may anticipate an adverse report, will quickly seek to strike the tardy report compelling all parties to initiate the whole process again. Commenter would like to recommend that when any report is not submitted by the 35th post exam day, a joint letter be sent to the physician and all interested parties indicating that if the report is not submitted within 10 working days from the receipt of the joint letter, it may not be allowed and payment for the exam may not be provided. This will cause the evaluator to address the timeliness of the report or face economic consequences.</p>			
General Comment	<p>Commenter opines that the administrative director and the Division’s attorneys have done well to translate the statutory changes to the role of the medical legal physicians and to clarify the scope of their authority.</p>	<p>Michael McClain General Counsel April 4, 2013 Written Comment</p>	<p>No response necessary.</p>	<p>None</p>
General Comment - QME Specialties	<p>Commenter states that the number of QME specialties recognized by the DWC is not consistent among the various QME Forms. Form 100 uses 47 specialties, Form 105 and 106 has</p>	<p>Julianne Broyles California Association of Joint Powers Authorities April 4, 2013</p>	<p>Agreed, however, this is beyond the scope of this rulemaking. This issue will be addressed in the future.</p>	<p>None</p>

Qualified Medical Evaluators – Disability Evaluation Unit	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>41 specialties, Form 31.7 lists 39 specialties, and Form 100 lists 54 specialties. Also, the description listed next to the 3-letter code differs from one form to another (several descriptions used on form 31.7 are different from those on forms 105 and 106.)</p> <p>Commenter recommends the creation of one uniform list of QME specialty codes and descriptions and use this one list where included on DEU QME forms.</p>	Written Comment		