



Medically Speaking

P O Box 8888 San Francisco, CA 94128

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Volume I No. 2

IMC Continues Med-Legal Review

by Anne Searcy, M. D.

The medical and legal staff is continuing work on its review of AME and QME reports for quality (Lab. Code § 139.2 (i)). The reports will be both selected randomly and be referred to us because of potential deficiencies. Each report is being examined for at least twenty-five different items. After the review, a letter will be generated to inform the physician of the results.

We are viewing this project as a way to educate physicians, not as a way to find 'poor performers'. We are finding that physicians often make the same mistakes in different reports. For instance, many reports do not contain information about the time that the physician spent face to face with the injured worker. We hope that by informing the physician of this oversight, that they will add this information to future reports. We also plan to make the results of the survey widely available so that all QME's can learn from the project.

The four most common mistakes noted in our study to date are: (1) Failure to state time spent face to face with the injured worker; (2) Failure to state that there is no violation of Labor Code §139.3 (self-referral); (3) Failure to note county where the mandatory declaration was signed and dated (LC §4628) and (4) Failure to include the mandatory declaration (LC §4628) in its entirety.

The study is ongoing and a report will be sent to Casey Young at the end of each year.

Tepperman, Cayton Replaced

Amster, Repko appointed to Council

The Industrial Medical Council is pleased to announce the appointments of Dr. Robert Amster, M.D. and Dr. Glen Repko, Ph.D. to the Council while at the same time regretfully saying good-bye to two of its distinguished members, Dr. Jerome Tepperman and Dr. Revels Cayton.

Dr. Amster has been in practice for 17 years and is Board Certified in Emergency Medicine & Occupational Medicine. He also has an MBA from Pepperdine University and is a Fellow of the American College of Emergency Physicians. He earned his M.D. at the University of Rochester in 1976.

He has broad experience in the workers' compensation community. For the past two years, he has served as Workers' Compensation Medical Director of Blue Cross of California where he developed treatment guidelines for workers' compensation treatment issues. He also supervises their Workers' Compensation PPO network. He has been a commercial pilot and is also an Aviation Medical Examiner for the Federal Aviation Administration.

Dr. Repko is a California licensed psychologist and has an independent private practice in Beverly Hills, California. He has performed med-legal evaluations, psychological testing & treatment of injured workers for over 15 years and published various articles on aspects of evaluating Worker's Compensation cases, psychological testing and personality disorder.

Dr. Repko has been a member of the Psychiatric Advisory Com-

mittee to the IMC for four years and worked with the Committee to revise and improve the Psychiatric Protocols for measuring psychiatric elements of a disability. He is also involved with the development of the Treatment Guidelines for Post-Traumatic Stress Disorder. His specialized training includes psychological assessment, experience with full range of psychological tests and special emphasis on intelligence testing, projective tests and neuro psychological assessment on the non-projective MMPI. Dr. Repko is also a member of the California Psychological Association.

Dr. Tepperman leaves the Council noting its struggle to overcome the odds. "The most interesting time was in the beginning when the legislature threw seven 'shirts' and seven 'skins' together into sort of a dysfunctional family. But we became a cohesive group and I'm very proud of the work we've done, especially the Psychiatric Advisory Committee completing the Psychiatric Protocols."

"Glen will be a good team player and I will continue to be involved in the post traumatic stress disorder guidelines and the Psychiatric Advisory Committee."

Notice of Public Meetings

Official Medical-Legal Fee Schedule

8/14/96 10am - 4pm

Medical Fee Schedule

8/15/96 1pm - 4pm

Sheraton Hotel LAX

6101 W. Century Blvd., LA

(310) 642-1111

D. Allan MacKenzie, MD, FAAOS

EMD Viewpoint

If the initial feedback is an accurate indicator, it would appear that the first edition of our newsletter was a resounding success. This is refreshing and reassuring. With your help, we will make this a progressively better instrument of communication. And now, the latest news....

Fee Schedules

Uppermost on many QME's minds these days are the subjects of fee schedules and guidelines. An article on the treatment guidelines is on page 5 so let me deal with the first topic here.

The labor code mandates the Council to advise the DWC administrative director (AD) on a variety of issues including the development and maintenance of the OMFS and the med-legal evaluation fee schedule (MLFS).

The last edition of each was developed by the AD with the input from an advisory committee from the Workers' Compensation community. This spring Mr. Casey Young publicly announced that he is returning this function back to the IMC. The Council has already convened a representative advisory body of members from the WC Community to meet to re-write both fee schedules. The next meetings will be held in August. The committee is planning that the revised OMFS ground rules and the entire MLFS will be implemented by April 1, 1997.

The advisory committees are chaired by Mr. Richard Sommers, Esq., medical economist, with oversight by Mr. Casey Young and myself. As noted below, the arduous line-by-line review of the fee schedules has already paid dividends.

Many of you have voiced concerns that both fee schedules are confusing, ambiguous, contradictory, and at worst, unfair and inequitable as remuneration guides for all participants in the WC community. Quite simply, many note difficulty finding the appropriate code for the procedure performed while hoping to be fairly remunerated for the work done. There are many complaints with the ground rules. Some note that even the clinical examples given are not pertinent to the great majority of the work performed for the WC Community.

The MLFS committee suggested that *this newsletter* be used as one of the vehicle to communicate with the Workers Compensation Community regarding fee schedule issues.

Conclusions: Read this newsletter to remain current on these important issues. If unable to attend the Council

Mission Statement of the IMC

The Industrial Medical Council (IMC) is the medical unit within the Department of Industrial (DIR). It acts in coordination with other State Agencies and the Administrative Director of the Division of Workers' Compensation (DWC) to set policy and establish guidelines on treatment and evaluation for injured workers in California.

The Council also regulates standards for physicians such as the Qualified Medical Evaluation program and advises the Administrative Director with respect to issues impacting the workers' compensation systems.

Our goal is quality care for injured workers at a reasonable cost.

meetings, please send me the essence of your constructive comments on the previous schedules.

Meetings of the Fee Schedule Advisory Committee

The charter meeting of this advisory committee was convened on the 13th of June. The agenda included a discussion of the make-up, the ground rules, timelines, and the fee schedule completion dates. A schedule was set for summer and fall meetings.

The first working session of the OMFS Committee was chaired by the EMD at 400 Oyster Point on the 27th of June and of the MLFS Committee on the 28th of June. Common to both sessions was the development of Mission Statements which resolved to develop fee schedules which *were not* confusing, ambiguous, or contradictory and *were* fair and equitable remuneration guides for all participants in the WC Community.

After further discussion regarding the mandated tasks, ground rules and completion dates, we resolved to have a revision of the ground rules for the OMFS and the completed revision of the MLFS implemented by April 1, 1997.

We then began the review of each of the fee schedules. I am delighted to be able to convey to you that both groups demonstrated remarkable 'group intelligence' and a genuine spirit of cooperation and willingness to work hard toward completion of this daunting task - successful fee schedules.

The MLFS Committee expressed an eagerness to remain active in the future by meeting quarterly to be able to address future problems and disputes arising from the MLFS. The fee schedule project is off to a promising start.

Public Meeting Updates

*May 16, 1996
Continental Plaza Hotel
Los Angeles, California*

The Council meeting was called to order by Dr. Richard Pitts and he also introduced Dr. Robert Amster as the newest council member. Dr. D.Allan MacKenzie advised the Council that a BCP proposing to eliminate the IMC had been forwarded to the Department of Finance and was expected to be approved and heard on May 22nd by the Senate Budget subcommittee at 9:00 am and that the Director of DIR suggested Council members attend the hearing. The BCP will also be reviewed by the Assembly Budget subcommittee at 4:00 pm the same day. AB 2540 (Knowles)-Suzanne Marria reported that copies of 5/2/96 revision of this bill, the Permanent Disability Reform Act, was distributed to the Council. A letter from Association of California Insurance Company to the Chair of the Assembly Budget subcommittee was read, proposing among other things, that the rules and regulations issued by the IMC not become effective if they raise the workers' compensation pure premium rates approved by the Insurance Commissioner. The letter also suggested that the treatment protocols being adopted by the IMC will add "billions" to the cost of the workers comp system if adopted. Rea Crane, of CWCI, stated the reference to 'billions' was not supported by any studies her organization is aware of. Moved and carried for the IMC to send a letter to the ACIC expressing concern about the allegations of increased costs and asking the ACIC to provide the IMC with such documentation. Motion amended to add that the letter suggest the ACIC present their concerns and any supporting documentation in the public hearing process. Casey Young commented that sending a

letter to the chair of the Assembly Budget subcommittee expressing the IMC's concerns also would be appropriate. The motion carried unanimously. Dr. Tain reported that the Treatment Protocols committee recommends that the extremities and neck guidelines be approved for sending to public hearing after some clerical and other corrections, which will be finalized by the committee today. Moved, seconded and carried to send the extremities guidelines to public hearing with changes deemed necessary by the Treatment Protocols committee. Council approved recommendation of the EMD to prorate the fees and to combine the date of reappointment and fee date. IMC needs to find a way to gather how many represented and unrepresented exams are being done. Dr. Larsen reported on the public hearings held on the proposed treatment guidelines for post traumatic stress disorder. In view of the comments received. Dr. Larsen stated he would like to have the consultants of the Post Traumatic Stress Disorder for a maximum of \$400 @ for 3 consultants. The public hearings on the proposed low back treatment guideline were announced. Moved, seconded and carried to extend the time for accepting written comments on proposed regulations to one week after the public hearing date. Mr. Young encouraged the IMC to move forward with completion of the treatment guidelines. On the Official Medical Fee Schedule, Mr. Young reported that DWC & IMC staff are working together on the transfer of responsibility for development of the OMFS to the IMC. A jointly sponsored public meeting to discuss a process for evaluating and possibly updating the fee schedules is being planned. Dr. Nathan Rothenberg will be notified that he has been put on probation as a QME for a term to run concurrently with probation imposed by the Medical Board. Meeting adjourned at 11:55 am.

Actions Taken

1) Letter to sent to ACIC unanimously approved.

- 2) Consent agenda items approved unanimously.
- 3) The guidelines on treatment of neck, knee, shoulder, wrist and elbow conditions were approved for public hearing. (Vote 9/12)
- 4) Motion to use two re-appointment dates per year and pro-rate fee approved unanimously.
- 5) Unanimous approval for up to \$1,200 for consultants to review revised guidelines for treatment of post traumatic stress disorders.
- 6) Written comments will be accepted until June 13, 1996 on the treatment guidelines of low back conditions.
- 7) Approved placing Dr. Rothenberg's QME status on suspension was stayed, and on probation for a term coinciding with his licensing board.

*June 20, 1996
Continental Plaza Hotel
Los Angeles, California*

Call to order at 10:03 am by Dr. Richard Pitts. Dr. Pitts welcomed new member, Dr. Glenn Repko. The Council approved 6/10/96 draft of evaluation guideline on cervical spine. Dr. Goldberg recommended requirements for named tests be moved to an appendix for illustrative purposes of tests that may be performed at discretion of physician. Carl Brakensiek & David Kizer agreed to attend to syntax and clerical items on the revised regulations. Motion approved to make "Amended Notice of Public Hearing, Proposed Adoption of Regulation" part of minutes. Meeting regarding Official Medical Fee Schedule and Medical-Legal Fee Schedule set for July 18, 1996 in San Francisco, July 25-26, August 14-15, 1996 in Los Angeles. Meeting adjourned at 11:05 am.

Actions Taken

- 1) Consent Agenda - Approved
- 2) Draft of Evaluation Guidelines for cervical spine - Approved

The Primary Treating Physician: Handle With Care (Pt. 1)

by David A. Kizer

This is the first of a two part series on The Primary Treating Physician

As most of the workers compensation community knows, one of the significant changes brought about by the 1993 Reform Act was the added provision that treating physicians are to complete what, for all practical purposes, amounts to a medical-legal evaluation (Labor Code § 4061.5). Simply put, the purpose of this change was to allow parties to settle claims on the treater's report without the need to resort to the QME process. For window period cases (1991-1993) the injured worker was *required* to go through the QME process, at least under the statute. Labor Code section 4061 stated that, for accepted claims after the injured worker was deemed permanent and stationary the employer *shall* provide the panel request form to the unrepresented employee and the employee *shall* select a QME. In represented cases the former section stated that parties *shall* attempt to agree to an AME before selecting their QME. There was no provision for allowing parties to settle claims on the treater's report and no provision in the Administrative Director's Rules for the treater's report to be submitted to DEU for a rating.

The amended section 4061 contains pretty much the same language as before except that now parties do have the option of settling on the basis of information in the treater's report. Previously, they had to slow dance through the AME/QME process. For represented cases, the dance was more allegorical as attorneys courted their QME of choice. Of course, treating physicians' reports have always been admissible under the statute, but so few of the reports were ratable that the parties were well advised to keep a short list of physicians to take to the dance.

Well the dance is still held. But the music has changed a little.

There are more than 100,000 treating physicians in the state of California. There are currently about 5,000 QMEs in the state who treat and write evaluations for occupational injuries. Generally, treating physicians who are unfamiliar with workers' compensation protocol don't want to write the extensive medical-legal reports because (a) they would rather just treat and they don't have time for it; and, (b) it's more paperwork and we all accept the fact that doctors don't like paperwork. Besides, they are already required to comply with the reporting procedures under 8 Cal. Code Regs section 9785.

A primary treating physicians report however, retains special status as an evidentiary document since it is presumed to be correct by the Appeals Board as compared to a QME report. Also, as discussed, it serves as the report that may allow parties to avoid the time and expense of protracted litigation. This makes finding a treating physician who can, (or even wants) to write a medical legal report somewhat problematic. Obtaining a well-written ratable report by a treating physician is like going to your high school reunion - you're hopeful, but most of the time, expect to be disappointed.

To assist treaters, the IMC has put out a **Treating Physician's Alert** with information pertaining to workers compensation claims and procedures as well as a **Primary Treating Physician's Form** (8 Cal. Code Regs. § 37 -available through the IMC). The form was developed after consultation with the physicians, attorney groups and payors. If used correctly, the form can greatly enhance the treater's ability to fully complete their reports. It combines

"check the box" simplicity along with a glossary and directions to enable the physician to write a narrative report summarizing their treatment and offering conclusions on issues like disability and QIW status. Perhaps the nicest thing about the form is that, where there is no disability, the treater is not required to write a narrative report. They can explain their conclusions on the form. Where disability is found, physicians using the form can check the boxes on relevant issues, narrate a report and simply staple the two together and serve the parties. Note that the treater must include additional information as necessary to adequately convey the factors which may affect the employee's entitlement to compensation [8 Cal. Code. Regs. section 9785.5(d)]. Stated another way, the more complex the issue the more the report should end up looking like a medical-legal evaluation.

Labor Code section 4061.5 provides that the primary treating physician's report is to be written by the treater or "the physician designated by that treating physician." The "designated hitter" rule has not been defined by statute or in regulation as yet, so no one knows who he or she is. At some point soon, physicians and payors will need to define this hypothetical physician. Options include allowing only physicians who have treated the injured worker in the past or requiring the treater to make a recommendation of a QME in the appropriate specialty.

If this issue does come up and the treater insists on designating another physician, until this issue is clarified in the law, parties would be well-advised to work out some reasonable compromise perhaps based on the treater's recommendation. The alternative is almost certainly a lengthy litigation process.

Council holds hearings on Low Back Treatment Guidelines

The IMC held public hearings on the proposed low back treatment guidelines on June 4, 1996 in Los Angeles and June 6, 1996 in San Francisco. The Council is currently reviewing the comments and evidence submitted by the public prior to making changes during the rulemaking process.

The IMC has already initiated formal rulemaking on other treatment guidelines at sections 72 ("Treatment Guideline for Occupational Asthma") and 73 ("Treatment Guideline for Contact Dermatitis") of Title 8 of the California Code of Regulations. Post traumatic stress disorder guidelines are near completion.

Guidelines cannot substitute for clinical judgment

Treatment guidelines are designed to assist health care providers in making decisions about how to most effectively and appropriately diagnose, treat and clinically manage specific disorders in individual patients. Guidelines are meant to be flexible enough to be useful in a variety of settings, and to allow for the diversity of clinical practice which is required by differences in individual patient characteristics. Guidelines cannot substitute for clinical judgment, which must play a role in addressing individual variability. Nor can guidelines diminish the substantial uncertainty about the true efficacy of various treatments for many disorders.

The term 'physician', as defined in the California Labor Code provisions which govern medical treatment for occupational injuries and illnesses, includes, "...physicians and surgeons holding an M.D., or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and

within the scope of their practice as defined by California state law." (Lab. Code § 3209.3.) In addition, injured workers in California may be referred for treatment to other health care providers, including physical therapists. Accordingly, the IMC was mandated under in Labor Code §139(e)(8) the develop treatment guidelines reflecting the expert opinion and clinical judgment of the full range of health care providers who treat problems in the workers compensation system.

The development of these treatment guidelines for use by providers treating injured workers in California's workers' compensation system is intended to address two issues of concern: the rising costs of the medical component of workers' compensation, and the variable practices of health professionals in the diagnosis and treatment of common work-related disorders.

Unlike the federal back guidelines (AHCPR) which are limited to the acute stage of injury the IMC guidelines extend to the chronic stage as well.

"The Council feels that the use of AHCPR guidelines is a relatively closed issue because these guidelines were not developed for use by a WC Community did not deal with chronic injuries i.e. beyond three months, nor addressed the full spectrum of 'physicians' as defined by the California Labor Code." said EMD D. Allan MacKenzie.

The low back guidelines must be viewed first and foremost as educational. It cannot be applied strictly to determine the appropriateness of care in any individual case. The goals of such treatment guidelines should be to improve patient outcomes and facilitate the rapid return to work of injured workers. Further research on the outcomes associated with various clinical management strategies

and treatments should be promoted by the guidelines. Periodically, as scientific knowledge and technology continue to evolve, this guideline will be revised and updated.

The initial guidelines, developed under the direction of Jordan Rinker, M.D. and Joseph LaDou, M.D., were an initial step in drafting evidence-based medical treatment guidelines

Unlike the federal back guidelines (AHCPR) which are limited to the acute stage the IMC guidelines extend to the chronic stage as well.

to provide health professionals guidance in choosing appropriate diagnostic and therapeutic interventions for injured workers in California. Input from practicing clinicians and appropriate specialty societies was sought during the initial guideline development. Relevant literature was reviewed by the initial contractors (using MEDLINE searches, review article citations and recommendations from experts), including research findings from clinical trials, consensus panel recommendations, and clinical policies or guidelines produced by a variety of professional societies and other states. The federal back guidelines (AHCPR) were also reviewed and integrated where possible. When scientific evidence was not sufficient to base a recommendation upon, professional judgment and consensus was used to ascertain current professional practices. In some cases, empirical evidence for a recommendation was lacking or so limited in scope that further research was considered necessary before some practices could be recommended.

The diagnostic techniques and therapeutic interventions listed are those which are utilized in routine prac-

(Continued on p.8)

IMC Appoints Investigative Staff

Under the direction & supervision of the Executive Medical Director, D. Allan MacKenzie, M.D., the investigative staff conducts sensitive and diverse statewide civil and administrative investigations.

At present there are approximately 5000 QME's providing service to 6,918 locations throughout California. Since 1991, IMC has sent out 277,976 panels. Staff assistants receive and input varying complaints provided by injured workers which are directed against QMEs. Those complaints are closely monitored and examined, and if warranted, are investigated for violations of the Labor Code or IMC regulations.

Mr. Thomas E. Brannon, Senior Special Investigator is charged with the conduct of those investigations. Mr. Brannon's duties include locating and interviewing witnesses, analyzing and evaluating testimony while gathering, assembling preserving and reporting facts. He also investigates the issue of medical evaluator privileges, procedures and guidelines and maintains liaisons with other law enforcement agencies assisting them in their investigative process while preparing reports of investigations and recommending actions to be taken.

The unit's mission is to enhance the quality of examinations of injured workers ensuring fairness and objectivity to all concerned in the investigative process. If you have complaints regarding any QME, please call Evelyn Ramos or Mr. Brannon at 1 (800) 794-6900.

Distinguished QME Concludes Career

by Thomas Brannon

In an age where confrontation is often the order of the day, many QMEs have served with distinction, a number of years in the workers compensation community. The IMC would like to hear from you, in order to acknowledge these individuals

Dr. Y. M. Alkar, M.D., of Carlsbad, CA is retiring after forty-five (45) years of dedicated, full-time practice. He turned seventy (70), on June 1, 1996.

Dr. Alkar served with distinction in the capacity of Qualified Medical Evaluator (QME) and honorably served the Workers' Compensation Appeals Board, the San Diego community, and the State of California notably in the capacity of IME, AME, and QME.

"Although I have elected to retire and enjoy my life and family etc. I am sure that I will miss all of my friends, attorneys and people with whom I have been involved, within the Workers' Compensation system,

as well as the Industrial Medical Council."

Dr. Alkar began his career during the turbulent years of World War II, having attended the University of Istanbul, Istanbul, Turkey in 1944 to 1952. After graduation he served as the Director of the Iskilip Health Center from 1952 until 1956. In 1956 he served his Country as a Medical Officer until 1958. After completion of his military service Dr. Alkar embarked on a new career which would take him throughout America as well as Canada. His resume reads of a professional who rose from the ranks to positions of trust and confidence leading from Psychiatric Residency Training to Staff Psychiatrist, to Director, Consulting Psychiatrist and Coordinator to Executive Medical Directorship.

In 1980, Dr. Alkar moved to California and passed the California State Board Examination for Medi-

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CME Provider Update

Since our last edition of **Medically Speaking**, we have approved the following providers to provide CME credit for QMEs.

Dept of Industrial Relations
Commission on Health & Safety & Workers' Compensation
30 Van Ness Ave., Rm. 2122
San Francisco, CA 94102
(415) 557-1304-Christine Baker

Livingstone-Lopez Consulting
132 No. El Camino Real, 265
Encinitas, CA 92024
(619) 944-6769-Dana Lopez

Osteopathic Physicians & Surgeons of California-455 Capitol Mall, #230
Sacramento, CA 95814
(916) 447-2004-Matt Weyuker

Glen A. Ocker, D.P.M.
1148 San Bernardino Road, #C-1
Upland, CA 91786
(909) 985-1831-Glenn A. Ocker

Adam Duhan, M.D.
1498 Solano Avenue
Albany, CA 94706
(510) 524-1680-Adam Duhan

Ronald A. Bortman, M.D.
400 Twenty Ninth St., #512
Oakland, CA 94609
(510) 231-8923-Ronald Bortman

Insurance Educational Association
1201 Dove St., #570
Newport Beach, CA 92660
(800) 655-4432-Martha Cockrell

Newsletter Staff

David A. Kizer, Esq.
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This newsletter is intended as an informational and educational source for QMEs and interested persons and may be reproduced.

QME → Q & A

What should QME's know about Continuing Education requirements?

All QMEs are required to complete 12 hours of continuing education during their 24 month terms.

The Council has now approved more than 45 providers of continuing education who meet the Council's requirements. QMEs should interview the course provider and talk with colleagues about which courses they have taken. While the courses may meet the minimum criteria, the quality of the course and the instruction may vary from course to course.

Finally, as your reappointment notice comes up, the IMC staff will remind you of your CME requirement and assist with any questions you may have. The coordinator for QME CME is Diana Cornell (800) 794-6900 ext. 2020.

Who certifies Doctors of Chiropractic for California workers compensation evaluation?

To date, the Council has approved four programs: The California Chiropractic Association; the Los Angeles Chiropractic College; Cleveland Chiropractic College and the International Chiropractors Association of California.

Can a treating physician select a specialty for an unrepresented worker?

No. This right belongs to the injured worker. (Lab Code § 139.2 (h). The treater may discuss and offer suggestions to the injured worker if requested but the worker makes the final selection and fills out the panel request form (8 CCR §30).

Must a QME send the appointment notification form to the claims administrator?

Yes. A QME is required to send the appointment notification form within 5 days of the making of the appointment. A phone call is not sufficient. (8 CCR §34). The sooner the form is sent, the sooner the medical records can be sent to the QME for review.

How does a QME report affect the burden of proof?

Labor Code §3203 states that the workers compensation laws of the state of California are to be "liberally construed" in favor of injured workers. This means that if there is a seeming conflict or confusion in the law before the Appeals Board, the board must resolve the conflict in favor of the worker. This does not mean the worker is relieved of the burden of proving his or her case or that if the worker puts on a very poor case that the WCJ has to "liberally construe" the evidence (testimony, employment records etc.) The WCJ is required to weigh the evidence as a trier of fact to ensure that a party has presented enough convincing facts to carry their burden on a given issue.

QME reports, of course, represent medical evidence which each party presents in the hope of sustaining their burden before the WCJ. The WCJ reads the QME reports for accuracy and compliance with all relevant legal requirements and considers the report in view of the treater's report, the medical records and the injured workers direct testimony and cross examination. The WCJ must then find that one of the parties has presented a preponderance of the evidence on an issue or issues (i.e. more likely than not). The party who has met their burden on presenting evidence prevails and WCJ will issue an appropriate Findings and Award or Findings and Order based on the evidence.

Obviously, this is a concise summary of the process but the key point to be made is that the WCJ must base a decision on competent, reliable evidence (i.e. not based on speculation or conjecture) and accurate, well-written QME reports are an integral part of this process.

INDUSTRIAL MEDICAL COUNCIL

(Continued from p. 5 - Low Back)

... are readily available and have scientific evidence or basis, or a consensus of expert opinion to support their use. Experimental modalities and techniques which are only available in research settings, and approaches for which there is no scientific evidence or consensus as to their efficacy or clinical utility, have been specifically excluded.

The general assumptions used in developing these guidelines were:

- 1) Assessment or treatment modalities which have no research evidence supporting their efficacy will generally not be recommended.
- 2) If the evidence for an assessment or treatment modality is weak or equivocal, and the potential harms are small it may be considered an appropriate option for some patients. If the potential harms are high, it will not be recommended.

Each guideline was organized to provide a sequence of appropriate and inappropriate assessment and treatment choices based upon the initial clinical presentation and any subsequent diagnosis made by a health care professional. These choices are neither exhaustive nor proscriptive. Individual patients may require special tests or treatments which are not included in the guideline, depending upon their personal and job characteristics.

"Many of you have heard me state publicly, that I am a refugee from poorly written Canadian guidelines. I accepted the job of Executive Medical Director of IMC primarily for the opportunity of being involved in the writing and development of a superior set of guidelines for the State of California WC Community. This may have been naive on my part but I do believe that we are well on the way." Dr. MacKenzie said.

All interested persons who commented will be receiving the amended guidelines for further comment when completed.

Question or comments concerning the guidelines should be directed to Suzanne Marria, Esq at (800) 794-6900 ext. 2005.

(Continued from p. 6 - QME Career)

cal Licensure & Practice. During the ensuing years he was noted as the Award Winner in QME Physician's Recognition Award in continuing Medical Education of the American Medical Association, which continued throughout his career from 1971 until 1991.

If you need information regarding QME panels or QME questions in general, please call 1-800-794-6900 or (415) 737-2767.

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