Medical Legal Fee Schedule Forum Comments

Leonard Gordon MD June 30, 2020
AME State of California

Thank you for the work on revising the med-legal fee schedule. An update of this schedule is way overdue.

While there are still problems that remain, I believe this to be a good first step in the process.

Considering the inordinate delays that we have seen, I strongly support moving forward expeditiously with this new schedule.

Joan Palmeiri June 30, 2020
Benedict Billing Solutions, Inc.

It was my understanding that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. I also understood that progress was made for fair and equitable changes for ALL QME specialists were discussed and terms were agreed upon. As such, I am again truly disappointed that DWC has undercut these levels and is attempting to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings. How is it that we are paid less than QME's in Nevada given our California cost of living is significantly higher? This is profoundly disappointing and this latest proposal is unacceptable.

Moreover, in December 2018, Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is truly demoralizing and disheartening.

Many of my colleagues will have to determine whether they will continue serving as a QME. Some have already left by their own choice and more will abandon their role now. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Christina Averill, Ph.D., QME June 30, 2020

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Mark Kimmel, Ph.D. June 30, 2020

The proposed fee schedule will result in less comprehensive evaluations that will be a disservice to injured workers. Psychologists and psychiatrists have a more complicated task in performing their evaluations and a 50% increase will not provide enough time to conduct such an evaluation. Many reports will not constitute substantial medical information and those that do will provide the bare minimum prompting requests for supplemental reports and depositions. These inefficiencies will cause delays workers receiving treatment and in settling cases. The unintended consequences are also likely to be more costly than a more generous fee increase. The adage, "you get what you pay for" is appropriate in this instance and the complaints of poor quality evaluations will likely increase. As a member of the DWC work group I heard various perspectives on the fee schedule and heard that payers were willing to increase fees if they were assured of quality evaluations.

A 100% increase for psychologists and psychiatrists would be minimal to the overall system but would incentivize evaluators to provide better quality reports. I also would recommend that an effort should be made to educate QMEs and establish standards for QME evaluations

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Dr. Michael D. Zeger, D.C., Q.M.E. June 30, 2020

The new proposed Med-Legal Fee Schedule has two major flaws.

First the proposal that the qualified medical examiners should only be paid to review medical records after the first two hundred pages is the same as asking the QME to work for free. Insurance companies demand that their premiums be paid, or you lose your insurance coverage. Attorneys expect to be paid for their part of the workers compensation process or they take you to court. Judges certainly expect to be compensated for their work. Court reporters and interpreters expect to be paid, even for missed appointments! So how is it reasonable for the med-legal fee schedule to allow for a loop-hole that will cost the qualified medical examiner hours of extra time and yet not compensate them. It is simply unreasonable. If there are any medical records to review, the qualified medical examiner should be compensated for reviewing those records.

Secondly, for years, the insurance company has refused to pay missed appointment fees based on an equivocal line in the current med-legal fee schedule which states, "ML100: Missed appointment for a Comprehensive or Follow-up Medical-Legal Evaluation. This code is designed for communication purposes only. it does not imply that compensation is necessarily owed." Just this month I have had four cancellations of medical-legal exams, some of which were on the night before the exam was about to take place. This means I cleared a minimum of a half day of patients in order to perform an exam and I won't be paid a dime for that time lost. There is no way I will have time to adjust my schedule in circumstances like this. Unfortunately, this practice is not an isolated incident. Attorneys and insurance companies have no regard for the time of the medical examiners and have no ramifications for wasting our time. It was a large enough problem that the proposed med-legal fee schedule actually addresses and fixes this problem, which I am happy about.

However, the proposed med-legal fee schedule now has a similar clause that allows insurance companies and attorneys to decide whether or not a supplemental report is compensable. This is simply absurd. Why would the insurance company ever pay a supplemental fee, when they can just state that the supplemental should have been covered in the original report? it doesn't matter if that is true or not, the insurance company's opinion is the only opinion that matters. Supplemental reports are not easy and usually require a re-review of records and a review of reports in order to satisfy the questions being asked. The proposed med-legal fees schedule is simply asking the medical evaluators to perform supplementals for free. Attorneys will simply request

supplemental after, after supplemental, after supplemental until the evaluator gives them the answer that they want to hear. I know, because that happens now.

Placing loop-holes in the proposed med-legal fee schedule, as I have described above, is going to cost the whole system time and money. Every time I have to have my staff contact a claims adjuster to collect on an unpaid med-legal fee, it costs me money and time and the insurance company money and time. Leaving vague and equivocal statements in the med-legal fee schedule is going to cost millions of dollars in time, money, and litigation. It will cause an already slow system to bog down even further.

Alison Magoun Moreno, Ph.D., QME June 30, 2020

I am a clinical psychologist who has been a QME for the past few years. I find the proposed changes to be unacceptable. If enacted, this fee schedule will increase the administrative burden on QMEs, not compensate them fairly, and undoubtedly reduce the already record-low number of QMEs still left in the system.

DWC has intentionally NOT applied the psych multiplier to record review. This makes no sense. Reviewing medical records from a mental health perspective is inherently more time-consuming and complex than reviewing medical records for a non-psych specialist. Furthermore, I have found that often valuable information is obtained from a careful and thorough review of such records. I urge DWC to increase the multiplier to at least 2.0x **and** apply the psych multiplier to record review fees, not just the flat fee.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders. Why has DWC ignored this widely supported proposal?

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Further, the fact that DWC has disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement DWC proposes is far below Sue Honor's recommendation and even less than the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Many qualified physicians have avoided becoming a QMEs because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge DWC to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

John M. Warrington, Ph.D., QME June 30, 2020

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Arbi Mirzaians DC June 29, 2020

Specifically, I am referring to the following language of the code descriptor for ML 206:

ML206
($0) Remedial Supplemental Medical-Legal Evaluations. This code is designed for communication purposes only. It indicates and acknowledges that compensation is not owed for this report. This code shall be used for supplemental reports following the physician's review of: (1) information which was available in the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report, (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation, or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795. Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

An additional concern which requires clarification within the MLFS is that of duplicate records. There are instances when the additional records submitted to the QME to review, contain duplicates of medical records previously submitted to the QME for review.

First, it requires that the QME review these records in order to discover which, if any, of the records are duplicates.

Second, as it applies to medical record review, it would only be reasonable to expect that the QME would be reimbursed at the per page reimbursement rate at any time additional records are submitted to the QME for review regardless of whether or not duplicate records are included within the records provided for review.

It is asked that the requirement to reimburse the QME for review of any duplicate documents clearly be outlined within the MLFS.

It is simply not feasible to not only review duplicate records without reimbursement, but to go through the arduous process of attempting to identify which of the records are in fact duplicates.

I respectfully ask that you review, consider and address these matters in the final version of the MLFS.

Michelle Furuta MD, QME June 29, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

J. Stuart Meisner Ph.D. June 29, 2020
Clinical Psychologist

The proposed changes are unacceptable. Quality psychological evaluations cannot be performed in most cases for this reimbursement rate. This opinion is based upon my 35 years experience providing these evaluations. During this period, I have trained other examiners and reviewed a huge number of examinations. There is a lot of low quality work out there. Those who remain under the proposed schedule will do a disservice to the entire endeavor. I will discontinue being a QME if it is accepted.

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William W. Deardorff, Ph.D., ABPP, QME June 29, 2020

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Michael A. Sommer MD June 29, 2020

It does not seem logical to exempt record review from the AME upcharge. After all it's usually what's in those records (gaining a good understanding of them) that makes such a case so difficult that it's an AME in the first place!!

Andrew (Andrzej) Bulczynski, MD June 29, 2020

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Mohammad Hanizavareh June 29, 2020

I have read the newly proposed changes to the DWC med-legal fee schedule and I have found them to be largely inadequate. I understand the purpose of the proposal is to reduce complexity and costs for insurers but I believe they are largely unworkable as written. The new schedule essentially proposes that psychiatrists perform the entirety of a med-legal evaluation and report within 12 hours if they do not want to take a pay cut. That includes a forensic psychiatric interview, psychiatric testing, record review of 200 pages and in-depth analysis. A quality evaluation and report cannot be completed in this time. Period.

Let's clarify what each aspect of a psychiatric evaluation requires. A forensic psychiatric interview, which a qualified/agreed medical evaluation is, requires multiple parts. There are directed questions towards obtaining basic aspects of history. There is an open-ended interview to obtain the history of industrial injury as well as nonindustrial factors. There is also the requirement of verifying/checking the history vs what is obtained in the record. Each aspect takes a significant amount of time. I generally average well over 4 hours per interview and have gone as long as over 7 hours. I do not see a thorough interview lasting less than 3 hours. A lengthy interview is required for a number of reasons, the first of which is that applicants seen in this system often have very little insight into the exact nature of their injury. For example, a very common situation is an applicant claiming emotional distress arising from a physical injury, multiple personnel actions and work stress. It takes time to parse this out with the applicant and arrive at what he/she believes is the predominant cause of the injury. Second, obtaining a thorough nonindustrial history requires a lengthy, open-ended interview in which the applicant is allowed to speak at length about his/her life. Just a few weeks ago, I had an applicant who responded "I don't know" when initially asked if they had ever experienced any form of abuse. When I rephrased my question and explained what I meant by abuse, the applicant denied experiencing the abuse. However, she appeared

upset at the question so I asked the applicant a third time at a much later point in the interview. The applicant broke down crying at this point and acknowledged being seriously abused. This whole process took over an hour, just to obtain a single factor of apportionment and this is a common occurrence during evaluations. Third, a psychiatric interview must consider credibility and motivation. This requires fact-checking/verifying with the records, sometimes line by line.

All of these portions of the interview require time and are absolutely critical aspects of a thorough psychiatric evaluation. Given the lack of time supported in the new billing proposal, I strongly believe that those who have been performing their evaluations in this manner, will no longer spend the time to get these additional details. Without these factors, I strongly suspect that most psychiatric claims moving forward will be found predominantly industrial as the applicant initially describes them, without analysis of different possibilities for causation (ie work stress vs ortho injury vs personnel action) and will not include a detailed apportionment analysis. Given the disincentive to perform re-evaluations, I also suspect that more applicants will be found P&S after their first evaluation. This will mean that insurers will actually see more predominantly-industrial claims, with lower GAFs and less in the way of apportionment.

Let's say that psychiatrists continue to perform thorough interviews in the context of the new billing regulations. Given that I have averaged over 4 hours per interview, let's round down to 4 and that leaves me with 8 hours to review 200 pages of records and write my report. Assuming I review those 200 pages in 2 hours, though I would argue that psychiatric treatment records and a deposition with a psychiatric focus take much longer to review, I am left with 6 hours to write my report. This is again if I do not want to take a pay cut. My current reports average around 70 pages and I have had two in the past few months that were over 150 pages in length. My reports do not contain the repetition seen in many treating provider's reports and I spend time discussing my analysis of every factor in my reports and include a thorough explanation of my reasoning for each opinion. It takes longer than 6 hours to do this in every single case.

For example, my most complex case this year involved a person with a claimed psychiatric injury stemming from a specific injury accident. This person was claiming a traumatic brain injury with ongoing symptoms years after the injury, posttraumatic stress disorder and major depressive disorder. The applicant had seen many, many doctors (none were psychiatrists) since the accident and they had prescribed many, many psychiatric medications and offered the diagnoses above without any analysis or explanation. The applicant also had a history of another prior industrial injury some 20 years prior with no interval work history during that time, a lengthy history of nonindustrial major depressive disorder, heavy substance abuse, lengthy prison time, the death of a child and a number of other major nonindustrial factors. There is simply no way to parse any of this out AND explain this to the parties in the allotted time of 6 hours. This may seem an uncommon scenario but even other cases in which I have a relatively young applicant who is claiming only a clear specific injury stemming from a one-time accident require more thorough analysis than 6 hours provides. If doctors aren't paid for their analysis, they will not provide it. I understand the newly proposed regulations provide a code for remedial evaluations in which we will not be paid in order

to answer questions someone arbitrarily decides we should have in a previous report, but I do not believe any doctor will operate in a situation in which we are expected to work for free.

To be clear, psychiatrist rates these days around $300/hour for contract/public clinical work and more for private clinical work. Forensic expertise is also generally paid at an even higher rate. The new regulations expect us to perform our work in 12 hours if we want to continue receiving the $250/hour we currently receive under ML-104. If we spend over 12 hours completing an evaluation, from interview to sending out a completed report, we will receive a substantial cut in our current pay. I do not believe 12 hours is adequate for all of the factors that go into a thorough psychiatric evaluation. I do not believe the parties can expect a thorough evaluation and report under the newly proposed guidelines. I also do not expect any doctor would be willing to work for free as expected to under ML-206. I am also unclear if the new proposal will meet its purpose of saving insurers money as more applicants will be found P&S at the first interview (usually with a lower GAF than they would have otherwise with recommended treatment), more claims will be found industrial at face value (ie without analysis of credibility/motivation or whether work stress vs personnel actions vs ortho etc were primary) and there will be less in-depth analysis of the factors of apportionment.

One could posit that we, as empathic and altruistic medical professionals, should be willing to take a pay cut in order to deliver high quality care to the applicants we see. However, one could also say that our skills would better serve applicants and patients in general if we simply stopped performing these types of evaluations and simply focus on direct patient care. QMEs/AMEs are varied in their motivation to continue performing this type of work, but at some point the math of time vs money turns factors in and the DWC will lose doctors that are willing to do a good job. Given these repetitive proposals of late, it appears that the DWC will enact some approximation of this fee schedule soon. I hope that you have considered the ramifications to the applicants, insurers, the system and yourselves

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William Tappin, Esq. June 29, 2020
Tappin and Associates

I will leave the discussion of the various modifiers relating to different medical specialties to the doctors impacted by those modifiers. However, with respect to modifier No. 93, it seems inadequate to address the time involved. Each question from the doctor has to be translated into another language. At that time, the patient responds in another language. The patient's response is translated back into English. In addition, many patients repeat the question, which generates even more questions. I think the time involved when there's an interpreter increases the period of the examination by one-third or more. However, I do think the modifier should move from .1 to .2.

Additionally, because many of the carriers, administrators, and employers ask and

often won't accept the basis for the increase in time relating to interpreters. The regulation should indicate the language the doctors need to use to guarantee they receive that modifier, whether it's .1 or .2.

William Tappin, Esq. June 29, 2020
Tappin and Associates

Doctors are subject to scrutiny and potential discipline for refusing a Panel Qualified Medical Evaluation assignment. The issue of the Uninsured Employer's Benefit Trust Fund must be addressed in the proposed medical-legal fee schedule regulations. I think most doctors who will issue comments with respect to this would agree that it is difficult, if not impossible, to be paid on a timely basis by the Uninsured Employer's Benefit Trust Fund. Regulations should be drafted requiring the Uninsured Employer's Benefit Trust Fund to be subject to the provisions of Labor Code § 4622 to further support the legislative intent that medical-legal providers be paid properly and timely. At the present time, doctors either are not paid at all or are paid four or five.years later.

That's inappropriate.

One has to question why an illegally insured employer gets a greater consideration than the medical-legal provider. In order to obtain a medical-legal report in an insured employer case, a fund should be established or some provision made for the doctor being paid within 60 days, as with other cases. Alternatively, a doctor should, at his sole discretion, be able to refuse to accept uninsured employer cases without a guarantee of payment enforceable at the Workers' Compensation Appeals Board. If an attorney sends a case to a doctor as an Agreed Medical Examiner or panel Qualified Medical Examiner without advising that the employer is uninsured, the attorney should be required to post payment or have his client post payment of a fixed amount in advance of the evaluation. In addition, the attorney must advise the medical legal provider that the employer is uninsured. If some provision is not made for payment on a timely basis on an uninsured employer cases, doctors should have every right to refuse to do an evaluation. If there is a provision regarding required payment by the Uninsured Employer's Benefit Trust Fund, I am unaware of it. Does the Uninsured Employer's Benefit Trust Fund fall under the provisions of Labor Code § 4622 and the administrative regulations?

William Tappin, Esq. June 29, 2020
Tappin and Associates

Medical legal providers should be given the option to refuse Panel Qualified Medical

Evaluations in cases where they have had ongoing issues with the carrier, administrator, or employer regarding payment of their invoices. It seems that a doctor should not be required to continue a relationship with a carrier that continually fails to pay either timely or appropriately.

Does Title 8 California Code of Regulations Section 41.5(d) govern this issue. Section (4) states:

"Any other relationship or interests not addressed by subdivision (d)(1) - (d)(3) which would cause a person aware of the facts to reasonably entertain a doubt that the evaluator would be able to act with integrity and impartiality."

Additionally, Title 8 California Code of Regulations Section 41.5(e) states:

"An Agreed Medical Evaluator or a Qualified Medical Examiner may disqualify himself or herself on the basis of conflict of interest pursuant to this section whenever the evaluator has a relationship with a person or entity in a specific case, including doctor patient, familial, financial or professional, that causes the evaluator to decide it would be unethical to perform a Comprehensive Medical-Legal Evaluation, examination or to write a report in the case."

If a medical legal provider has a relationship with a carrier, administrator or employer which is negative and, which the doctor feels would impair his or her ability to issue an unbiased report, would they be able to refuse the assignment? If so, what procedure would they follow. Should this be clarified in detail in the Regulations. The above referenced section does not say the relationship has to be positive, it merely says a relationship, which could in fact be negative.

I also note Title 8 California Code of Regulations Section 41.6(d) which states:

"Any dispute on whether a conflict of interest of an evaluator may affect the integrity and impartiality of the evaluator, with respect to an evaluation report or a supplement report, and any dispute over a waiver of an evaluator's conflict under this section shall be determined by a Workers' Compensation administrative law judge."

41.6 relates to procedures after Notice of a Conflict of Interest and waivers. The Code infers this would be exercised by one of the parties and perhaps not the doctor. However, if a doctor reporting as a medical legal provider has an ongoing issue with any particular insurance company, administrator or employer that the doctor feels would cause them concerns about their ability to issue an unbiased report, shouldn't they be able to refuse the assignment without penalty?

I think this should be addressed. I know it's someone outside the fee schedule issue, but it flows from the fee schedule and potential bias on part of the doctor. No doctor should be forced to issue a report in a case where he or she has a bias against a particular administrator, carrier or employer. The Medical Unit may say the doctor shouldn't have a bias, but if in fact, the doctor has a bias, is he allowed to

refuse the assignment? If he refuses the assignment, is he subject to any discipline or punitive action?

William Tappin, Esq. June 29, 2020
Tappin and Associates

This comment relates to Title 8 California Code of Regulations§ 9794(a)(1) and Title 8 California Code of Regulations§ 9795(b). Section 9794(a)(1) does not include costs of clerical expense to produce the report. Section 9795(b) indicates that "the fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses."

This is consistent with the prior Title 8 California Code of Regulations § 9795 and the language has not been amended. This has been an ongoing issue as medical-legal providers have been disciplined and required to pay monies back relating to the inclusion of charges for clerical services to produce the report. This should be addressed as we're attempting to move forward with some additional clarity regarding what changes are allowed. Regulation 9794(a)(1) and 9796(b) should be amended to indicate clerical costs are in addition as opposed to being included in the scheduled fee. Doctors should not be disciplined or threatened with non-renewal of certification for billing for clerical costs associated with the production of the medical-legal report. The state audit of the Department of Workers' Compensation specifically indicated that the recertification process was used to discipline doctors. Many doctors, when they are audited, must reimburse to the defendant carrier the costs associated with production of the report by a typist. Obviously, it is not in the doctor's interest to litigate that issue because it may result in his non-recertification and given the relative values costs a great deal in terms of litigation versus the amount of repayments involved.

Labor Code §4628(d) states:

"No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense." (emphasis added)

This comment relates exclusively to the "reasonable costs of clerical expense necessary to producing the report." The statute clearly indicates that the doctor is entitled to reasonable costs of clerical expense necessary to produce the report. This is clear and unambiguous language in Labor Code §4628(d). There is no misconstruing the meaning of that language.

Labor Code§ 5307.6 directs the administrative director to adopt and revise a fee schedule for medical-legal expense. There is no question that the administrative director has the authority to enact regulations to interpret the Labor Code. However, the enabling statute reflected in Labor Code§ 5307.6 is subject to limitations. California Government Code § 11342.2 states:

"Whenever by the express or implied terms of any statute a state agency has authority to adopt regulations to implement, interpret, make specific or otherwise carry out the provisions of the statute, no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute." (emphasis added)

In this particular case, the statute indicates clerical expenses necessary to produce the report are in addition to the medical-legal fee. Title 8 California Code of Regulations § 9795(b) is in conflict with the statutory requirements of Labor Code§ 4628(d). In addition, it does not effectuate the purpose of Labor Code§ 4628 and the legislative scheme surrounding that statute. With respect to medical-legal expenses, Labor Code

§ 4622(e)(2) states:

"The Appeals Board shall promulgate all necessary and reasonable rules and regulations to ensure compliance with this Section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced."

Labor Code§ 4622 is captioned "Employers' Liability for Expenses; Penalty." The statutory scheme and intent in amending Labor Code § 4622 effective January 1, 2013 was to stem the outflow of panel Qualified Medical Examiners and Agreed Medical Examiners from the workers' compensation system by ensuring that they were paid timely and in a proper manner. Reading Labor Code § 4622 and 4628 in conjunction, the legislative intent is clear. There's no ambiguity in Labor Code§ 4628(d) when it says the clerical cost of preparing the report are in addition to the medical-legal providers professional time.

When the Appeals Board or the Courts interpret workers' compensation statutes the fundamental objective is to determine the legislature's intent so as to effectuate the purpose of the law. The best indicator of legislative intent is the clear, unambiguous, and plain meaning of the statutory language. In interpreting statutory provisions, the court will first look to the express language of the statutes themselves. When the statutory language is clear and unambiguous, the court will enforce the statute according to its plain terms. *(DuBois v. Workers' Compensation Appeals Board* (1993) 5 Cal. 4th 382 [58 Cal. Comp. Cases 286])

The DuBois case, supra, reflects the general administrative law rule that statutes have primacy over regulations. The regulations cannot be inconsistent with or contrary to the plain unambiguous language of the statute. In this case the clear unambiguous language of Labor Code§ 4628(d) is that the doctors are now, and

have always been, entitled to the clerical cost for the preparation of a medical-legal report over and above the professional time charged. The unamended Title 8 California Code of Regulations

§ 9795(b) and the current amended 9795(b) are unquestionably inconsistent with the clear and express language of the statute and inconsistent with the intent of the legislature in enacting the statute. I won't go into detail in this comment relating to the documentation of the legislature's intention but can do so if the DWC desires.

In the en bane case of Mendoza v. Huntington Hospital/Sedgwick, the Appeals Board addressed a very similar issue. The question was whether an administrative director rule is invalid because it is inconsistent with Labor Code§§ 4060(c), 4062.2, and 5402(b). In that case, the Court was very specific. It stated when considering the validity of a regulation enacted by the Administrative Director, "Our task is to inquire into the legality of the ... regulation, not its wisdom." (Citing Moore) (Further citations omitted). The court cites Government Code § 11342-2 and states, "No regulation adopted is valid or effective unless consistent with and not in conflict with the statute." Please note in this case the statute was not the enabling statute but rather the underlying statutes of 4060, 4062.2 and 5402(b). They further cite additional cases which will not be specifically enumerated based on limitation of space that state "A regulation that is inconsistent with the statute it seeks to implement is invalid. (Esberg

v. Union Oil). There are numerous cases relating to agencies in addition to the Department of Workers' Compensation that have found a regulation is invalid on its face if it is inconsistent with the statute. An administrative agency has no discretion to promulgate a regulation that is inconsistent with the governing statutes. Administrative regulations which exceed the scope of the enabling statute are invalid and have no force or life. Administrative regulations may not contravene terms of statutes under which they are adopted. (Boehm and Associates v. Workers' Compensation Appeals Board (Lopez) 64 Cal Com Cases 1350).

In this particular matter, the proposed amended regulations mirror the prior regulations. Both the prior regulations and the current regulations are inconsistent with the intent of the legislature in enacting a scheme for payment of medical-legal providers and specifically in clear violation of the unambiguous language of Labor Code§ 4628(d).

The current amended regulations should reflect the intention of the legislature and the clear language of Labor Code§ 4628(d) and not perpetuate the errors reflected in the earlier version of Title 8 California Code of Regulations § 9795.

There are, many cases both within the workers' compensation system and other agencies that support this position. Administrative regulations that violate acts of legislature are void. (Daley 276 Cal.App. 2d 801). An administrative agency may not promulgate a rule or regulation that alters or enlarges the terms of a legislative enactment (Cleveland Chiropractic College 11 Cal.App. 3d 25).

In reviewing the proposed regulations, I note Title 8, California Code of Regulations

§ 9795(b), last sentence indicates:

"The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service."

It seems, based upon the discussions about the fee schedule and the current "flat rate" process, that this sentence should be completely eliminated from Title 8, California Code of Regulations § 9795 consistent with the intent of the recent renumbering and clarifying of the regulations. This appears to relate only to the prior complexity factor analysis which is being replaced.

Daniel Lee June 29, 2020

ML206 should be clarified further. The advocacy letter should state precise key points that the examiner should address as it is all too common for the requesting parties send generic letter with multiple questions.

Also, the examiner should only have to address the body parts in the agreed letter and not have to rely on the history of the patient.

Kari Tervo, Ph.D., QME June 29, 2020

I am getting really tired of writing you letters to beg to be adequately compensated for the complex medical-legal work that I do.

I’m sick of begging you to be reasonable for the sake of injured workers.

I’m frustrated that I have to keep trying to say the same thing in different ways every time you pull the stunt of not only failing to even give us our first cost-of-living increase since 2006, but actually *decreasing* our wages significantly and expecting us to work for low wages, or in some cases, for free.

This is ridiculous! What are you doing? You’re intentionally trying to destroy the workers’ compensation system from within, is how I see it. You want doctors to review records for free—disorganized ones at that. You want us to write supplementals for free. You’re giving us a fee schedule that compensates California doctors less than Nevada doctors, when it’s so much more expensive to live in California. What could possibly be going through your head?

I'm done with being polite. I'm done wasting my time trying to explain things you already know but don't care to acknowledge. Do your job, stop purposely making the workers' comp system hemorrhage QME doctors, and stop playing these ridiculous and insulting games with workers' lives and doctors' livelihoods and careers.

Knock it off. Give us a fee schedule that adequately compensates QME doctors for the complex work that we do. Stop expecting us to work for free. This is outlandish and ridiculous and immoral. Yes—immoral. Injured workers need timely medical care and QME doctors chose this career because it's a good fit for their skills, and you're playing games with everyone's life.

You're also forcing doctors to reconsider their career options in the middle of a pandemic and quarantine! It's unconscionable.

Stop. If you don't want to do the work and do the work fairly, hand it off to someone who actually cares about the injured workers of California and who has some respect for QME doctors, because it's clear on both counts that you don't.

I do not want to have to write another letter like this. I'm sick of fighting about this. I just want to do my job and be treated fairly. DO. THE. RIGHT. THING.

Keith Bridges June 29, 2020

If DWC wishes to adopt a set fee structure similar to the one used in Nevada, then the pay rate should be 15% higher than Nevada to reflect higher overhead costs in California. Cost of living increases in payment should be automatic. Carrier requirements should be the same as Nevada.

Emily Todd, MD, PhD, QME June 29, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also

contained many critical qualitative changes that would decrease friction for all stakeholders.

Sue Honor's proposal and the accompanying petition can be found here: https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Dinesh Sharma MD June 29, 2020

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I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported

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Dr. Louis Rosen June 28, 2020
Physical Medicine & Rehabilitation

The proposed changes are unacceptable. I am a newer panel QME, and I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada,

a much lower cost-of-living state than California. Also, I am baffled that you have not included a COLA, an essential requirement for the QME community.
I am a new QME, recently listed with the State, and was optimistic that the fee schedules would be resolved in a fair and equitable outcome despite all of these issues. I am not so sure now, and am questioning my involvement with the California DWC QME system

This proposal will be the final straw for many QME providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

Thank you for your reconsideration of the currently disappointing and unacceptable proposed QME fee schedule change. In addition to a more equitable reimbursement rate, a COLA must also be included.

Alireza Esfahane, MD, MSCR, QME June 28, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor

reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Anonymous June 28, 2020

The proposed regulations are again terrible.

As everyone knows, the DWC used underground regulations to go after QMEs and were found to be in the wrong by the District court. The QME thought everything was fine now because the DWC was to follow the laws and rules as written. Then, the DWC gave their first proposal for a fee schedule and it appeared to be in retaliation to the unjust conduct of the DWC. Then, the DWC proposed another fee schedule that appeared to be a cut to the QME fees. Many pointed out that they DWC was trying to get the QME into a system like Nevada. The DWC did not want to tell the community where they got the second fee schedule from, but it was later found out that it came directly from an insurance company. That confirmed what everyone already knows, which is the DWC is biased towards the insurance carriers. So, the DWC has been antagonistic towards QMEs on an ongoing basis.

There was an audit of the DWC. The audit showed different areas where the DWC had gone wrong and indicated there should be a rate increase and compensation based upon quality.

After terrorizing the QME community and acting in bad faith, some in the QME community acquiesced and decided to try to work with the DWC on a new schedule. The current schedule is superior because it is equitable to all specialties and values a QME's time. The workers could be heard, research could be conducted, reports could be prepared considering all the issues because it was compensated for, and the records could be reviewed adequately. However, some QMEs mistakenly felt that bargaining with the DWC would prevent an even worse schedule being proposed for a next round. For this current proposal, the DWC made some effort to try to have the appearance of some sort of process for coming up with new fee schedule recommendations at a stakeholder meeting. However, the process was poor and not everyone in the QME community were notified about this and given an opportunity to participate. It was just certain groups coming together to force a consensus. The payers had an outsized voice and did not consider suggestions for pay increases based on quality, the amount of work, and the fact that QME rates have not gone up in a very long time. The negotiations were based on supply and demand of QMEs. There was an undersupply for orthopedists, so the payers agreed to boost pay for ML 102 and ML103 evaluations to get more orthopedists. However, for the mental health specialties, the payors said

there was an oversupply or psychologists, and rather than negotiate based upon the complexity of the evaluations, there was only a low multiplier assigned because the payors had no problems getting a psychology panel. Also, for psychology, the meeting was surprisingly short and occurred late when everyone was tired and wanted to go home. There was no adequate consideration for complicated issues facing mental health. There were also persons who had no idea what mental health did vote on the mental health multiplier. For example, an orthopedic representative voted for the lower multiplier and admitted having no understanding of why mental health evaluations took as long as they did. The mental health stakeholder meeting was initially characterized as a sham. At the stakeholder meeting, there was also no adequate representation for QMEs that do complicated reports. There was no discussion of a multiplier for complicated evaluations. There was no discussion that the number of records provided to a QME does not equate to complexity and that some of the most complicated cases come with the fewest records while taking the most time.

The DWC's current proposal not only put into place parts of the poor outcomes from the stakeholder's meeting but also incorporates other factors that essentially destroy the quality of the Worker's Compensation system.

Those doctors that are for this proposal likely like it because they are going from being poorly reimbursed under ML 102 and 103 to a higher minimum flat fee of 2,015 dollars. However, they probably don't realize that they are being paid less than the Nevada schedule. Under the Nevada schedule, an evaluator will get 1784.12 dollars for a flat fee and this includes 50 pages. Above 50 pages, you get 4.46 dollars for each page reviewed and then an additional 0.97 cents for organizing records. So, for an evaluation with 200 pages of records, you will get under the Nevada schedule, assuming records were provided in chronological order, 1784.12 + 4.46(150) = 2451.12 dollars. Under the Nevada schedule, if you were given pages out of chronological order, a QME would get 1784.12 + 4.46(150) + 200(0.97) = 2645.12 dollars. So that is already, over 600-dollar less that a QME would get from high cost California versus lower cost Nevada.
For California, the reimbursement for reviewing records between the number of pages from 201 to 1000 is 3 dollars. Then, it is two dollars from pages 1001 and above. For lower cost Nevada, you continue to get 4.46 dollar per page above page 51 and then 0.97 cents to put those in chronological order. So basically, QMEs in California, are given a much lower reimbursement as cases increase in the complexity and numbers of records than in lower cost Nevada.

For Nevada, the number of pages sent to the QME is specified. For California, this is not specified, and the QME must spend a significant amount of uncompensated time counting pages.

We can also see how the DWC is trying to get the cost even below lower cost Nevada in failed appointment fees. For Nevada, the failed appointment fee is 669.04 dollars. For California, the proposal is 504 dollars. We know that many carriers are currently taking advantage of QMEs by not paying any failed appointment fee or a fraction of a failed appointment fee. Also, a mental health professional loses much more when someone fails an appointment because a whole day may need to be reserved and that entire day

is lost. A non-mental health professional may lose an hour of face to face time or possibly less. There is no justification for giving less compensation to non-Nevada physicians and to mental health professionals.

In Nevada, they pay 325.41 dollars for each body part evaluated in excess of the first two. For the DWC proposal, it is zero. So, we can see again, that for complex evaluations, the DWC proposes paying less than Nevada.
For Nevada, they have an automatic COLA increase. For California, the DWC proposes no COLA increase. The DWC has gotten away with underpaying QMEs for a long time and with the proposed schedule, they can get away with another decade without addressing underpayment.

The psych multiplier is unacceptably low. The proposal pays mental health professionals at a rate of 1.6 times what non mental health evaluators will get. Non mental health evaluators can easily do two or three evaluations or more in the time it takes for a mental health professional do one evaluation. A mental health professional can take two or three times as long or more to evaluate a patient, review records, and compose as report than a professional in another specialty. It is not uncommon for just face to face evaluations along with testing to take an entire day. This is without record review, scoring testing, analyzing the data, and composing a report. There is simply much more data that needs to be evaluated and taken into consideration for a mental health professional. Because the law is designed to deny as many mental health claims as possible as compared to other specialties, mental health professionals have to take much longer evaluating industrial and non-industrial factors, determining predominant cause, considering personnel action, dealing with apportionment, a Rolda analysis, etc. Again, the faulty stakeholder meeting did not consider these factors and did not have adequate/sophisticated persons with knowledge about what mental health professionals do when considering the low multiplier of 1.6. So mental health professionals are left with this supply and demand multiplier that regardless of the amount of work, the payors will not pay more because it is easy for them to get a panel. Therefore, mental health professionals are not being paid equally to other physicians and there is no justification of it based upon work. Mental health reports are more than 1.6 times more complicated than regular reports and are actually likely 2 ½ times to 3 times or more complicated. Also, for mental health evaluations, every human on this planet is different, brings in different life experiences, and has different experiences at work. Initially, they may be referred as someone suffering from mental health issues form an orthopedic claim but then they may start taking about 10 years of being sexually harassed, but no one took the time to talk to them. So, a multiplier is inappropriate for mental health and the current schedule is superior in capturing the time and considerations necessary for mental health evaluations.

There is no multiplier for complicated cases. For example, there are complicated orthopedic, neurologic, internal medicine, toxicology, and other cases. All specialists can have complicated cases. They require talking to a patient for a long time, a careful review of the records, and a detailed report. However, again, there is no incentive for reports reflecting the complicated issues to be produced. This means less time exploring non-industrial causes of injuries. This means less time in giving a thoughtful

analysis as to why an injury might be industrially related. Since records are to be reviewed at 100 pages an hour, even for complicated evaluations, that means many pertinent and useful information will be missed.

What is also egregious is that if a case requires any research, the DWC has cut off compensating for research. That means if a patient had a toxic exposure, the QME is not incentivized to adequately research the patient's case. A patient may have developed cancer from a chemical that was only recently been found to cause cancer and the research helps to support that was the cause. Research helps to strengthen opinions and because medicine evolves, it is necessary that updated research be used when evaluating the effectiveness of treatment, the appropriateness of treatment, and future medical recommendations. On the Federal level, as part of the Daubert standard, scientific knowledge of experts is based upon whether it has been subjected to peer review and publication. So now that the DWC wants to unilaterally not compensate for research, the entire Workers' Compensation system will change to less scientifically sound reports. To access quality research, QMEs often have to pay money for that research. QMEs would be less willing to pay, at a loss, for research that may be necessary for someone's case. So, the result of this is that the reports will be of poorer quality because the opinions will be less scientifically sound. Given that attorneys in the current system rarely challenge QME reports based upon substantial medical evidence, these low-quality reports will become the norm. This fee schedule would benefit from a legal challenge based upon non compensation of research alone.

What is also bizarre about this proposal is that QMEs are responsible for counting pages. For how long are QME's going to be responsible for holding onto all of their records if there is a page count challenge by the insurance carriers? Who pays for that storage cost? How come all the additional time it will take to count all the records is not compensated for?

I also note that there is a proposal for remedial supplemental reports where a QME may be forced to do a supplemental report without being paid if it is determined that a question should have been answered in an original report. So, if asked to do a supplemental report, a QME may be working for free or face discipline.

So, what does this all mean for a patient? Well, all the quality controls have been tossed out the window by the DWC. There are no complexity factors for causation, apportionment, research, record review, or face to face time. This means the QME has no incentive to see patients to explore all the pertinent issues. If you are a patient, that means that if there are other body parts that are part of your claim that were not addressed, the QME has no motivation to address that and there is now a financial incentive not to address other issues. In the current system, the concern is for fraud by overbilling. Well, the motivation here is for fraud by performing substandard work. The faster the evaluation and the smaller the report, under the new system, the more per hour a QME will get. So that is great for an ML 102 and ML 103 evaluator because now, without having to think about addressing issues based on complexity, you can see many more people in a typical week and get much more pay for less work. Another problem for patients is that because QMEs are now motivated to give barebones reports

under the new proposal, there will be more depositions and requests for supplemental reports. The good thing for those doing these barebones reports is that because attorneys don't want to challenge reports based upon them being substantial medical evidence, they will become the low-quality standard. Patients will likely be part of a patient mill. That means the QME will schedule patients for a short appointment, ask relatively few questions, will not be motivated to talk to you in any great detail, and then generate a fast report that may have profound impact on your life and you have little recourse. Patients probably would do best by advocating for their Primary Treating Physician's report be taken into greater consideration than a QME report because at least, although a Primary Treating physician lacks the neutrality of a QME, has seen the patient for a longer period of time while the QME may have a shoddy report analogous to some of these medication reviewer reports.

If a patient has a complicated injury or injuries, a continuous trauma or traumas, a harassment claim, a first responder with a lengthy injury history, etc, that patient is especially harmed under this system. Patients first have to face all the factors listed under the previous paragraph. There is no financial incentive for a QME to spend any extra time to talk to a patient about the injury or injuries. If the patient is a first responder, the QME will be disincentivized to spend more time with a patient to talk about all the factors you think are pertinent to their claim. The QME does not have to spend more time addressing issues of causation or apportionment. The QME does get any more money producing a 10-page report versus a 20-page report. The sickest patients do the worst under this schedule because after 2000 pages, the QME is getting paid less to review your records. The current model is based upon paying QMEs per hour to review records. That means the QME can spend time to review the records and think of the complexities of a case. The DWC is proposing a record review of 100 pages per hour. Can you imagine trying to review records for a complicated, or even a simple case, at 100 pages per hour? Remember, the QME has to read all of your records and try to put them in some sort of order to make sense of them. Basically, the more time a QME spends with a patient and producing their report, the less the QME makes. So, if the patient gets an unsupported opinion, that patient may be stuck with that faulty opinion, or the patient may be subjected to months or years of delay to resolve the issue.

For a mental health patient, they should be concerned that the DWC and the stakeholders did not take the stakeholder's meeting seriously. They should be concerned that the evaluator will not get any more compensation listening to your six-hour history as they would a one-hour history. For example, if a patient has a harassment claim and needs hours to talk about how they were sexually harassed at work, the QME has no financial incentive to go through that because they get the same pay regardless of if they spend 6 hours with a patient or 1 hour with a patient. On the other side, they should be concerned that non-industrial factors will not be significantly explored.

Would deposing a QME will help? Well, QMEs are supposed to get paid per hour of deposition preparation and deposition time. Because of the DWC, QMEs are paid one hour of preparation time and one hour of deposition time. The lawyers will pay QMEs

more if QMEs spend more hours in actual deposition time but will not pay QMEs more even if there is more preparation time, even for complicated cases. That is, the DWC will back the low payment of 1 hour of preparation time despite the number of hours it takes to prepare a case. So, in addition to lower quality evaluations and reports, there is no additional incentive for a QME to prepare for and provide a higher quality deposition. Some doctors have tried to sell the DWC proposal saying that for some reports the QME will lose money and for some reports, the QME will profit. The idea is that, in the end, the doctor will have overall gains. A patient does don't want to be viewed by their doctor as a patient that will cause the doctor to lose money. This is systemic discrimination based upon the type of injury being introduced by the DWC. That will mean these patients reports are more likely to be of lesser quality and the doctor will want to spend much less time on these cases. It may be that offices from doctors will start asking screening questions to determine which patients will cause them to lose money. One remedy, other than paying doctors for the actual time they spend on a case, to this is to allow QMEs to refuse cases. Unfortunately, applicant attorneys did not allow for that and this forces doctors to have a financial loss. We know that applicant attorneys can choose what cases they have to take on based on financial considerations and can choose to no longer represent them after they are permanent and stationary, leaving patients to essentially navigate the system by themselves for the rest of their life. So, there is an inherent hypocrisy in that position that ultimately harms patients. The DWC is therefore knowingly underpaying QME doctors for certain cases and the QME will have to accept them no matter what. It would be interesting to know what other state administered system knowingly allows underpayment to those performing work. A properly incentivized system would allow all claims to be paid at a rate there is no loss. This would be good grounds for a legal challenge.

We are also talking about diversity nationwide. We know that the lower rates will lead to decreases in the ability for doctors to be able to provide QMEs near underserved areas. We know that the QME population lacks a significant amount of diversity and those specialties hit hardest by this proposal will face even more significant declines in representation. We can already see that for some areas, there are no treaters in various specialties because of how the DWC gutted the treatment system. With this proposal, QME's will find it more financially difficult to travel to satellite offices to perform evaluations.

In summary, they DWC wants to change the system. They want to cut the amount paid for reports but are willing to increase incentives for specialties they need such as orthopedics, while simultaneously, still keep payments for these specialties lower than neighboring lower cost Nevada. The DWC has been constantly targeting the ML 104 under the guise of tacking overbilling. However, the new proposal ushers in a nefarious form of overbilling by providing fast and substandard evaluations. The clear losers in this are patients, especially those that have complicated claims, and those QMEs that want to do quality work that recognized that many evaluations take time. The clear losers are also judges who will have the following: less scientifically sound reports, reports that cut corners to maximize profits, the delay in processing claims because of the need to do additional depositions and supplementals, and the admission into evidence far more reports that are not substantial medical evidence because the parties

clearly are not interested in challenging reports. The clear winners are the DWC, those who will do substandard reports, and the payers. The DWC has been aligned with payers for a long time to help them deal with cutting the cost of complicated patients and their associated complicated reports.

All QME are also the loser because the DWC is still in a QMEs life in a major way because they are asking the QME to count pages and to do supplemental reports deemed to be remedial, for free. The end result is that while more people can be seen, and the system is harmed by an increasing number of low-quality reports.

The current schedule did not nothing to address fraud and overbilling because the new incentive is to overbill by doing much less work. The stakeholder meeting should be audited. This proposal, if implemented, would benefit from legal challenges. It would benefit from an analysis as to why doctors, who do complicated evaluations, will get paid less per hour, than doctors doing less complicated evaluations. It would benefit from being examined as to why there are no quality modifiers, no COLA increase and no overall increase in rates. It would be interesting to know why, when the DWC was aware of the Nevada scheduled last time around, chose to propose this current schedule to reimburse much less than lower cost Nevada does. The proposal would also benefit from a scrutiny as to why there is no parity between medical legal experts in the Workers' Compensation system as opposed to outside the Workers' Compensation system as required by law.

There current schedule is a superior to the proposed schedule in every way, and to make this a better system, the DWC should work on not trying to change the system as often as they are and treating QMEs fairly. They are already losing QMEs left and right and irreparably harming the entire Workers' Compensation system from at all levels from treatment to medial legal examinations.

Stewart Lonky, MD June 28, 2020

I have just finished doing a number of supplemental reports for cases I saw in the past. They each required more than 3 hours of medical research as well as a review of prior reports by me. More than 4 hours each. While I learned a lot, I have no desire for your proposal to underpay me for my time and research. The flat fee of $650 is insulting.

There needs to be an increase of the base for Internal Medicine doctors. We get very complex cases, and the amount of time required and the effort required to do a reasonable job for both the patient and the insurer demands a higher base amount for the initial report here. The base needs to be increased to a level 1.5 above what is proposed.

I would suggest that all the meetings and hearings you have had with stakeholders have not really moved DWC far from its original proposal. This is still NOT A RAISE after 14 years. It looks like the insurance companies continue to win, and I am really concerned

that the good/quality doctors will leave this system. The reports you will get will be lacking quality, and in the end you will pay more for appeals and re-evaluations. Please do not be so short-sighted. Give us what we have earned by waiting for all these years; reasonable pay for the job(s) we do. Rewarding "toxicologists" and "oncologists" is a bit of a joke. As a pulmonologist, half of my cases are toxicology, and I spent more years training than any toxicologist! And, I am far more capable of rendering more "inclusive" diagnostic impression than any toxicology "specialist".

Dr. Pamela V. Ford, D.C., Q.M.E. June 28, 2020

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This proposal will be the final straw for many providers, including myself.
I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported.

Roy Curry June 28, 2020

[Note: Roy Curry is responding to Mr. Lieberman's comment below.]

Jacob Rosenberg June 28, 2020

[Note: Mr. Rosenberg is responding to Mr. Lieberman's comment directly below.]

I agree with you.
There is an extraordinary lack of institutional respect from payers and the DWC about how complex evaluations require sophisticated, knowledgeable, experienced, nuanced evaluators.

Then they complain about poor quality reporting (which is an issue) but fail to have any plan (or desire) to reward evaluators for doing extraordinary complex work.

I can tell you that Mike Post and I raised these issues at the stakeholder meetings
The resistance to continuing the (token)25% AME modifier was astounding. After an hour we prevailed (making arguments similar to your points)
Now we find the DWC ignored the stakeholder consensus and rolled us back to a flat $700 bump regardless of how complex an evaluation is.

But this isn't over. Make your points on the DWC website, send a letter to khagen@dir.ca.gov and write your assemblyman. If we all do this then we will get changes.

If only a few respond then the DWC will assume it is safe to proceed
I'm doing my best for CSIMS members but more help is always welcome.

For the first time I can remember we have a lobbyist who is effective. Think back to the schedule published last August. This is much better

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Richard Lieberman MD June 28, 2020
Associate Clinical Professor
UCSF, San Francisco

I have been an AME since 1994, having examined several thousand people, and, together with my few remaining senior psychiatric (medical doctor) colleagues still doing this work, we have saved the insurance industry and the state of California millions of dollars by addressing four tasks assigned specifically AMEs, not QMEs.1..to provide a

comprehensive medical record review, (unassignable to non MD QMEs) in reviewing complex medical and psychiatric sequelae from injuries involving ALL specialties, not just orthopedics and pain management, 2. to explain in detail how and why we came to the conclusions we did, facing deposition otherwise to push this, appropriately, towards closure of the case, 3.to address causation of injury, disability, and apportionment, 4 to recommend timely and appropriate treatment where indicated, immediately helping to finalize the case. Medical and nonmedical QMEs are not required to address this set of complex assignments with full accountability. There is a quantum difference in the assignments to the QME and AME. Hence, with the obvious coming elimination of AME psychiatric and other specialties, such as neurology and neuropsychology, reflected in the new fee schedule, the costs to settle a case and the endless and ineffective treatment currently rampant in the system, will rise geometrically. The AME system was designed to expedite and finalize complex situations where injuries are serious enough and chronic to involve multiple specialties to bring to an end unnecessary expenditures to close out these cases. To save money. And it worked.

I see no evidence anywhere of any sensitivity to this historical argument by the DWC, especially as it pertains to the few remaining psychiatric AME physicians, such as myself, who will undoubtedly retire from this venue for lack of recognition of unique assistance we have provided to injured workers. No, it is not the failure to increase the fee for these services to which I object, it is the absolute neglect of the value we have brought to patients, insurance companies, and litigating attorneys through savings and timely care which will now be lost forever. Our contribution is being eviscerated.

The insensitivity is remarkable with respect to this , for as an ex president of CSIMS, 2013, I have yet to see any, any comment from anyone on this subject, in dialogue publically, other than senior applicant and defense attorneys who agree completely with what is written here.

Dr. Mikiko Murakami June 28, 2020

The proposed changes to reduce the current fee schedule for physicians is not acceptable.

I would like to be able to continue serving as a QME; these new proposed changes do not take into consideration my costs to serve each report.

At bare minimum, I would like to propose that no changes be made to the current fee schedule, and if possible, I would like for the following to be considered:

- Sue Honor's proposed fee schedule - this has received > 2,750 signatures from the community.

- The cost of inflation to be added on to the current fee schedule

And although not payment related, it would be very cost and time efficient for everyone involved if:

- All reports, records and correspondences could be done digitally. The current regulation regarding electronic transmission of reports have been helpful!

- If the DWC could create a software to avoid multiple data entry. Currently, there is a lot of wasted time with the same data being entered by every party, with errors being made in the process. I would love to help with this if there is a need.

Thank you for your consideration and attention to this matter.

Alan Rashkin, MD June 28, 2020

I am concerned that the recent proposed changes, which were not the ones previously agreed upon, will harm my practice and ability to continue with future QME participation.

I urge you to replace this proposal with Sue Honor's proposal. If the fee schedule is changed, I will harm my practice and other QME's and it is very important that fair reimbursement for the time spent will permit QME physicians to continue working for the Department of Industrial Relations in California.

Karl Robinson June 28, 2020

Hello, and thank you for taking the time to listen to my concerns about the new proposed fee schedules. My principal concern and reviewing these new proposals is that there appears to be a significant reduction and reimbursements for the same services that we have need providing.

I certainly hope we can take the time to take into consideration these concerns that I have. Firstly, $2 a page over a 1,000 pages is is less than what is currently accepted and therefore requiring QME physicians to take a pay reduction when handling complex cases with lengthy medical records. Second, under the new proposed fee schedule we do not get paid for lengthy face to face time or needed medical research. Certain complex cases with multiple injured body parts will require lengthy face-to-face time above 2 to 3 hours. That results in the physician working without compensation for time spent with the applicant. Additionally, to give an updated and research validated answer to certain questions on causation and return to work, and assessment of a medical research is necessary. Yet with the new proposed fee schedule any additional research will not be reimbursed. Thirdly, the new proposed fee schedule does not take into account cost of living increase, in fact is a pay decrease. Home values in my neighborhood have increased by an average of over 70% of the past 14 years, yet QME

reimbursements have stayed the same, and in the proposed schedules are being actually reduced.

I would hope you could reconsider these concerns when taking into account any finalized changes. Taking all this into consideration, and the amount of time and effort that goes into providing quality reports, if this new fee schedule goes into effect as has been proposed, I am fairly certain I will not continue to operate as a QME.

Thank you for taking the time to listen to my concerns.

Meghan Marcum, PsyD, ABPP, QME June 28, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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Sloane Blair MD, QME June 28, 2020

I am a QME for more than 15 years. While I am glad to see there is some effort to improve QMEs in the State of California, the new proposal has problematic issues. The specific issues are uncompensated time.

Allowing insurance companies to decide if we should be reimbursed for supplements is akin to letting the wolf guard the henhouse. There is no motivation for them to pay us fairly or at all. It is a business. The barrier has to be the DWC. I don't understand why the DWC treats lawyers so well, in terms of reimbursement, and treats doctors relatively poorly.

Allowing an unlimited number of add on body parts also expects us to do uncompensated work. I cannot understand or discern why we are again expected to offer uncompensated work.

This is a sure path to poorer quality and fewer QMEs. If I have a sloppy, out of order record review dumped on my lap, and I am not reimbursed for sorting that review, I will review it as presented to me. It will result in lack of clear and sequential thought. I will blame you and the insurance companies.

While COVID 19 may result in perhaps an increase in QMEs to compensate for the decline in our practices, this will not last forever. Medicine is partly a business too, and the components with the most aggravation, least joy and least money will rise to the top to be eliminated once elective care normalizes. Look at the delays you have now, and difficulties scheduling. The new fee schedule will make that worse.

Of the 3 components of the QME, 2 are very profitable, doing well, and have a supply of participants that exceeds demand. Those 2 are the lawyers and the insurance companies. Again, I don't understand what you have against the medical providers, but even on its face it seems unfair that we are singled out.

Again, thank you for the effort, and the positive parts of the proposal.

Perminder Bhatia June 27, 2020

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Medical Legal Fee Schedule Forum Comments

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Dr. Bob Chen June 27, 2020

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Jamie Rotonfsky, PhD, QME June 27, 2020

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I believe even Sue Honor's Propsoal does not even go far enough. The proposed new fee schedule is absurd, lower than current QME billing rates which have not been increased in decades. This is unacceptable and as usual benefits the insurance companies and not the applicants or QME's as the system will be no longer be effective in addressing applicant needs as many of the existing QME's will discontinue including me. This will make it even harder for an applicant to be assessed, Perhaps this is the purpose.

Michael Bazel, MD June 27, 2020

The new rules are concerning to me. It seems DWC is trying to get QME's work for free at the time, when most doctors are leaving the specialty. There's no cost of living increase and reimbursement per page is much lower than other States. There're some instances, which would require QME produce reports for free.

In addition, I would like to see recommendations on how to document Medical-Legal reports done by PTP.

Arsalan Malik, M.D. June 27, 2020
Private Practice of Psychiatry
Diplomate, American Board of Psychiatry & Neurology
Diplomate, American Board of Integrative & Holistic Medicine
Clinical Associate, New Center for Psychoanalysis
Clinical Instructor, UCLA Department of Psychiatry
Qualified Medical Examiner

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Tigran Garabekyan, M.D. June 27, 2020
Board Certified Orthopedic Surgeon
Sports Medicine and Joint Replacement
Southern California Hip Institute

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Carol W. Fetterman, Ph.D., Q.M.E. June 27, 2020

After the meetings which took place between insurance payor and QME's over the past several months, general reimbursement levels and terms were agreed upon for the most part, although the DWC's flat fee proposal has never been accepted for psychological/psychiatric evaluations. Even though the proposed fees were agreed upon by the other disciplines, the DWC is again reneging and proposing reimbursements that are less than those agreed upon.

Furthermore, the particular issues inherent in psychological evaluations have yet to be acknowledged by DWC.

It appears that the rate for Psychological evaluations is actually a reduction of the current fee structure **and for most cases would reduce payment**.

Therefore, this portion of the proposed fee schedule should be addressed to also provide an **increase for Psychologic evaluations**. Psychologic evaluations are 2-3 times the length of most medical examinations and are inclusive of many more factors which bridge both the medical events of a claimed injury and the Psychological/personnel claims being made.

It makes no sense to cap the time arbitrarily that the QME will be compensated for a psychiatric report. There is a great variety in the complexity of cases, resulting in vast differences in the amount of time needed to obtain information. It is completely unreasonable to expect a complex exam with the Injured worker to be completed [which

takes 4-6 hour face time] along with the review of records which should or could include medical, psychological, personnel and Investigative records **and to pay less for this service**.

There is a wide variance in amounts of records received. Not all these categories of records apply to all of the cases, and even when they are needed, frequently very few records are provided. Therefore the added rate per page is an uncertain modifier as no provider ever knows how many records will actually be received. To base the fee for a report in large part of the number of pages provided, does make sense in these type of reports. The Psychologic cases should have a modifier of at least 2.5 of the base rate to become close to what is *currently charged* for these cases, let alone see an increase which is the purpose of the committee's recommendation.

Capping the time spent on initial and supplemental reports, regardless of the amount of records or the complexity of issues being requested will likely result in psychologists and psychiatrist QME not being willing to take complex cases or spending the time needed to write a thorough and comprehensive report.

As a psychologist, the volume of psychiatric evaluations I receive is very small; usually no more than one per month.. However, because of the complexity of the cases I do receive, I am often required to write ML 102, ML 103, and ML 104 evaluations. The proposed fees for these evaluations are woefully inadequate.

In conclusion, the main consideration should be that psychological evaluations are very different from physical evaluations. They are different in complexity, in the amount of time it takes to do them, and in the fact that typically psychologists/psychiatrists receive only a fraction of the medical records that the other disciplines do.

Emily B. Fine, Ph.D. June 27, 2020

Licensed Psychologist
Clinical Neuropsychologist
Qualifed Medical Evaluator

The proposed QME fee schedule changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

Many quality doctors have quit serving as a QME, or have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues. This proposal will be the final straw for many providers, particularly

psychologists and psychiatrists, who will be adversely affected the most.

I urge you to replace this proposal with one where QMEs from all disciplines will receive an increase in reimbursement for all QME services provided.

Dr. Bruce Roth June 27,2020
QME Psyciatrist

The proposed changes are unacceptable and will lead to a major loss of QME providers.

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

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This proposal will be the final straw for many providers, including myself.
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Medical Legal Fee Schedule Forum Comments

David A. Sami MD June 27, 2020

Though I appreciate the efforts by the DWC to address deficiencies in the med-legal fee schedule, once again the proposed changes have a net effect of reducing the overall re-imbursement and fail to impose penalties for management companies and insurers who abuse the system.

1. The new fee schedule imposes a $500 penalty for a missed appointment, but at the same time values a comprehensive med legal eval (including 200 pages of records review) at $2000.

   Writing a well thought out and researched report takes at least 10-12 hours, and more so if there are multiple risk factors or injuries / exposures to consider.

   I presume the $500 missed appointment penalty is to compensate the physician for the 1-2 hours (average of 1.5 Hrs) of time and preparation that is set aside for each applicant. On this basis the minimum compensation for a comprehensive med-legal eval should be at least 8 x the missed appointment rate: Namely $ 4000. Further, there needs to be a cost of living adjustment (e.g. 5% every 2 years) in the fee schedule.

2. There is no explanation as to the reasoning behind reducing payment for records review over 2000 pages. If anything it should be higher, since organizing, collating, cross-referencing of records becomes increasing more difficult with increasing volume of pages.

   At minimum the reimbursement for additional pages over 2000 should be reimbursed at a similar $3 per page rate, not less.

3. There is not an explanation in the proposed schedule of how the records summary is expected in the physician report. Only that the physician is to "include in the report a verification under the penalty of perjury of the total number of pages reviewed by the physician as part of the medical-legal evaluation"

   I would propose the responsibility of counting the number of pages should fall with the insurance carrier. This way no party is at risk of perjury and the insurer has no reason to dispute the page count. As part of the evaluation the insurer should provide a detailed listing of records and page count for the physician.

4. There should be an explanation as to why Psychiatrists, Psychologists, Oncologists, and Toxicologists have been singled out as specialties that deserve higher reimbursement.

5. What is the rational for the description of ML202 as follow-up "which occurs within 24 months of the date on which a prior comprehensive medical legal evaluation was performed."

Per labor code 9785 Permanent and stationary is described as the point where the applicant's "condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment." When a "follow-up" is requested that is greater than 1 year from the initial / prior evaluation, it is generally because the applicant was deemed to be permanent and stationary, but subsequently had a change is status or other complications that necessitated a repeat evaluation.

Follow up evaluations should be limited to re-evaluations that are within 1 year or less of the prior evaluation. Any evaluation that is more than 1 year from the prior evaluation should be excluded from the ML202 designation.

6. The description of ML205 is confusing. Does the fee for reviewing Sub Rosa recordings include the time spent to discuss changes to prior discussions of apportionment and disability rating? Is this not a supplemental report? What happens when a Sub Rosa film is received along with additional records and a request to submit a supplemental report?

7. The description of ML206 needs further clarification. In particular what agent or who determines under section (3) whether or not the physician is "addressing an issue that should have been addressed in a prior comprehensive medical legal evaluation, a prior follow-up medical evaluation or a prior supplemental…"

8. There is no mention of research / references to support the diagnoses, causation, apportionment and future medical considerations.

   Has the time spent for research been entirely removed from the fee schedule? Has the standard for references to establish "substantial medical evidence" in med-legal reporting changed?

9. Page 4 section 9794 (b) states that all medical legal expenses shall be paid within 60 days after receipt by the employer of the reports and documents…. Is there a penalty if payment is not made within 60 days? And if so is there a mechanism to enforce it?

10. A physician should be given the right to refuse requested evaluations by an insurer who has demonstrated a consistent and repeated pattern or denying payments. There should be a mechanism to report the abuse to an entity that is not aligned with the insurance companies.

James L. Deck, Ph.D., QME June 27, 2020

After 33 years of doing evaluations, this again proves that the Insurance Carriers control the system to the great detriment of all injured worker Applicants.

David W. Baum M.D. June 27, 2020

I am pleased that a reasonable med-legal fee schedule is finally being proposed. A fair updated fee schedule will salvage the workers' compensation from inevitable attrition and ultimate elimination. Young physicians might also be attracted to workers' compensation; although, understand that indoctrination to the procedures, case law and report writing is a steep learning curve which takes years. Finally, you have proposed a fee-schedule which will no longer anger the few remaining QME and AME physicians, most of whom invest themselves in their workers' compensation activities to the best of their ability.

As an internist, I propose several ideas for your consideration:

1) I am of required to invest extraordinary time addressing four to eight claims. My report must be responsive, regardless of the foundation for these claims. If a report requires that more than three body parts or systemic disorders be addressed, the fee schedule should include an accommodation;

2) In the case of highly unusual disorders requiring extensive medical research, a complexity factor should be introduced. As an example, a systemic parasitic disorder caused by a bat in a claimant whose job requires exposure to bat excrement;

3) A cost of living adjustment is expected . There has been no change in the medical-legal fee schedule since 2006. It is not difficult to envision the proposed medical-legal fee schedule in perpetuity. A cost-of-living increase commensurate with the increase in, for example, social security compensation, should be considered.

Thank you for your anticipated assistance and cooperation.

Steward Lonky, M.D., F.A.C.P. June 26, 2020

I am a QME and have been since 1995. I recognize you want to simplify the fee schedule, but you have grossly underestimated the complex issues faced by Internal Medicine doctors when they evaluate patients. The cases are frequently convoluted, complex, and require some degree of literature research. Even tho there is no requirement for research or credit given for research, most of us will be doing it anyway. I always have and can't see this stopping. There are detailed histories that need to be taken, with extensive past histories, family histories, and a detailed recounting of medications used during the course of employment (and afterwards) to be certain that what we are seeing as internal medicine impairments aren't just medication side effects or interactions. There is also a need to evaluate lab data, radiographic data, and heart and lung test data. In short, it is very time consuming.

I believe there must be an increase in the base pay rate for internal medicine cases, and I believe that a 1.5 multiplier is warranted on the base fee, and an increase in the per-page rate to $3.50 per page up to 2000 pages and $2.50 for pages 2,000+. I do not believe this "page rate" should be lowered.

The current proposal is disrespectful of internal medicine doctors, and diminishes their commitment to "getting it right" for both parties. The time in weighing all the issues in a case is worthy of this increase in reimbursement.

By keeping the current proposal you will fail to give us any increase in reimbursement. The fee schedule revision was undertaken to recognize the lack of any raise for us for over 12 years. You have failed to meet your promised obligation to give us an increase in reimbursement with the current recommendations.

Thank you for your time and understanding.

Max Matos, M.D. June 26, 2020

I believe the proposed fee schedule is adequate for the most part. I am writing to offer my input and recommendations as follows:

- I disagree with the following requirement for a reimbursable ML203, supplemental report as follows.

  (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation.

It should not be enough for the parties to request the issue to be addressed. If I do not have the necessary documentation to give my opinion on the issue then I should be able to get compensated when I get what I need to issue my opinion. Oftentimes, for example, I cannot address apportionment even though I have been asked to, because I need the images of previous studies. If all the necessary information has been provided to the evaluator, then the supplemental report should not be separately reimbursable but, when we are getting piece meal information and we have to issue a supplemental report then we should be reimbursed for our work.

Recommendation: add verbiage to (2) above as follows "… provided the information was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report; This would align with the definition under 9793 (m) for supplemental report.

- I have the same issue with the "Remedial supplemental report"

Consider revising as follows:

Remedial Supplemental Medical-Legal Evaluations. This code is designed for communication purposes only. It indicates and acknowledges that compensation is not owed for this report. This code shall be used for supplemental reports (1) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation, or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795. *provided the information was available in the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report*

The physician should not be paid extra for doing sloppy work. So, if all the necessary information for the physician to address the issues presented has been received TIMELY, then, the physician should issue a thorough report addressing the issues presented by the parties. Let's say, I am asked to address work status and I failed to do so. I should not be paid for a supplemental report when the parties send me a letter saying, hey, doc, what's the work status?

On the other hand, if the applicant tells me there were x-rays done, I will request the images of the studies to address impairment/apportionment. I later get a letter telling me the x-rays cannot be obtained or I get the images and they did not take views I need, etc., I then have to order xrays to issue my opinion and will have to issue a supplemental report even though I was asked at the very beginning to address impairment rating and apportionment. That supplemental report should be reimbursable as I will spend 2 maybe 3 hours reading the images, preparing the impairment rating, formulating my opinions and dictating my report. I trust you will agree this is not "remedial" work.

- The timeliness of the information received should be reference by code, CCR 35 (i) in the Definition section (m) or under Authority.

I believe if you revise the verbiage concerning supplemental reports you will prevent billing disputes.

- Consider changing the effective date of the Med-Legal Fee Schedule to October 1, 2020.

We all know this revision is long overdue and we should not have to wait another six months to be adequately compensated.

Thank you for your consideration.

Karen Montalbano, D.C. June 26, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Sarvanan Ram June 26, 2020

The new proposed medical legal fee schedule is positive and in the right direction and will ensure retention of highly qualified experts to provide this invaluable service and serve the needs of the injured workers, attorneys and the Division of Workers' Compesation.

Dr. Tim Walth June 26, 2020

Should you take all the meat out of the reimbursement for evals and all of the associated reimbursable expenses you will be left with vermin picking at scraps. The quality of the evals will become diminished.

Reasonable adjustments can help but without taking into consideration of the costs of practicing and living in this state and make allowance for that as well as COLA adjustment is unreasonable.

Angelica K.C. Acton L.Ac., QME June 26, 2020

As a QME of 4 years, I know how important the QME is for the workers compensation system and for injured workers. It is a shame to see the state of California and the DWC does not see this.

As we all know the process of performing exams and writing reports is already a tedious process. By decreasing the pay for QME's, you are at risk of losing them. My specialty of Acupuncture already has very low numbers. The pay decrease will not help this matter.

Please reconsider the payment changes for QME compensation.

Raphael Morris, M.D. June 26, 2020

I currently have a large clinical practice in San Diego, treating all sorts of patients, including injured workers, who have for many years been a terribly underserved population that are chronically trapped in a chaotic treatment setting due to the top priority being cost savings.

I have continued to serve this population with chronic pain and treatment resistant mood disorders with medications, psychotherapy, and more recently with Transcranial Magnetic Stimulation. I have also been conducting criminal forensic psychiatric consultations around the country for the past 19 years and after moving to California around 13 years ago, I became a QME.

Although I accepted the challenges inherent in producing quality evaluations based on the limits of having to rely on the records produced by the carriers, I considered that my fellow QME’s and I were carrying out the important function of attempting to make

sense of these cases and sort out the issues for the applicants and the attorneys involved.

Regarding reimbursement, I have yet to meet a fellow QME who was satisfied with the fee schedule, particularly because conducting QME's requires you not only accept an hourly fee that is below that which you would earn doing clinical work and because accepting QME work necessitates that you pay a skilled support staff to organize the cases, send out mailings, and field all the calls that accompany every report and every request for supplemental reports. I rationalized that the trade off was being able to charge for the time required to produce the reports.

For many years, this $250 per hour rate has been much lower than most physicians can earn in private practice seeing patients and the only saving grace for QME work was that the record reviews and report writing could be done at your convenience in a home office. In addition, clinical work requires much less clerical support.

I never complained that the fees for depositions never increased in all these years despite the fact that most physicians can command $400-800/hour for depositions.

I could spend hours complaining about the following:

- The extreme waste of resources spent on 3rd party reviewers for treatment cases and how the medical reviewers are not provided the entire file before they deny medically critical treatments that force responsible physicians to waste their time writing up appeal letters that get lost.
- The way adjusters are switched on cases without ever telling the treating physicians, who only find out when treatment is delayed and efforts are made to contact the adjuster but to no avail. Can you imagine if a physician left his or her caseload without informing the relevant parties?
- The number of times I had not received a call back from a carrier when all I needed was clarification of a letter has been maddening.

When I read your proposal for a flat fee for psychiatric QME reports of around 3K and supplemental reports for much less and having to count the number of pages I review, I was ready to weep. Where is the appreciation and respect for the experts who are already underpaid and willing to evaluate these extremely complex situations?

In looking over my cases, I would say that my fees have ranged from 2.5K to 7K with the majority of cases ranging between 3.5 and 5K per evaluation. If you lower the reimbursement to 3K, I may have to consider passing on future referrals. Only a case with scant records can be conducted in less than 12 hours at $250/hour. Many of my colleagues have already quit doing QME's because the reimbursement is already too low.

As all medical legal reports are subject to possible subpoenas and depositions, it is in the back of my mind that my report can become part of a public record. I can't be asked to rush to form a medical-legal opinion that if unsubstantiated, could be referred to in a future trial by a cross examining attorney. I have to be able to arrive at an opinion that is

substantiated by a careful review of documents related to the case (which are often incomplete at the time of the evaluation).

The proposed cuts in essence will create the following reality:

In order to provide a responsible opinion with adequate medical evidence, The DWC is asking experts to work pro bono by spending multiple unreimbursed hours reviewing records in order to avoid arriving at incorrect opinions.

In my experience, the average psychiatric QME takes between 15 and 25 hours to produce, depending on how far back the injury goes and how many records must be reviewed.

Only very few will require more than 30 hours and almost none will take less than 12 hours.

These evaluations affect the lives of the injured workers and in my humble opinion, it is poor judgment to encourage experts to do less work than is reasonably indicated.

Can you imagine any self respecting forensic psychiatrist hired on a murder case being told they had to do the evaluation for a embarrassingly low flat fee. It doesn't make sense and it's inappropriate.

Don't we want to attract the best and brightest to do QME's. A recent graduate of an East Coast forensic psychiatry fellowship program just asked me several weeks ago about doing QME's in California as she is planning to move here and now I don't know if I can recommend doing them under these constraints.

I rarely charge for research but if the case is complicated, then some research should be conducted.

As for counting pages, it's not the number of pages that matter but how long it took to carefully review those records. Are we going to penalize an expert because the records were more dense and reward one who had 10 times the number of pages but most were billing records or medication logs. Does that make sense? Does it even make sense to ask a physician to spend time counting pages?

Are we trying to dumb down our evaluations?

I am all for ensuring that billing is reasonable but there has to be a better way to save money than to reduce reimbursement for the experts who are in my experience are already losing interest in doing these cases.

Judith A. Thurber, DC, QME June 26, 2020

The proposed changes to the QME Fee schedule are totally unacceptable. If you adopt this new fee schedule YOU ARE FORCING ME TO STOP DOING QMEs after 30 years.

I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, **general reimbursement levels and terms were agreed upon**. It is APPALLING and discouraging that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

It is becoming quite clear to me that the DWC is not interested, in the slightest, in protecting the injured worker's rights and providing the injured worker with a competent and knowledge QME physician.

Although you are proposing to increase the rate for the initial evaluation, you limit the rate on the follow-ups and supplemental reports, You have disregarded if there is a complex history to take, requiring more time, multiple injured areas, multiple injuries over time and if medical research IS REQUIRED.

In my practice the initial evaluation is usually a Basic QME, because the carrier hasn't sent any records, the patient isn't P&S etc. It's the follow-ups and supplemental reports that are very time intensive.

Everything under the new fee schedule is under a flat fee. This is TOTALLY UNREASONABLE. Injured workers present with many varied issues. With Complexity factors and hourly rates I can do what is necessary for each case with reasonable reimbursement. In the last 3 QMEs I've done each one has required 2-4 hours of medical research to explain to all the parties the complexity of the worker's condition. One of them required a supplemental report on about 800 pages of records. I AM NOT WILLING TO DO THIS FOR FREE.

While you have adopted the ***structure*** of the Nevada state IME fee schedule, You inexplicably continue to propose much lower ***fees*** than those found in the Nevada schedule. Additionally, you wants me to review 200 pages before I get compensated for any record review. Nevada thinks 50 pages is more reasonable. Why would I want to spend about 2 hours of my time on records? I AM NOT WILLING TO REVIEW RECORDS FOR FREE.

Under the current proposal, if I get a lengthy set of records to review, then I can only bill $2/page after the first 1,000 pages. Today, on average I bill $2.50/page (assuming $250/hr and 100 pages reviewed per hour). So you want to slash my reimbursement by 20% from $2.50 to $2.00 per page. So then I "get to" bill at 1996 rates in 2020 in Northern California. **And to top it off YOU WANT ME TO COUNT THE PAGES, so I**

have the opportunity to fight with the carrier about how many pages I reviewed to get paid. This is TOTALLY UNREASONABLE.

And you still have not included a cost of living increase. Is that how your reimbursement for your works for your performance at work?

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was I endorsed and was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is demoralizing. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California. If you adopt this Fee schedule ***I CAN NOT AFFORD*** to perform QMEs any longer.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement, deal with the carriers delays or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues. I believe that the injured worker deserves a knowledgeable Doctor to determine their case. This proposal will destroy that.

This proposal will be the final straw for many providers, including myself. Again, if you adopt this proposal YOU ARE FORCING ME TO STOP DOING QMEs after 30 years and harming the injured worker.

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

I truly hope that you change your mind and **PROTECT the injured worker's rights.**

Gregg M. Baringoldz, Ph.D., Q.M.E. June 26, 2020

I have reviewed the proposed changes regarding compensation for medical/legal evaluations, and find them unacceptable. I understand that DWC hosted stakeholder meetings between insurance payers and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these agreed upon levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Sharon Goldstein, Ph.D. June 26, 2020

I have been performing psychological evaluations in the Workers' Compensation system for thirty years. I have been a QME from the beginning of this requirement.

I am greatly concerned about the rate changes put forth by the council. If they go through as proposed, I anticipate the degradation in the quality of evaluators and the

psychological evaluations. This will only lead to a poorer outcome for the injured workers themselves, though not the insurance companies.

Speaking for myself, I do not know if I will continue to work as a PQME beyond the renewal I just sent in.

I strongly encourage the council to re-evaluate their decision.
Thank you for your consideration in the matter.

Anonymous June 26, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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Adam G. Brooks June 26, 2020

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This proposal will be the final straw for many providers, including myself.

As a physician who both diligently and efficiently completes QME reports in a timely manner, and a physician who relies on QME reports to help facilitate future treatment for my patients, I am extremely disappointed and frankly scared of what the consequences of such a change will cause.

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William G. Moseley, M.D. June 26, 2020

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I am one of 2 remaining Urology QMEs in San Diego and will quit being a CA QME in Urology. I you enact this proposal and it becomes law, I will quit being a Urology QME. Your proposal is totally unfair and not worth my time being a QME.

Michael Carlish, Ph.D. June 26, 2020

I am a psychologist and have been a QME since 2016. I have valued the opportunity to work in this field and hope to continue as a QME for many years - I see applicants at 10

locations and I would use more locations and do more evaluations if this were available to me.

The proposed fee changes would force me to limit my QME practice, however. I am deeply concerned that this fee structure would decrease my compensation to the point that acting as a QME would no longer be cost effective. A lot is asked of doctors in these cases and my reports, and the reports of colleagues which I have reviewed, are quite comprehensive. It takes a lot of time to produce these reports - which face scrutiny from all parties - and I think it's fair that doctors be compensated accordingly.

I hope the DWC will reconsider this proposed fee schedule, both for QME's such as myself and for the injured workers who rely on experienced and professional doctors to move their cases along.

Michael G. Bloom, M.D. June 26, 2020

I as others as internists do an extensive amount of work evaluating work comp patients in a fair objective manner. The present fee schedule is adequate but the new proposed one is not worth my tireless effort in providing an excellent evaluation of the many complex issues involved in a case. Please consider not making any changes to the present fee schedule.

Theresa Phillips PsyD., QME June 26, 2020
Clinical Psychologist

I am writing to address the proposed changes to the QME payment schedule comparing our rates to the state of Nevada.

As a psychologist, we are required to obtain a license, work for five years without infraction, take a course, take an exam which can take six to seven years post licensure.

With all due respect, this may pose a problem in having well qualified examiners. Many will choose to follow a different path. Since the outbreak of the Coved 19 virus and subsequent shelter in place, many are choosing not to go back to this type of work.

AND THERE IS A BACKLOG OF EVALUATIONS TO ADDRESS. NOT TO MENTION ADDITIONAL CLAIMS DUE TO THE CORONA VIRUS.

THE CLAIMANTS WHO DESPERATELY NEED ASSISTANCE WILL BEAR THE COST OF THIS PROPOSAL AS WELL.

QME's have not have a raise in payment in over four years and now you are asking us to work for less?

Office expenses and support staff costs have increased and now you are asking to have it cut into our pockets.

These stressful times have created an unprecedented need for therapy and now tele therapy is an option for examiners to work from home and seek other employment sources.

I would like to see a per diem amount for remote locations to be addressed as well.

Thank you for your time and consideration.

Feel free to contact me if you require further assistance or have any questions or concerns.

Rachyll Dempsey, PsyD, QME, ABPP June 26, 2020

I am writing this in response to the most recent proposal for a flat rate fee for qualified medical evaluator assessments and reports. I can only speak for psychologist, but it does not make sense to have a flat rate because this will encourage shortcuting which in turn Defeats the purpose of having an expert evaluate an individual.

For some reports, testing with an individual is quite extensive and may require six+ hours (plus scoring and interpretation), for others there's only a couple of hours of testing. For those that require a lot more testing, with this new proposal, I can see a lot of experts reducing the amount of very much needed diagnostic testing Due to the lack of compensation. In essence, a flat rate structure will result in poorer quality, less informed answers to the Trier of Fact, and injured workers not receiving the expertise needed.

Further, it will encourage people to leave the practice therefore reducing the amount of experts on the panel.

I urge a reconsideration of this bill

Baba Singh, Psy.D., QME June 26, 2020

I have reviewed the current proposed changes to the QME fee schedule, and I am extremely disappointed at this 'stealth' effort to cut QMEs out of the conversation, to agree to listen to us then just do what was planned anyway. I think it's in bad faith, and it's an insult to the work we do for the state. I do hones work as a QME – it's not my

primary income, it's a service to injured workers in the service of California. I take pride in it, that I can do some part time work as a public service. I do good work for California, and this latest proposal is a slap in the face. Please find a more reasonable fee schedule that includes the interests of all parties involved in QME work.

Delia M. Silva,Psy.D, ABPP-CN, QME June 26, 2020
Board-Certified in Clinical Neuropsychology

I am a board-certified neuropsychologist and QME in San Diego, who continues to do psychological QMEs, even after the DWC eliminated neuropsychology as a subspecialty. The current proposals to change the QME fee schedule is an additional slap in the face and may be the last straw for me in continuing to do QMEs if it passes. I am cutting and pasting the following email that I am sure you have received from others, which details the concerns QMEs have with the proposed changes.

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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The fact that you have disregarded essentially all of Sue Honor's qualitative suggestions is disheartening. Additionally, the reimbursement you are proposing is far below Sue Honor's recommendation and even beneath the reimbursement paid to IMEs in Nevada, a much lower cost-of-living state than California.

Many of my colleagues have quit serving as a QME. Some left by their own choice while others were thrown out by DWC based on underground regulations. Most quality physicians have avoided becoming a QME because they don't want to accept the poor reimbursement or deal with DWC's punitive actions towards providers. I have continued to serve as a QME despite all of these issues.

This proposal will be the final straw for many providers, including myself.

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Mark Shabason June 26, 2020

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Anne C. Welty, MD June 26, 2020

QME Psychiatry

The proposed QME fee schedule will definitely ensure that quality examinations from experienced QME's will continue to decline and disappear. The current fee schedule is low enough, and with additional cost of office rental, dictation costs, and staff expenses, does not adequately reimburse current QME's.

There have been several more reasonable fee schedule proposals. I urge your consideration in order to give injured workers the quality examinations they deserve.

Linett Mace June 26, 2020
Coastal Medical Evaluations & Billing

After long review, I find the proposed changes to be unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

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This proposal will be the final straw for many providers, and what degree of professionals will be left to handle future QME casework.

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William W. Deardorff, Ph.D, ABPP, QME June 26, 2020

I can understand the need for cost-containment measures, but the proposed changes will have significant unintended consequences. As a psychologist, I am an expert in human behavior and reinforcement principles. If you implement these changes, you will be reinforcing some behaviors and punishing others. Unfortunately, the behaviors you will be reinforcing will not be good for the WC system and the behaviors you will be punishing will cause high-quality QME doctors to stop doing QME work.

If you implement these changes, the result will be poor quality, highly templated evaluations and reports, (done by doctors accustomed to operating on a lien basis), that do not validly address the issues in dispute.

Given the significant drop in reimbursement, you will also see a mass exodus of quality doctors from the QME panel system. These doctors will be replaced by those with minimal experience and will to operate on a lien basis.

If these changes are implemented I simply could not afford to complete a high- quality evaluation and report. I cannot speak for other disciplines, but for psychology, the evaluation process is extremely labor and time-intensive. This complicated process is inherent in addressing all issues in dispute but primarily causation, apportionment, and impairment.

If these changes are implemented, and the likely reimbursement decrease follows, I would likely stop doing QME evaluations. I will address some of the consequences of these proposed changes in the following:

If prior agreement of the parties is required under any provision of this regulation, the physician may not condition performance of the evaluation on receipt of prior agreement of the parties.

I have had many cases in which applicant's attorney (AA) have set up a QME evaluation either without the agreement from Defense or despite objections by the Defense. In these cases, I do not complete the QME until I get prior agreement from the parties since I do not take liens and never have. If I do not have agreement from both parties regarding the QME, I will not schedule it. Under the above, AA could set up any QME desired. The only consequence is that the QME is forced to do the evaluation and put it on a lien. The AA request for QME evaluations will likely increase significantly since they have nothing to lose. They are not out the time and effort it takes to do a QME evaluation that has to be put on a lien. You will see QME doctors who do not take liens leave the panel system.

Secondly, if this provision is passed, why would the Defense provide prior agreement to ANY evaluation? Why not allow it to proceed on a lien and fight the costs later? At the very least, the Defense would begin to be very, very conservative in agreeing to any QME unless forced to do so (since the QME would be forced to proceed without Defense agreement).

If this condition is passed you will get a group of QME doctors that are willing to do a lien QME practice and all the other reputable ones will quit. The AA's will use these doctors through the panel process and the rate of QME requests (under these conditions) will increase dramatically (likely all poor quality). If this provision means that I would have to do QME evaluations that are not approved (e.g. go to a lien), I would stop doing QME work. This provision will result in a lien-driven, low quality, AA oriented, QME process.

A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the start of the evaluation, that the evaluation involves extraordinary circumstances.

For psychology/psychiatry, this provision will often be at odds with the one cited previously. Psychology QMEs are inherently complicated and usually required an ML104 evaluation. However, the previous provision says we cannot require agreement by the parties before completing the evaluation. So, I would most likely be doing ML104 evaluations but I cannot require the parties to agree on the evaluation. This means that I would be forced to do ML104 evaluations on a lien basis which I will not do. I would quit the QME system.

Another consequence of this provision for psychology is that the Defense would begin to only authorized ML103 and lower (there would be no reason for them not to). The vast majority of the QME and AMEs that I complete are at ML104 due to their complexity. If I cannot complete the evaluations in a valid and ethical manner, I would stop doing them. I cannot do most of my QMEs at ML103 or lower.

For ML104, four or more complexity items are required and "The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be billed for report preparation."

I understand the goal to contain costs, but this provision would make doing a proper Psychology QME impossible. The cases I evaluate are extremely complicated and time-consuming. My reports are typically between 40 and 100 pages simply due to the number of issues that must be addressed and the amount of material involved. Report preparation includes the time to formulate the conclusions, the time to dictate, transcription, editing the final product, etc., etc. If I do a QME evaluation on a Monday, the following 4 to 5 days are necessary to complete all aspects of the report (maybe 15 to 35 hours of report preparation time. I address all issues completed. As such, I have never had the charges disputed by an insurance and I have only been deposed once in the last 6 years about something that was not clear in a report. I truly put in the time documented in the report and it is all necessary.

If I was limited to 3 hours of report preparation time, it would impossible to do a high-quality report. If this is implemented, you are going to get very highly templated reports that largely all reach the same conclusion for every patient (since there would be no time to individualize the report). You are going to see a very significant drop in the quality of reports. This will be for two reasons: All of the doctors who can do high quality reports will no longer be in the QME system (like me) and doctors who stay will give you just 3 hours of report preparation time (you get what you pay for). These will be all templated and not individualized.

For ML106 - No more than three hours may be billed for report preparation under this code. No more than two hours may be billed for medical research under this code. In order to bill for medical research under this code, the physician must use sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon medical research in billing. An evaluator who bills for medical research under this code must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon.

The 3-hour report restriction is a problem here for reasons cited above. In addition, what about the case in which a patient is seen but the QME wants more information in order to address all issues in dispute. The new information comes in (e.g. 500 pages of medical records), and the supplemental report then addresses everything. For that report only 3-hours of preparation would be allowed. Imagine the quality of the report you will get if a doctor only spends 3 hours preparing it (including dictation, transcription, editing, copy, and sending).

Another issue here is arbitrarily limiting the medical research to 2 hours. I rarely go over 1.5 hours for medical legal research but I have on occasion especially when the parties ask for conclusions about a complicated subject (e.g. whether or not a fainting episode was conversion, pseudo-seizures, work-related, etc.). Again, if you limit it to 2 hours then that is what you will get. QME doctors will research for 2 hours and, if the question is not answered, they will “wing it”.

I can understand wanting to have the QME include the copies of the medical evidence (beyond citations) but you are going to end up with massive reports. If I included the actual articles that some of my reports cite, the page count could easily go to 200-300 pages while not adding anything substantive to the report.

Jeffrey T. Miller, D.D.S. June 26, 2020

The proposed changes are unacceptable. I understand that DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is

shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings!

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule. Sue Honor, the former manager of the DWC Medical Unit, submitted a proposal which was widely endorsed by the QME community. Her proposal received over 2,500 signatures. Not only did her proposal modernize reimbursement for QMEs, but it also contained many critical qualitative changes that would decrease friction for all stakeholders.

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This proposal will be the final straw for many providers, including myself.

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Cheri Adrian, Ph.D., QME June 25, 2020
Cheri Adrian, Ph.D. Psychological Services, PC

The proposed changes to the QME compensation schedule are absolutely unacceptable. DWC hosted stakeholder meetings between insurance payors and QMEs over the past several months. During those meetings, general reimbursement levels and terms were agreed upon. It is shocking and disappointing that DWC has undercut these levels and is attempting, AGAIN, to reduce QME reimbursement to less than what was agreed upon at the stakeholder meetings! You are not serving the interests of workers, at all. Workers need competent evaluations. You won't get them this way.

In December 2018, DWC requested proposals for a new Medical-Legal Fee Schedule.

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It is impossible to function as a QME in California with this fee schedule, ESPECIALLY for mental health issues Many of my colleagues have quit serving as a QME. Most quality psycholgoists have avoided becoming a QME because they cannot survive on the current schedule let alone what this proposal would mean for an hourly wage. The free time required for reviewing 200 pages of records! is especially insulting and ridiculous. No one can review psych records in the time that would be required under this fee schedule.

You propose a fee schedule making it impossible for a QME in psych especially to do a competent report sufficiently based in data and argument; and then you will discipline QMEs for not making a sufficient argument with regard to their conclusions. We lose on both ends. Who will work under these conditions?

I urge you to replace this proposal with Sue Honor's proposal which the QME community has already broadly supported. https://www.change.org/p/support-suzanne-honor-vangerov-s-medical-legal-fee-schedule-proposal

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Kevin Deitel June 25, 2020

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Michael Fischman, MD, QME June 25, 2020

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I am only one of a few QME physicians in the category of occupational medicine/toxicology. My evaluations typically involve medical research regarding the toxicology of the involved chemicals. I cannot continue to do quality QME evaluations if I am unable to bill for the time required to do necessary medical/toxicology research. Because of the administrative burden and the poor present reimbursement, I have considered abandoning my role as a QME (something I have done since the inception of the QME program many years ago). I will have to reconsider participation if the current proposed changes go into effect.

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Stephen Dell, M.D. June 25, 2020

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Shaul M. Saddick, Ph.D., QME June 25, 2020
Clinical & Forensic Psychology
Clinical & Forensic Neuropsychology

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Stephen M. Pfeiffer, Ph.D., QME June 25, 2020
Fellow – America Psychological Association
2015 California Psychological Association – President

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Elliot Gross MD June 25, 2020

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Alec Koo, MD, Urology QME June 25, 2020

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James Deck, Ph.D., QME June 25, 2020

This is a joke, proposed strictly by insurance carriers for financial gain, at the direct expense of applicants.

Vladimir Lipovetsky, MD, FIPA June 25, 2020

I have been a psychiatry QME for 10 years. Over the last few years the DWC has consistently attempted to reduce the level of compensation for medical legal reports, whether it is under the abusive assumption the all QMEs are engaged in fraudulent activity or for other reasons never disclosed to the public or the QMEs. I have been repeatedly complemented on the thoroughness of my reports by attorney's on both sides during the depositions and I take pride in carefully preparing the reports. As a psychiatrist, I see the claimant for 2-3 hours face to face to take "the usual careful history" that the advocacy letter asks for. Between the integration of interview and medical record material, dictation and editing (without including the record review) the process takes me a total of 12-13 hours. If you include 200 pages of review, it will take and additional 2-3 hours on average.

So for 15 hours you are proposing I should be compensated $3000, or $200 per hour, or 20% reduction in pay. Now I am supposed to believe that the great honor of participating in the illustrious Workers' Compensation system is worth taking that paycut when online clinical work pays $250-350/hour, private practice pays $400-500/hour and forensic work in the state of California pays $300-350 per hour? Really? And this is happening after the Auditors report that brings up as has been brought up over and over again that the fees never went up after 2006? Are there any DWC employees of who this could be said, that their salaries stayed the same since 2006? If this proposal is implemented or if some gimmick is added as a "correction" without respectful payment for the work that you have been appointed to oversee, I and people like me, who aim to produce quality reports, will leave the field, which is likely what is wanted. Perhaps DWC would be happy to appoint nurse practitioners, chiropractors and MFTs to do the same work for minimum wage or generously double it.

You obviously intend to drive the present system into the ground and I am sure someone will be paid handsomely for it. The injured workers will be less than thankful for the disappearance of neutral opinion. Perhaps the applicant attorneys could consider tort suits against employers due to the failure of the great compromise. When the whole thing falls apart and employers are in an uproar over their increased liabilities, I am sure you all will move on to other government positions and deny all responsibility.

Dr. George Joseph Grosso June 25, 2020

Inadequate reimbursement is leading me to conclude that after 25 years as a QME that it is no longer financially feasible and time to move on to reasonably reimbursed work.

Kevin Li, MD, QME June 25, 2020

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Stuart Fischer, M.D., F.A.C.P, F.A.C.C. June 25, 2020

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Elizabeth Preston Cisneros, Ph.D.
Clinical Neuropsychologist
Qualified Medical Evaluator

June 25, 2020

I am reading with absolute horror the new proposed changes to the QME med-legal fee schedule. I thought these issues had already been addressed in stakeholder meetings, but it appears that DWC is going back on those agreements.

I have been a QME for five years and am one of the few QMEs who is a practicing clinical psychologist and neuropsychologist in my area - most others just do QME evals at multiple clinics and crank them out. I take great pride in providing injured workers and workers compensation case managers with a fair evaluation that is in keeping with what I provide my cash pay or Medicare clients. Psychological evaluations are extraordinarily complex. Our interviews are far longer, our testing is far longer, and our reports are far more comprehensive than other QME disciplines. That's why it has been recognized as a complexity factor.

Under the current proposed changes to the fee schedule, I would be getting paid significantly less per hour of my time for a complex med-legal psychological evaluation than I do for a basic Medicare evaluation. The flat fee schedule encourages QMEs to perform the most basic of evaluations, rather than really evaluating the issues to the extent that is needed to treat both workers and workers comp companies fairly. It will also put much more of the onus on the QME to do the work that should fall on the workers compensation insurance company or case manager - keeping up with pages of medical records, for example. It also provides so many opportunities for insurance companies to try to cheat QMEs out of payment that they are rightly owed - through requests for supplemental reports that they think "should" have had things addressed initially, for example. As a QME, our rates have already not increased in 14 years. It is clear that DWC does not respect the QME or the level of detail and intensity that these evaluations require to do an ethical job. Why would DWC propose to pay us less than what we have been making in the last 14 for more work.and to make it harder to be paid for what we are rightly owed? I routinely have to fight for a year just to get paid for a QME exam that I have done in good faith, when the insurance company just doesn't want to pay their bills. These proposed changes will make those instances increase exponentially.

If these changes go through, I will no longer perform QMEs. I will not be party to a system that will pay me less than what Nevada is paying their similar experts and for a fee that is less than Medicare rates per hour. You will be left with a shoddy system that only has doctors who spend almost no time with the patient and just submits boilerplate reports so they can see as many patients as possible to maximize their reimbursement under this new fee schedule. This proposed fee schedule makes it very clear that DWC is favoring insurance companies over injured workers and medical professionals who have devoted their lives to providing high quality medical care to patients.

Dr. Sanjay Agarwal June 25, 2020

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Dr. Zachary D. Torry June 25, 2020
Adult and Forensic Psychiatrist

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Troung P. Nguyen, DC, QME June 25, 2020

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Dr. Anthony Fenison June 25, 2020

Great job!! I know it was difficult and it's impossible to please everyone but I think what the DWC did was fair.

Hose Kim, M.D. June 25, 2020

Orthopedic Surgery

I have several concerns about the new proposed MLFS:

- For initial M-L 201: I am alright with a flat free as long as the 200 page record review is not included. First of all, it takes much time and effort to review 200 pages of medical, especially orthopedic records. The proposed fee schedule, in my opinion, would not result in that much of an increase as compared to the current fee schedule. Secondly, the insurance company will likely try to keep the records under 200 pages, which will likely result in cherry-picking records, thus frequently leaving out critical pieces of records. This will obviously result in substandard PQME reports, which doesn't really help anyone, certainly not the injured worker. I strongly propose a flat fee system, ***not including*** the 200 page record review requirement.
- $3 per page of record review is too low. In Nevada, they are paying *more than* $5.50 per page. The cost of living and doing business/practice in California are higher (certainly not lower) than they are in Nevada. So, why such a big discount?!?
- My biggest concern is in regard to ML-202 *and* -203 for a similar reason. As everyone knows, on more instances than not, re-evaluation and supplemental report requests come in many months or often more than a year after the initial evaluation. There may be new records (up to 200 pages record review included as initial, which again I am against) sometimes not. But what about the pre-existing old records, which need to be reviewed again to adequately answer and address the questions posed to the PQME? There appears to be no provision for that. In that case, the PQME will not be reviewing the pre-existing records, which

often include his own deposition transcript, because that takes much time and effort. Hence, the quality of the report would certainly suffer if the evaluator does not re-familiarize himself with the pre-existing records as they relate to the new ones. This issue needs to be addressed.

I am sure there are other issues I may have overlooked, but these are the main ones.
Thank you for reading.

Dr. Keri Jones June 25, 2020
Clinical Psycologist
Qualified Medical Examiner

I just reviewed the medical legal fee schedule for psychiatrists/psychologists-the initial evaluations and re-evaluations.

Boy, talk about a rate cut and a slash in holding mental health in parity with other injuries and illnesses. This is hard to take. Are we in 2020?

I would ask that you reconsider this RATE CUT and contemplate how complex mental health evaluations are, and the time it takes to review records, and to provide thorough analyses of the cases set before us.
Really.

Cliff Straehley III June 25, 2020
QME Psychiastrist

Psychiatric cases usually require various psychological test which are not free for the physician. I did not see an explanation of payment for the costs of those tests

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Claude S. Munday, Ph.D June 25, 2020
Psychologist

There is a math issue that requires your attention.

If we have a psych evaluation the basic fee is $2015 x 1.6 or $3224. I would think if the eval is an AME that we should then apply the AME modifier of 1.35 which gives us 4352.40.

However, you are proposing a 1.85 modifier for a psych AME. This results in a fee of $3727.75. Essentially a psych eval is not getting the full benefit of the AME modifier.

Please reconsider.

Cliff Straehley III June 25, 2020
Psychiatrist QME

When preparing both supplemental reports and additional reports concerning additional "face to face" evaluation reports, it is necessary to review and briefly summarize all prior reports including especially the initial evaluation report. Just paying for reviewing the number of pages of new records does not pay for the time spent reviewing prior reports. Those reviews are necessary in order to prepare an accurate and useful subsequent report. Commonly, subsequent reports are requested years after the earlier reports and it is not possible to remember important details of the earlier reports without reviewing them. The time spent on those needed reviews should be paid for. Not doing those reviews would decrease the accuracy and value of subsequent reports.