

DETOURS ON YOUR ROAD TO CLOSURE: THE NEW QME REGULATIONS

I. THE LEGISLATIVE CHANGES IMPLEMENTED IN 2003/2004:

A) SOURCES OF OUR CONTROLS:

- 1.) Through SB 228, AB 227 and SB 899, we have UR, MPN'S, the fee schedule, Labor Code 4060- 4064 and Labor Code 4600(b), which, for the first time in California, provides a statutory definition for reasonable and necessary medical care.

B) *What is currently true and the almost certain future about medical treatment costs?*

- 1.) WCIRB, in its pure premium rate filing of 2010, concludes the average medical losses per claim since 2005 have escalated 15% per year. They project longer term trends “may moderate” to 13% per year.
- 2.) CWCI's June 2009 Analysis concludes increases on total classified medical payments for accident years 2005-2007 rose 20% percent on all claims and 28% on all indemnity matters.
- 3.) In a June 2009 “Spotlight” report, CWCI reported growing alarm about the increasing use of schedule II opiate drugs in the treatment of work related injuries.
 - a) Schedule II drugs increased from less that 1% of the prescriptions dispensed to greater than 6% in the 3 year period form 2005-2007.
 - b) The amount paid increased 64% to \$280 per prescription.
 - c) One of every four workers with back conditions classified as a non-surgical sprain/strain received at least one opiate prescription. On average, they received 5.2 each prescriptions.
- 4.) As will be demonstrated in later sections, our sense is the WCIRB and CWCI cost information may not be a truly accurate measure for medical costs going forward. In our view, the evolving and cumbersome CMS processes for MSA approval will delay, and in

some cases prevent settlements, it will increase medical costs in during that process, and having MSA estimates which comment on covered and non-covered lifetime estimates will be a natural driver documenting greater monies needed to settle medical care in a C&R.

- 5.) Of equal, if not more importance, are the new QME rules, including Rule 30(d) and the vagaries of the QME process. Our projection is that current enforcement of Rule 30(d) by OBAE and the WCAB will increase the number of cases determined to be compensable, will increase the medical costs for those increased cases, and will limit the claims organization from ever obtaining a medical opinion, other than that of the original QME. Finally, the delays impacting benefit delivery and employability decisions, combined with the FEHA questions and resource allocations required from this overly burdensome QME process cannot be understated.

THE NEW QME REGULATIONS: **YOUR ROAD BLOCK TO CLOSURE**

I. The 3 Grounds to Request a Panel

- A. §4060 (Compensability exam)
- B. §4061 (PD dispute)
- C. §4062 (Medical treatment, UR, or other reason under 4062)

II. New Forms

- A. Form 106: Represented cases
 - i. Attach first written proposal identifying disputed issue and naming at least one AME
- B. Form 105: Unrepresented cases
 - i. Attach claims administrator's notice and correspondence sent to injured worker with panel request form

- C. Other attachments may be necessary, such as the medical basis for requesting a different specialty from that of the PTP (See §31.1)

III. The §4060 Exam and Rule 30(d)

- A. “If a medical evaluation is required to determine compensability at any time after the filing of the claim form....” (Labor Code §§4060(c) and (d))
- B. To determine compensability during the 90 day period (Labor Code §5402) after claim form filed (before claim is accepted or denied)
- C. Represented case: must follow AME/QME process in Labor Code §4060(c) and §4062.2
- D. Unrepresented case: must follow Labor Code §4060(d) and §4062.1
- E. If any body part is accepted, §4060 does not apply. Once claim is accepted, a request for a panel may only be filed based on a dispute arising under Labor Code §4061 or §4062. 8 CCR 30(d)(2)
- F. **Once claim is denied, only IW may request a panel under Labor Code §4060.** (8 CCR §30(d)(3).) Is this regulation lawful? Does it not limit Section 4060(c) which says “at any time after filing of the claim form?:
- G. **After the Labor Code §5402(b) presumption takes effect, a request by the claims administrator for a panel under Labor Code §4060 will be issued only where a WCJ makes a finding the presumption has been rebutted and issues an order for a panel on compensability.** 8 CCR §30(d)(4)
- i. Note Regs. §10109 regarding Duty to Conduct Investigation
 - ii. Are there non-medical grounds to deny?

IV. The §4061 Exam

- A. Unrepresented case
- i. Claims administrator can request panel
 1. After IW is provided with notice per LC §4061(a); and
 2. After IW is provided with QME panel request form per Labor Code §4061(d); and
 3. More than 10 days have elapsed and injured worker has not requested a panel and selected a specialty (Labor Code §4062.1(b))
 - ii. Applicant can request panel

1. After objection to PTP opinion on PD issue
- B. Represented case
- i. DOI on or after 1/1/05
 - ii. First object to PTP on PD issue
 - iii. More than 10 days after first AME offer naming at least one physician per Labor Code §4062.2

V. The §4062 Exam

A. Applicant

- i. Use to dispute UR denial, delay or modification
- ii. For any medical treatment or other dispute under Labor Code §4062

B. Claims administrator

- i. Must use **UR** to dispute need or extent of medical treatment (*Sandhagen*)
- ii. Labor Code §4062(b) provides a separate process for spinal surgery.

Cervantes v. El Aguila Food Products, Inc., et al (2009) ADJ3675309, ADJ2967795, ADJ3517685, ADJ1962561 (SAL) [en banc]:

The procedures and timelines governing objections to a treating physician's recommendation for spinal surgery are contained in Labor Code sections 4610 and 4062 and in Administrative Director (AD) Rules 9788.1, 9788.11 and 9792.6(o) and are as follows:

- 1) When a treating physician recommends spinal surgery, a defendant must undertake utilization review (UR);

Exception: The only exception to this rule is if the surgery's medical necessity is undisputed and the defendant solely challenges whether the industrial injury caused or contributed to the need for the surgery because the *cause* of a need for treatment is not an issue subject to UR. (See *Simmons v. State of California, Dept. of Mental Health* (2005) 70 CCC 866, 869, 873-874; see also Cal. Code Regs., Title 8, §9792.6 ("Utilization review does not include determinations of the work-relatedness of injury or disease. . . .").) Nevertheless, if a defendant solely disputes industrial causation, it still must timely object under section 4062(b).

- 2) If UR approves the requested spinal surgery, or if the defendant fails to timely complete UR, the defendant must authorize the surgery;
- 3) If UR denies the spinal surgery request, the *defendant* may object under section 4062(b), but any objection must comply with AD Rule 9788.1 and use the form required by AD Rule 9788.11;

[Note: A defendant must authorize the spinal surgery if it fails to comply with AD Rule 9788.1 and use the form prescribed by AD Rule 9788.11. A failure to comply with those Rules is the functional equivalent of no timely objection.]

- 4) The defendant must complete its UR process within 10 days of its receipt of the treating physician's report, which must comply with AD Rule 9792.6(o), and, if UR denies the requested surgery, any section 4062(b) objection must be made within that same 10-day period; and
- 5) If the defendant fails to meet the 10-day timelines or comply with AD Rules 9788.1 and 9788.11, the defendant loses its right to a second opinion report and it must authorize the spinal surgery.

The Board in *Cervantes* also held that it was expressly disapproving of *Brasher v. Nationwide Studio Fund* (2006) 71 CCC 1282 (Appeals Board significant panel decision) case to the extent *Brasher* holds that: 1) a defendant may opt out of UR and instead dispute the requested spinal surgery using only the procedure specified in section 4062(b); and 2) if a defendant's UR denies spinal surgery, it is the *employee* that must object under Labor Code section 4062(a).

Defendant has filed a Petition for Writ of Review of the *Cervantes* decision.

[Note: As per DWC Newline No. 02-10 dated January 5, 2010, effective December 25, 2009, the DWC Medical Unit will reject requests for spinal surgery second opinion evaluations that are incomplete; or, that fail to provide evidence of the completion of UR within 10 calendar days of receipt of a valid request for authorization recommending spinal surgery; or, that fail to provide a full copy of the requesting treating physicians' report with the DWC Form

233 (entitled “Objection to Treating Physician’s Recommendation for Spinal Surgery”).]

[Note: As per *Labor Code section 4062(b)*, “[i]f the second opinion report does not recommend surgery, *the employer shall file a declaration of readiness to proceed.*” (Emphasis added).]

Elliott v. WCAB (Newsgroup of Sacramento) (2010) 2010 Cal. App. LEXIS 235:

The Court of Appeal, 1st Appellate District reversed the WCAB decision in *Elliott v. WCAB*, agreeing with the en banc decision in *Cervantes* regarding the procedures to be followed as relates to requests for spinal surgery pursuant to *Labor Code §4062(b)*.

In *Elliott*, the Court held that objections to a treating physician’s recommendation for spinal surgery are pursued by the employer in the following manner: When an employee’s treating physician recommends spinal surgery, the employer must process that request through its UR process. During that process a physician, contracted by the employer or its insurer, evaluates the treatment request. If the physician decides to deny the request, a dispute arises which must be resolved in accordance with *Labor Code §4062(b)*. *Labor Code §4062(b)* and the governing regulations require the *employer* to object to the treating physician’s recommendation within 10 days of receipt of the request, in compliance with *Title 8, California Code of Regs. §§ 9788.1 and 9788.11*.

- iii. If for non-UR reason, such as P&S date, compensable consequence determination, etc., claims administrator may seek Labor Code §4062 exam

VI. Issuance of Panel

- A. In the event request form is incomplete or improperly completed, it shall be returned to the requesting party with an explanation of why the QME Panel selection could not be made. The Medical Director may also delay issuing

- a new Panel, if necessary, until it receives additional reasonable information requested (8 CCR §30(c))
- B. What specialty? The Medical Director shall utilize the type of specialist indicated by the requestor, unless otherwise provided in the regulations (8 CCR §30.5)
- i. §31.1(b) provides that a party in a represented case requesting a specialty other than that of the treating physician *shall* submit with the request form any relevant documentation supporting the reason for requesting a different specialty.
- C. When the Medical Director receives two or more panel selection forms on the same day, pursuant to Labor Code §4062.2 (represented case) and the forms designate different physician specialties, the procedure to be followed is outlined in 8 CCR §31.1(a)
- D. In the event the Medical Director is unable to issue a panel in a *represented* case within 30 calendar days of receiving the request, either party may seek an Order from a WCJ that a panel be issued. Any such order shall specify the specialty of the panel or the party designated to select the specialty. (8 CCR §31.1(c))

VII. Selecting the Physician and Scheduling Exams

- A. Unrepresented Injured Worker
- i. Within 10 days of having been furnished with the form, the unrepresented injured worker shall select a physician from the panel, schedule the appointment and inform employer of selection and appointment (8 CCR §31.3(a))
1. Employer and claims administrator not to discuss the selection with the injured worker (8 CCR §31.3(b))
2. **If, within 10 days of the issuance of the QME Panel**, the unrepresented injured worker fails to select a doctor or fails to schedule the appointment, the claims administrator may schedule an appointment with a panel QME only as provided by Labor Code §4062.1(c) and is to notify the injured worker of the appointment as provided in that section (furnish payment of estimated travel expense) (8 CCR §31.3(c))

- B. Represented Injured Worker
 - i. Parties need to engage in conferring and striking process described in Labor Code §4062.2(c)
 - ii. Then injured worker shall schedule the appointment within 10 business days of the date a QME is selected from the panel, or else claims administrator may arrange the appointment and notify the injured worker and injured worker's attorney. (8 CCR §31.3(d))
 - iii. The Agreed Panel QME—per §1, “Agreed Panel QME” shall be entitled to be paid at the same rate as an AME under 8 CCR §9785 for medical-legal evaluation procedures and testimony
- C. ***Alvarado v. WCAB***: Parties do not get an extra five days for mailing once the panel issues. **The time in which the party must act to agree and/or strike starts on the day the panel issues, not the day of receipt and there is no CCP 1013 5 day extension for mailing.**
- D. If a party with a legal right to schedule an appointment with a QME is unable to obtain an appointment with a selected QME within 60 days of the date of the appointment request, the QME may be replaced unless that party waives replacement to accept an appointment within 90 days of the request. (8 CCR §§31.5(a)(2) and 33(e))

VIII. Appointment Notice

- A. QME shall complete QME Appointment Notification Form (Section 110) and it shall be postmarked or sent by facsimile to the injured worker and claims administrator/employer within 5 business days of the date the appointment was made. (8 CCR §34(a))
- B. In a represented case, a copy of the form shall be sent to each party's attorney, if known. (8 CCR §34(a))
- C. For IW's convenience only, and upon written request, QME may move location of evaluation to another of QME's DWC-certified offices. (8 CCR §34(b))
- D. The QME shall include within the notification whether a Certified Interpreter is required and specify the language. The interpreter shall be arranged by the party who is to pay the cost as provided for in Labor Code §5811. (8 CCR §34(c))

IX. Appointment Cancellation and Rescheduling

A. By physician:

- i. AME, Agreed Panel QME and QME shall not cancel less than 6 business days before scheduled appointment, except for good cause. Must give parties written reason for cancellation and issue of “good cause” reserved for WCAB. (8 CCR §34(d))
- ii. Agreed Panel QME and QME must reschedule for a date within 30 days of date of cancellation, and no more than 60 days from date of initial appointment request unless parties agree in writing to accept later date. (8 CRR §34(e))
- iii. AME who cancels must reschedule within 60 days of cancellation unless parties agree in writing to no more than 30 days beyond 60 day limit. (8 CCR §34(f))

B. By party:

- i. Not to cancel or reschedule appointment less than 6 business days before the appointment, except for good cause. (8 CCR §34(h))
- ii. Cancellation shall be made in writing, state reason for cancellation and be served on opposing party. Oral cancellations to be followed with written confirmation within 24 hours. (8 CCR §34(h))
- iii. IW not liable for any missed appointment fee whenever an appointment is cancelled for good cause. WCAB may resolve disputes regarding “good cause”. (8 CCR §34(h))

X. Consultations --§32

A. Acupuncturist QME

- i. If issue of disability is in dispute, acupuncturist must obtain consultation from QME to evaluate the disability issue.

B. No other QME may obtain a consultation to address permanent disability and apportionment consistent with Labor Code §§ 4060 - 4064 and AMA guides.

C. For post-1/1/1994 DOI, QME may obtain consultation(s) from any physician as reasonable and necessary per Labor Code § 4064(a). **Section 32 seems internally inconsistent and inconsistent with Rule 35.5(d) regulating evaluations in a different specialty. A few at the DWC suggest this provision means the QME may obtain a consultation in**

accordance with Labor Code 4064 on issues of medical treatment. Some Applicant's attorneys are trying to use this Section to obtain "consults" on injury questions to new body parts.

- D. Referring QME must arrange the consultation. Consulting physician must serve report on referring QME and referring QME shall incorporate and comment upon such report in his/her report. Referring QME shall file a timely report. If consulting report not yet received by referring QME, referring QME must still issue a timely report, and must also issue an additional report within 15 calendar days of receiving the consulting report.
- E. All party communications to consultant must be written, **and sent through referring QME**
- F. Agreed Panel QME or QME who decides needs consultation becomes 'referring' physician.
- G. *King-Patriquin v. Sutter Memorial Hospital*: Once pro per becomes represented, do they stay on the "unrepresented track"-- and what does that mean for purposes of choosing or striking a doctor?

XI. Additional Panels

- A. Evaluator must address all contested medical issues from all injuries on one or more claim forms prior to appointment. (8 CCR § 35.5(c))
- B. Once AME, Agreed panel QME or QME issues medical/legal report, when new medical dispute arises, parties to extent possible must obtain follow-up or supplemental evaluation from same evaluator.(8 CCR § 31.7(a))
- C. Evaluator Notice of need for other specialty. (8 CCR § 35.5(d))
 - i. Evaluator must advise parties at earliest opportunity, or by date report is served, of any disputed medical issues outside scope of practice or clinical competence so parties may obtain evaluation on those issues; Agreed panel QME or QME must send copy to Medical Director at same time as parties.
- H. "Good cause" for an additional QME panel in a different specialty (8 CCR § 31.7):
 - i. Order by WCJ that also designates party to select specialty or states specialty and residential or employment-based zip code area.
 - ii. Written notice from AME, Agreed panel QME or QME to parties and Medical Director that he/she has addressed disputed issues

within his/her scope of practice and clinical competence but recommends an evaluator in another specialty is needed for one or more disputed medical issues outside of the evaluator's areas of clinical competence.

- iii. Written agreement by the parties in a represented case that there is a need for an additional medical legal report by an evaluator in a different specialty, that attempts to select an AME have failed, and including the specialty that the parties have agreed upon.
- iv. Unrepresented case, that parties met with an Information and Assistance Officer; explained the need for an additional QME in another specialty; that in the presence of and with the assistance of the I&A officer, the parties reached agreement on a specialty; and I&A noted this on the panel request form.

XII. Panel Selection Issues in Represented Cases

A. Represented party requesting panel in specialty different from PTP must submit *relevant* medical documentation supporting choice of specialty; *Not entire* medical file.

(8 CCR § 31.1(b))

B. Specialties

- i. When panel requests received same day from each represented party listing different specialties, procedure to select specialty is the following:
 - 1. If one party requests same specialty as PTP, the panel shall be issued in the specialty of the PTP unless the Medical Director is persuaded by supporting documentation provided by the requestor that explains the medical basis for the requested specialty;
 - 2. If no party requests a panel in the specialty of the PTP, the Medical Director shall select a specialty appropriate for the medical issue in dispute and issue a panel in such specialty. (8 CCR § 31.1(a))

- C. In represented case, when parties strike two QMEs and remaining QME must be replaced for reason in § 31.5, all three QME names will be replaced. (8 CCR § 31.5(c))

XIII. Information sent to Panel QMEs, Agreed PQMEs and AMEs -- §35

A. What can be sent

- i. No ex parte communication – all communication must be written and sent simultaneously to the opposing party (§35(b)(1))
- ii. AME and Agreed PQME: Parties must agree on the information being sent (§ 35(b)(2))
- iii. Unrepresented cases
 - 1. Claims administrator **MUST** and injured worker **MAY** provide PTP relevant medical records and also UR records if the treatment is disputed;
 - 2. **Claims administrator MUST attach a log or list to the front of the records provided to the doctor listing the reports in order as they are attached (§ 35(c))**

B. When must it be sent

- i. Regulations still require that the documents and information be served on the opposing party 20 days before the appointment
- ii. If a party objects within 10 days, the disputed records must not be provided to the evaluator until WCJ rules on the issue (§35(d))
- iii. **DO NOT** send:
 - 1. Medical/legal reports rejected by a party as untimely per Labor Code section 4062.5
 - 2. Any evaluation or consultation report by a physician other than a treating physician, the PTP or secondary physician, or a Labor Code Section 4060 to 4062 evaluator that addresses impairment, PD or apportionment, unless that report has been ruled admissible by the WCJ;
 - 3. Reports that are stricken, deemed inadequate, or deemed inadmissible by WCJ.
- iv. The Appeals Board will resolve disputes over records objected to and issues regarding alleged ex parte communication

C. Use of Discovery

- i. Either party may use discovery to establish accuracy or authentication of non-medical records or information prior to the evaluation. (§35(f))
- ii. Whenever either party is legally entitled to depose the evaluator, the evaluator **MUST** make themselves available within 120 days of notice of deposition.
- iii. Unrepresented cases: If the injured worker requests and it is consistent with Labor Code section 5710, the deposition must be held at either the location at which the evaluation examination was performed, or at a facility or office chosen by the deposing party that is no more than 20 miles from the evaluation location (§35.5(f))

D. DEU Forms for Unrepresented Employee

- i. The insurance carrier or self-insured employer shall provide the employee with the Employee's Disability Questionnaire (DEU Form 100) prior to the appointment scheduled with the QME. The employee is to complete the questionnaire and provide it to the evaluator at the time of exam. (8 CCR §10160(b))
- ii. The insurance carrier or self-insured employer shall complete a Request for Summary Rating Determination (DEU Form 101), a copy of which shall be served on the opposing party. The requesting party shall send the request, including proof of service of the request on the opposing party, to the Qualified Medical Evaluator together with all medical reports and medical records relating to the case prior to the scheduled examination. (8 CCR §10160(c))

XIV. Contents of Report – QMEs shall:

- A. Write all portions of report discussing medical issues, research used for determinations and medical conclusions; if two doctors signing, must state parts each wrote. (8 CCR § 41(c)(7))
- B. Address *all contested* medical issues arising from *all injuries* reported on *one or more claim forms* prior to date of exam and in issue letters. (8 CCR § 35.5(c); LC § 4062.3(i))
- C. List all records received and summarize all records reviewed. (8 CCR § 41 (c)(2))

- D. Medical treatment discussion: Must be consistent with and apply the standards of MTUS or other evidence-based guidelines, and otherwise explain medical basis for reasoning and conclusions. (8 CCR § 35.5(g))
- E. Permanent disability discussion
 - i. Claim subject to 1/1/2005 PD Schedule (DOI 1/1/2005 or after, discuss permanent impairment and disability by applying AMA Guides [5th ed.] and 2005 PD schedule. (8 CCR §§ 44(b); 45(b); 46(b); 46.1(b); 47(b))
 - ii. Claims not subject to 1/1/2005 PD Schedule, discuss permanent disability by applying evaluation guidelines adopted by IMC and 1997 PD schedule. (8 CCR §§ 44(a); 45(a); 46(a); 46.1(a); 47(a))
 - iii. Psychiatric disability (8 CCR §§ 43(a) and (b))
- F. Claims subject to 1/1/2005 PD schedule: describe symptoms, social, occupational and if relevant school functioning, and describe rationale for assignment to level of impairment per 2005 PD schedule.
 - i. Not subject to 2005 PD schedule: use IMC psychiatric protocol and 1997 PD Schedule.
- G. Apportionment discussion: Consistent with LC §§ 4663 and 4664.
- H. Date of Exam and street address of exam must be stated. (8 CCR § 35.5(b))
- I. If sign report on any date other than exam date, must enter date of signature next to signature. (8 CCR § 35.5(b))
- J. Attachments – Proof of service forms [either QME Form 122 or in unrepresented cases with PD QME Form 111]; Consultation reports, if any (§ 32); In psych claim, HSC 123115(b) determination on QME form 121 if applies

XV. Time Limits for Reports

- A. Initial and follow up evaluation reports
 - i. 30 days from date of evaluation, unless an extension is approved by the Medical Director (Labor Code § 4062.5, 8 CCR §38(a))
 - ii. Applies to AMEs, Agreed PQMEs, and QMEs
- B. Requests for extensions
 - i. From 112: Request a 30 day extension at least 5 days before the end of the 30 day period. A 15 day extension can be requested in extraordinary circumstances.

- ii. If the Medical Director denies the extension, the parties will receive QME Form 113 where they will state whether they request a new evaluator or are willing to accept the late report. Labor Code section 4062.5 requires that both parties must agree on the decision
 - iii. No extensions just because relevant medical records or DEU form not received.
- C. Delayed consultation report
 - i. Must either serve medical-legal report on time and issue supplemental upon late receipt of consultant report
 - ii. Or timely request and get extension approval by Medical Director (8 CCR § 32(f))
 - iii. Must serve supplemental report within 15 days of receipt of consultant's report
- D. Supplemental report
 - i. 60 days from date of request for supplemental
 - ii. May be extended by 30 days if parties agree without a request from Medical Director
 - iii. If no agreement on extension, timely request extension from Medical Director
- E. Consequences of Late Reports
 - i. Neither party liable for payment for the medical evaluation which was not completed within the required timeframes unless both parties waive the right to a new evaluation and elect to accept the original evaluation, in writing or by signing and returning to the Medical Director either QME Form 113 or 116 (Labor Code 4062.5 and 8 CCR § 38(a))
 - ii. Agreed PQMEs and QMEs may be replaced if report is late and party requesting replacement objected to report due to lateness prior to date report was served (§31.5(a)(12))
 - iii. May be grounds for denial of reappointment (§ 38(i))

XVI. Serving the report

- A. Unrepresented cases: If the report addresses PD, needs to be served on the DEU
 - i. EAMS Document cover sheet

- ii. DWC-AD Form 100 DEU (Employee Disability request)
 - iii. EAMS separator sheet
 - iv. DWC-AD Form 101 DEU (Request for Summary Rating Determination)
 - v. Use QME Form 111 (Findings Summary Form)
 - vi. POS is part of QME Form 111
 - vii. Must serve report, POS and QME Form 111 on parties
- B. All other reports: Use QME Form 122 (AME or QME declaration of service of medical-legal report)

XVII. Psyche Reports

- A. Voluntary Alternate Service – Unrepresented Cases only. (8 CCR §36.5(a); Form 120)
- i. Evaluator must advise injured worker of options - serve injured worker's copy of report on injured worker or on physician designated by injured worker to review and discuss report.
 - ii. Injured worker must designate in writing on QME form 120 before leaves evaluator's office
 - iii. Designated physician may be, but is not required to be, the PTP in the WC claim.
 - iv. Employer must pay for one office visit with designated physician. (§ 36.5(f))
 - v. HSC §123115(b) findings as described in 8 CCR §36.5 and on QME Form 121
- B. Medical determination made by evaluator.
- i. Basis: Substantial risk of significant adverse or detrimental medical consequences to injured worker from seeing or receiving a copy of part or all of report per CA Health & Safety Code §123115(b).
- C. Evaluator advises IW that report may only be served on physician injured worker designates on QME Form 121, or if none designated, on the injured worker's attorney if represented, or if unrepresented on the PTP.
- D. Evaluator makes determination on QME Form 121; places copy on front of report. Serves report with Form 121 within report time limits on designated physician (or PTP or applicant attorney), claims administrator, and when represented on parties' attorneys,

- E. Copies of report must be kept confidential; when filed at WCAB; *filing party* must obtain protective order. (8 CCR §36.5(e))

XVIII. Requests for Supplemental Reports in Unrepresented cases with PD - §36(e)

- A. Once the report finding and describing permanent impairment, permanent disability or apportionment is served, *QME shall not issue any supplemental report on those issues* until after DEU has issued an initial summary rating, or unless directed to do so by DEU, AD or WCALJ.
- B. Party seeking supplemental per section § 10160(f), based on objection to or need for clarification on these issues, must send request to DEU, not QME, within section §10160(f) time limits.

XIX. QME Replacement Panels

- A. When can a replacement be requested?
 - i. QME on panel does not practice in specialty requested.
 - ii. QME on panel cannot schedule an exam within 60 days of initial request for an appointment or within 90 days of initial request if party with legal right to request panel waives 60 day time limit per 8 CCR §33(e).
 - iii. Injured worker moved residence since panel was issued and prior to the date of exam.
 - iv. Physicians are members of same group practice per Labor Code §139.3.
 - v. QME unavailable per 8 CCR § 33.
 - vi. Prior evaluator in case is no longer available as QME.
 - vii. QME on panel currently is or has been the injured worker's PTP or secondary physician *for the injury currently in dispute*.
 - viii. Submit written agreement of claims administrator and injured worker to get panel in area of workplace for injured worker's convenience only
 - ix. QME violated section §34 (appointment notification and cancellation), *but only if* replacement requested within 15 calendar days of

requesting party's awareness of violation or within 15 days of receipt of report, whichever earlier.

- x. Evaluator issued late report and party requesting replacement *objected to report for lateness prior to the date the report was served*; must attach objection to panel request
- xi. Disqualifying conflict of interest per 8 CCR § 41.5.
- xii. AD rating recon order for new QME.
- xiii. Evaluator refuses to provide either complete report or explanation of why evaluator is not medically qualified or medically competent to address one or more disputed issues.
- xiv. QME panel list was issued more than 24 months before request received and none of the QMEs on the panel have examined the injured worker.
- xv. When Medical Director replaces a QME per §1.5(a), timeframes in LC §§ 4062.1(c) and 4062.2(c) are tolled until the date the replacement panel is issued.

XX. Conflicts of Interest

- A. Evaluator shall not request or accept any compensation or anything of value that creates or could create a conflict with duties as an evaluator. (Labor Code §139.2(o); 8 CCR § 41.5(a))
- B. Conflict with duties of evaluator' means having disqualifying conflict and failing to disclose.
 - i. Must disclose 'disqualifying conflict' when become aware of such conflict. (8 CCR §§ 41.5 and 41.6; QME Form 123)
 - ii. Must be replaced in all unrepresented cases.
 - iii. Replaced in represented case unless parties waive conflict in writing per 8 CCR § 41.6.
- C. 'Disqualifying conflict' includes
 - i. Familial relationship, fiancé or cohabitant
 - ii. Significant disqualifying financial interest
 - iii. Professional affiliation (same medical group or other business entity comprised of medical evaluators who specialize in workers compensation medical-legal evaluations)
 - iv. Any other relationship or interest which would cause a person aware of the facts to reasonably entertain a doubt that evaluator would be able to act with integrity and impartiality

- D. AME or QME may disqualify self, and must disclose to parties within 5 business days of becoming aware of conflict
- E. Notice at minimum: that disqualifying conflict exists; party or entity arises with; category of conflict (familial, significant financial [amount not disclosed], professional, other)

XXIII. Resources

- DWC Medical Unit: Phone (510) 286-3700
- QME list (to locate a QME by specialty and/or zip code)
<http://www.dir.ca.gov/databases/dwc/qmestartnew.asp>
- QME forms: <http://www.dir.ca.gov/dwc/forms.html>
- QME regulations:
http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm
- UR process FAQs:
http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm

RETURN TO WORK EFFORTS

- A. Introductory Observations:
 - 1.) With the transition from vocational rehabilitation as a benefit to the voucher system, employees and their legal representatives are scrutinizing employers' efforts in attempting to return employees to work, especially where the efforts are unsuccessful.
 - 2.) Since employees have a broader scope of potential causes of action and remedies, in light of the *Moorpark* decision, and a greater likelihood of succeeding on such claims, in light of the expansion of the definition of disability under F.E.H.A., employers must allocate adequate resources to the process and efforts to return injured employees to work.
 - 3.) The statutory provisions concerning return to work will again be reviewed in the 2010 Legislative session.
 - 4.) Recent cases

- a) Schermerhorn v. Los Angeles Unified School District (9/19/08)

The employer's failure to engage in the interactive process following surgery for a work related left hip condition results in a finding of discrimination and a verdict totaling \$380,306 in damages, \$21,836 in costs, and \$568,108 in attorneys fees.

- b) Anderson v. American Airlines (8/19/08)

A 29 year old flight attendant received a jury verdict of \$1,238,333 for discrimination following a work related incident leading to a mental disability.

- c) Morales v. Los Angeles County Metropolitan Transportation Authority (10/28/08)

A jury awarded \$2,247,137 for discrimination. The work related injuries included carpal tunnel and neck stiffness. The employer asserted the employee was too disabled to work safely as its basis for failing to engage in the interactive process or to accommodate.

- d) Cortes v. Montebello USD (8/15/08)

A jury awarded \$1,400,000 in damages and \$200,000 in attorney fees to a teacher injured in a work related fall. Despite the employee's claims that she could work, she was replaced based on the District's views as to the severity of her disability.

- e) Fatheringham v. Avery Dennison (3/19/08)

Damages of \$60,000 and attorney fees of \$383,810 were awarded following termination. The employee had work related hand injuries. She was terminated the day after her employer received a letter requesting accommodation. The matter has been through the Appellate Courts on two occasions. It is again back on the trial level. Punitive damages are included in the remaining issues.

B. Supplemental Job Displacement Vouchers and Permanent Disability Supplements Associated With Regular/Modified/Alternate Work.

1. Intended to replace vocational rehabilitation, provides for educational and/or retraining vouchers
2. Applies to dates of injury on or after January 1, 2004, causing permanent disability and where the employee does not return to work within 60 days of termination of temporary disability.
3. Modified or Alternative Work
 - a) If, within 60 days of the disability becoming permanent and stationary, the employer offers regular, modified or alternative work, within the definitions of Labor Code and CCR, then, whether the employee fails to accept or rejects the offer, the employer is entitled to reduce permanent disability payments by 15% from the date of the offer. *Labor Code §4658(d)(3)(a)*
 - b) If, within 60 days of the disability becoming permanent and stationary, the employer does not offer regular, modified or alternative work, within the definitions of Labor Code and California Code of Regulations, then permanent disability payments remaining at the end of the 60 day period are increased by 15%. This provision does not apply to employers with 50 or fewer employees. *Labor Code §4658(d)(2)*

(1) Modified work as defined by newly added Labor Code §4658.1

- (a) “Modified work” means regular (U&C) work modified so that the employee has the ability to perform all essential functions of the job which is located within a reasonable commuting distance of the employee’s residence at the time of injury and lasting 12 months

(2) Modified work as defined by California Code of Regulations

- (a) An injured employee's regular work with the same employer modified so that the employee can perform "all of the functions of the job" with pay at 85% of the pre-injury level.

(3) Alternative Work as defined by newly added Labor Code §4658.1

- (a) "Alternative work" means work that the employee has the ability to perform, offers wages and compensation that are at least 85% of those paid to employee on date of injury, and is located within a reasonable commuting distance of the employee's residence at the time of injury. Note: For offers of modified work, there is NOT a wage requirement.

(1) See Mandatory Form DWC-AD 10133.53

(2) For the purposes of determining whether wages and compensation are equivalent to those paid at the time of injury, any wages and compensation for any increase in working hours over the average hours worked at the time of injury shall not be considered.

(3) The requirement that the modified or alternative work be located within a reasonable distance may be waived by the employee if the employee accepts the offered work and does not object to the location within 20 days.

4. *Labor Code §4658.5* requires AD to adopt regulations to administer the Supplemental Job Displacement Benefit
5. Regulations governing the voucher and modified/alternative issues have been adopted.

b) Requires

(1) Within 10 days of the last payment of temporary disability, the claims administrator must send, by certified mail, the Notice of Potential Rights. (Title 8, California Code of Regulations §10133.51)

(a) See Mandatory Form DWC-AD 10133.52

(b) The regulations do not provide a definition for or guidance as to the terms of “last payment.” This is especially important in situations where temporary disability ends because of a return to light duty or a trial of full duty, before a permanent and stationary status is established.

(c) *Labor Code §4658.5(a)* mandates the existence of permanent partial disability and the employee does not return to the work for the employer within 60 days of the “termination” of temporary disability.

(2) If the “claims administrator” does not offer modified or alternative work within 30 days of the termination of temporary disability indemnity payments, and if the injury causes permanent disability and the employee hasn’t returned to work within sixty (60) days after the termination of temporary disability, the employee may be eligible for the Supplemental Job Displacement Nontransferable Training Voucher. (Title 8, California Code of Regulations 10133.56(b))

(3) The voucher must be provided within 25 calendar days from the date the WCAB issues a permanent partial disability award. (Title 8, California Code of Regulations §10133.56(d))

(4) Query: What if the case is settled by Compromise and Release and no permanent disability level is indicated?

(5) The voucher shall allow direct reimbursement to the employee upon presentation of documentation and receipts or as a direct payment to the provider. The voucher must also indicate the appropriate level of money available to the employee in compliance with Labor Code §4658.5

(6) The voucher shall certify that the school is approved and if outside of California, approval is required similarly to the Bureau for Private Postsecondary (BPPVE).

(7) See proposed Mandatory Voucher DWC-AD form 10133.56

c) Liability Terminates

(1) Liability for the supplemental job displacement voucher terminates when:

(a) The employer offers modified work meeting the requirements of *Labor Code §4658.6* and *CCR §10133.56(a)(7)* or alternative work as defined in *CCR §10133.50(a)(i)*.

(b) The benefit is settled by properly drafted and approved Compromise & Release.

(c) For seasonal employees, the obligation to provide alternative work is terminated after 12 months if the employee was hired on a seasonal basis prior to the injury, the offer of modified or alternative work is on a similar seasonal basis, and the offer is made on the DWC-AD Form 10133.53 meeting the conditions of *Labor Code §4658.6*

(d) The maximum funds allowed by the voucher have been exhausted.

(2) Pursuant to Mandatory Form DWC-AD 10133.53, the employee is deemed to have rejected the offer if the employee does not respond within 30 days.

LABOR CODE SECTION 4658

Ornalez v. Albertson's Inc. (2008) WCAB Case No. ADJ3682264 (Unpublished):

The 60-day clock for the employer to offer regular, modified or alternative work starts to run on the date the permanent and stationary report is served and not the date of the appointment or the date the report is drafted. If the permanent and stationary report is mailed, the 60-day timeframe is also extended five-days for mailing per CCP §1013.

[Note: OBAE, however, takes the position that the 60-day timeframe starts from the date of the medical report, even if the report is not mailed out until after the date of the report.]

Tsuchiya v. County of Los Angeles Sheriff's Dept. (2009) ADJ2508984 (Unpublished):

The provisions of Labor Code §4658 only apply to cases where the employee is not working. If there is no lost time, the applicant is not entitled to a 15% increase and the defendant is not entitled to a 15% decrease.