GLENN L. SILVERII & ASSOCIATES
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

GLENN L. SILVERII
NANCY CHAMBERLAIN-STRUPP
SCOTT K. KUBIS
STEPHANIE PROFFITT
RENARD KHOODA
PETER J. GORELICK
DAVID J. CARASH
ALEXANDER ANOZIE
ROGER C. KONIA
LISA CHEUNG
LUPE CARRASCO

2122 N. BROADWAY
SANTA ANA, CA 92706
714 547-7900 / 714 547-3145 FAX
www.silverii.com

LOS ANGELES OFFICE:
626 Wilshire Boulevard
Suite 714
Los Angeles, Ca 90017
(213) 225-5555
Fax: (213) 225-5566

LEGAL UPDATES IN WORKERS' COMPENSATION

Presented by:
Glenn L. Silverii
Email: gsilverii@silverii.com

TABLE OF CONTENTS

CASE LAW UPDATE

Diane Benson v. WCAB and The Permanente Medical Group

Court of Appeal, First Appellate District
February 10, 2009

WHY IMPORTANT

Apportionment based on causation, requires that each distinct industrial injury be separately compensated based upon its individual contribution to the permanent disability. This decision invalidates the rule in Wilkinson that allowed a continued award of permanent disability in successive injury cases.

BACKGROUND

Benson alleged a cumulative trauma through June 3, 2008, and a specific injury of June 3, 2003, to her neck. The two injuries became permanent and stationary at the same time. The AME apportioned ½ of Benson's permanent disability to the CT and ½ to the specific injury. Also, the AME opined there was no basis for apportionment to non-industrial factors. The combined permanent disability was 62%, which has a value of $67,010.25. The WCAB judge issued a Findings & Award of 62% permanent disability for $67,010.25.

The defense maintained that pursuant to Labor Code sections 4663 and 4664, there should be an Award for each injury at 31% permanent disability of $24,605.00, which totals $49,210.00 that is $17,800.25 less than the Award for 62% permanent disability.

HOLDING

That based upon Labor Code sections 4663 and 4664, applicant is entitled to an Award of 31% permanent disability for each injury, which totals $49,210.00.

The Court stated that "the plain language of section 4663, subdivision (c), which calls for a physician to make an apportionment determination 'by finding what approximate percentage of the permanent disability *was caused by the direct result of injury arising out of and occurring in the course of employment* and what approximate percentage of the permanent disability *was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries*'" (italics in original).

The Court emphasized that the legislature requires an assessment "of the approximate percentage of permanent disability 'caused by the direct result of *injury*' and not injuries". As such, the Court stated that the statutory scheme suggests the "legislature's intent to require apportionment on an injury-by-injury basis and no longer only for 'previous permanent disability'".

Consequently, the Court stated that the clear change in the statutory language indicates an intent to invalidate Wilkinson. The Wilkinson ruling arose from a California Supreme Court decision, which

held that whenever a worker sustains successive injuries to the same part of his body and these injuries become permanent at the same time, the worker is entitled to an award based upon the combined disability.

However, the Court of Appeal also indicated that "there may be limited circumstances, not present here, when the evaluating physician cannot parcel out, with reasonable medical probability the approximate percentages to which each district industrial injury causally contributed to the employees overall permanent disability. In such limited circumstances, when the employer has failed to meet its burden of proof, a combined Award of permanent disability may still be justified". It was noted by the Board that the burden of proving apportionment falls on the employer, because it is the employer that benefits from apportionment.

COMMENT

It should be noted that this is a decision from the Court of Appeal, First District. However, there are two cases, Forzetting v. WCAB and Vilkitis v. WCAB pending before the Court of Appeal for the Second District, which concern the same issue. Both Vilkitis and Forzetting are set for oral argument on March 11, 2009.

If the Second District of the Court of Appeal rules differently, there will be a conflict in the law that will have to be determined by the California Supreme Court.

Almaraz v. Environmental Recovery Services and State Compensation Insurance Fund

En Banc Panel Decision, ADJ1078163 (BAK 0145426)
February 3, 2009

Guzman v. Milpitas Unified School District

En Banc Decision, ADJ3341185 (SJO 0254688)
February 3, 2009

WHY IMPORTANT

The AMA Guides portion of the 2005 permanent disability rating schedule (hereinafter "2005 Schedule") is rebuttable.

BACKGROUND

The Almaraz Case

Mario Almaraz sustained an admitted specific injury to his back on November 5, 2004, while employed as a truck driver, for which he had back surgery. After a period of temporary disability, the applicant worked as a truck driving instructor at a truck driving school. The AME opened that there was 12% whole person impairment (WPI) under the AMA Guides, with 20% apportionment to non-industrial factors. Also, the AME indicated the applicant was limited to light duty work and precluded from prolonged sitting.

The parties stipulated that before apportionment, applicant's injury would rate 17% under the 2005 Schedule and 58% under the 1997 Schedule. The Workers' Compensation Administrative Law Judge (WCJ) issued an Award for 14% permanent disability after apportionment. In a Petition for Reconsideration, Almaraz argued that the AMA Guides are not conclusive, and that where the AMA Guides do not fairly and accurately address the injured workers impairment, other measures of disability should be used.

The Guzman case

Guzman sustained an admitted cumulative trauma claim of injury to her bilateral upper extremities ending on April 11, 2005, and was employed as a secretary. The AME found 3% WPI, for each upper extremity and also noted that the injury caused a 25% loss of pre-injury capacity for pushing, pulling.

In a subsequent report, the AME stated that the applicant's injury precluded her from very forceful, prolonged, and repetitive work activities. Also, the AME noted that there is a discrepancy between the disability and the impairment and that the applicant's disability did not rate very much under the AMA Guides, but based on her loss of activities of daily living, each upper extremity would have a 15% WPI,

but stated that this method is not sanctioned by the AMA Guides. The permanent disability rating was 12%, based upon 3% WPI for each upper extremity and 39% based upon 15% WPI for each upper extremity. The WCJ issued an Award for 12% permanent disability, and Guzman filed a Petition for Reconsideration arguing that the AMA Guides have limitations and that the evaluating physician should be able to exercise clinical judgment.

HOLDING

The WCAB held as follows:

(1) The AMA Guides portion of the 2005 Schedule is rebuttable.
(2) The AMA Guides portion of the 2005 Schedule is rebutted, by showing an impairment rating based upon the AMA Guides, will result in a permanent disability award that will be inequitable, disproportionate, and not a fair and accurate measure of the employee's permanent disability;
(3) When an impairment rating based on the AMA Guides has been rebutted, the WCAB may make an impairment determination that considers medical opinions that are not based, or are only partially based on the AMA Guides.

The WCAB explicitly noted that it was not determining whether the standards for rebutting the AMA Guides portion of the 2005 Schedule had been or may be met, and referred the case back to the assigned WCJ to decide the question. Also, the WCAB went on to further "expressly proclaim that our holding does *not* open the door to impairment ratings directly or indirectly based on any Schedule in effect prior to 2005, regardless of how 'fair' such a rating might seem to a physician, litigant, or trier of fact".

REASONING

The WCAB determined that the 2005 Schedule is *prima facie* evidence of the percentage of permanent disability and may be rebutted. The WCAB noted that *prima facie* evidence can be contradicted and overcome by other evidence, and therefore specifically concluded that the AMA Guides portion of the 2005 Schedule is rebuttable and not conclusive.

The Board cited as reasons for its decision, that the AMA Guides themselves recognize its limitations and that the Guides should not be the sole determinant of the work impairment, and that the Guides specifically state that the impairment ratings estimate the impact of an injury and the individuals overall ability to perform activities of daily living, *excluding work* (italics in original). The Board notes that the impairment ratings were designed to reflect functional limitations and not disability.

The WCAB acknowledged that there is a long established case law that an injured worker can rebut the permanent disability rating schedule, by showing his or her disability is actually higher than what the Schedule would provide, and conversely, an employer can rebut the Schedule by showing that the injured worker's disability is actually lower.

The WCAB noted that based upon its conclusion that the impairment rating under the AMA Guides can be rebutted, the following questions have to be answered:

1) What standards should be used in determining whether the AMA Guides impairment rating has been rebutted;
2) What evidence may be presented to establish that those standards have been met;
3) If the standards have been met, how is the impairment determined?

Answer to Question Number 1:

The Board held that the answer to question 1 is that an impairment rating strictly based on the AMA Guides is rebutted by showing that such an impairment rating will result in a permanent disability Award that will be inequitable, disproportionate and not a fair and equitable measure of the employee's permanent disability. In support of its conclusion, the Board makes reference to California cases and out of state cases addressing circumstances under which the AMA Guides need not be strictly followed.

Answer to Question Number 2:

As for question 2, evidence that may be presented to rebut the AMA Guides, the Board again indicates that the AMA Guides may be rebutted by showing that the impairment rating will result in a permanent disability award that is inequitable and not commensurate with the disability the employee has suffered.

To do so, a physician may invoke his or her judgment based upon his or her experience, training and skill. As such, a physician may depart from the specific recommendations of the AMA Guides and draw analogies to the Guide's other chapters, tables or other methods of assessing impairment. Also, the Board noted that in evaluating impairment, the physician may consider other generally accepted medical literature or criteria which can include, but is not limited to, other AMA publications, or publications of other established medical organizations. That Board went on to state that a physician may consider a wide variety of medical and non-medical information.

As noted by the Board, when a physician believes that an impairment rating based on the AMA Guides will not be a fair and accurate measure of the employee's degree of impairment, then the physician may assess how the permanent affects of the employee's injury impair his or her ability to perform *work* (in original) activities, as well as assess the medical consequences of performing certain work activities. However, the Board emphasized that their decision does not permit physicians to deviate from the AMA Guides simply to achieve a more desired result, and that the reasons for such a deviation must fully explain the alternative methodology and set forth in sufficient detail, so as to allow a proper evaluation of its soundness and accuracy, and that a clear, accurate and complete report is essential to support the rating of permanent impairment.

Answer to Question Number 3:

As for question 3 raised by the Board, how to determine the employee's permanent impairment, once it has been shown that an impairment rating based on the AMA Guides will result in a permanent disability award that will be inequitable, disproportionate and not a fair and accurate measure of the employee's permanent disability, the Board stated as follows:

The Board states that a physician that relies on factors for assessing impairment outside the four corners of the AMA Guides "should state his or her best opinion regarding the employee's percentage of

impairment and explain how and why this impairment percentage was determined". The Board goes on to state that it "may accept the opinion of a single physician or it may make a finding within the range of the medical evidence presented, and that it is not necessary that there be evidence of the exact degree of disability".

As such, the Board went on to quote from a California Supreme Court decision that "Arriving at a decision on an exact degree of disability is a difficult task under the most favorable circumstances and necessarily involves some sort of conjecture and compromise…." and further stated that "Of necessity every medical opinion must be in a sense speculative [but] this does not destroy the probative value of such an opinion".

The Board went on to further state that "a physician's estimate of the percentage of an employee's impairment may be accepted even though this estimate is not exact, provided that the physician's opinion is adequately explained and is based upon factors" as set forth in the Board's decision, "including the physicians judgment, experience, training and skill".

COMMENT

These cases are in the process of being appealed, but the En Banc opinion will control in pending cases before the WCAB, until another ruling or determination on the issue is made.

The Board by this ruling has apparently opened the door wide for varying assessments of impairment that will involve greater subjectivity, which deviates from the mandate of Labor Code section 4660(d), that the 2005 Schedule should "promote consistency, uniformity and objectivity". As such, it is anticipated that we will see reports by the physicians exercising their "clinical judgment" to assess the amount of impairment.

Ogilvie v. City & County of San Francisco

En Banc Decision, ADJ1177048 (SFO 0487779)
February 3, 2009

WHY IMPORTANT

The WCAB held that the diminished future earnings capacity (DFEC) portion of the 2005 Schedule is rebuttable. In the decision, the Board sets forth a method for rebutting the DFEC portion of the 2005 Schedule.

BACKGROUND

Ogilvie sustained an admitted specific injury to her right knee, low back and neck on April 1, 2004, while working as a bus driver. At the time of injury, she was 59 years old. The applicant did not return to work after the injury, and had surgery, including a right knee replacement.

Each party obtained a QME report, with their being a wide discrepancy in the findings of permanent disability between the applicant's QME and the defense QME. At the time of trial, the parties stipulated that if applicant's disability was rated pursuant to the 2005 Schedule, it would rate 28% permanent disability, at $26,700.00. The applicant sought to rebut the agreed to 28% permanent disability and each party submitted a written report of a vocational rehabilitation consultant, on the issue of diminished future earnings capacity.

The WCJ issued a Findings & Award holding that the applicant had rebutted the 2005 Schedule, because the permanent disability indemnity she would receive would not fairly, adequately and proportionately compensate the applicant for her diminished future earnings capacity. The WCAB determined that there was 40% permanent disability with a value of $43,150.00. In arriving at the 40% permanent disability rating, the Workers' Compensation Judge discussed three alternative rating methods.

HOLDING

The Board held as follows:

1) That the DFEC portion of the 2005 Schedule is rebuttable, and cited that the Schedule is *prima facie* evidence of the percentage of permanent disability to be attributed to each injury covered by the Schedule. In ruling that the DFEC portion of the 2005 Schedule can be rebutted, the Board held that to rebut the 2005 Schedule, "it must be done in accordance with Labor Code section 4060(b)(2) utilizing a numeric formula based on empirical data".

The Board rejected the proposed methods used by the WCJ and set forth a method to rebut the DFEC portion of the 2005 Schedule. The rebuttal method set forth by the Board that is consistent with Labor Code section 4660 and the RAND data, is as follows:

1) Obtain two sets of wage data (one for the injured worker, and one for its similarly situated employees), for a time period of generally three years, but depending on the circumstances, the time period can be shorter or longer;
2) According to the Board, do some simple mathematical wage calculations with the wage data to determine the injured workers individualized proportional earnings loss;
3) Divide the injured workers whole person impairment by the proportional earnings lost to obtain a ratio;
4) Determine if the ratio falls within certain ranges of ratios in Table A, for 2005 Schedule, and if it is does, then a determination of the employees DFEC adjustment factor is simple and relates back to the 2005 Schedule, and if it does not, then according to the Board, a "non-complex formula is used to perform a few additional calculations to determine an individualized DFEC adjustment factor".

The Board set forth what it described as a non-complicated method for rebutting the DFEC portion of the 2005 Schedule. However, the method set forth by the Board has several phases, and within each phase, there are various mathematical steps that need to be performed. For example, the method requires that you obtain post-injury earnings information for the injured worker, as well as post injury earnings information for similarly situated employees, and the Board suggests obtaining this information from EDD's labor market information division website (www.labormarketinfo.edd.ca.gov/). However, the Board also notes that it may be necessary to obtain customized empirical wage information from EDD, or in the alternative, it may be appropriate to hire a vocational expert to obtain empirical wage data.

COMMENT

The defendant in this case, the City and County of San Francisco, has confirmed that it plans to appeal the en banc decision.

Although the Board describes the formalistic approach that it adopted as simple and non-complex, in actuality, the procedure is very time consuming and is referred to in the dissenting opinion as being "complicated and limited". Furthermore, the method adopted by the Board has limitations that can allow subjectivity to enter into the calculations, for example if the injured worker minimizes his or her post-injury earnings, either by malingering or deliberately; whether an injured workers post-injury earnings accurately reflect his or her true post-injury earning capacity and what affect the recession that we are now in, has on the injured workers post-injury earning capacity.

Maria Tapia v. Skill Master Staffing/ Liberty Mutual Insurance Company

En Banc Decision, ADJ4564224 (LBO 0322121)
September 17, 2008

WHY IMPORTANT

An outpatient surgery center, or any medical lien claimant, has the burden of proving that its charges are reasonable.

BACKGROUND

The lien claimant SB Surgery Center (hereinafter "Surgery Center") billed $23,529.00 for services that were provided in connection with surgery performed upon applicant's right wrist at its facility and defendant paid $1,667.66, leaving a claimed balance by Surgery Center of $21,861.34. Pursuant to the parties stipulation at trial, Surgery Center provided 3 hours of operating room time and 1.7 hours of recovery room services.

The only issue was the reasonable amount that should be allowed as a fee for services provided by the Surgery Center.

HOLDING

The Board held as follows:

1) An outpatient surgery center lien claimant (or any medical lien claimant) has the burden of proving that its charges are reasonable;

2) The outpatient surgery center lien claimant's billing, by itself, does not establish that the claimed fee is reasonable, therefore, even in the absence of rebuttal evidence, the lien need not be allowed in full if it is unreasonable on its face; and

3) Any evidence relative to the reasonableness may be offered to support or rebut the lien, and therefore evidence is not limited to fees accepted by other outpatient surgery centers in the same geographic area for services provided.

REASONING

As the Board noted, the essential question is whether the outpatient surgery center lien is reasonable? In answering this question, the Board stated that it "is *not* a defendant's burden to prove that an outpatient surgery center claim fee is *not* reasonable". (Italics in original). The Board went on to state that "to the contrary, the outpatient surgery center has the affirmative burden of proving that its lien *is* reasonable, and it must carry this burden by a preponderance of the evidence….Imposing the burden of proving the reasonableness of its charges upon the outpatient surgery center is consistent with the well-established

general principal that a lien claimant has the burden of proving *all* of the elements necessary to establish its lien". (italics in original.)

The Board went on to set forth what type of evidence can be submitted to prove or disprove the reasonableness of the charges. The Board confirmed the decision of the WCJ that the Surgery Center failed to carry its burden of proving that the $23,529.00 it billed for outpatient surgery center services was reasonable, and upheld the WCJ determination that a fee of $4,700.00 was reasonable.

NEW QME REGULATIONS

HIGHLIGHTS OF
NEW QME REGULATIONS

The new regulations pertaining to the Qualified Medical Evaluator process became effective on February 17, 2009, but there is a grace period.

The new regulations and forms are set forth at:

Title 8, Cal. Code Regs. Sections 1-159 (8 CCR §§1-159)

The regulations are posted online at:

http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm

The forms are posted online at:

http://www.dir.ca.gov/dwc/forms.html

Forms:

QME Form 105 is used to request a Panel QME in an unrepresented case.

QME Form 106 is used to request a Panel QME in a represented case.

Highlights of the Regulations for Requesting Panel QME, and the QME/AME Process

- You must list the reason for requesting the Panel QME by checking one of the five boxes.

- One reason to request a Panel QME is for a Labor Code section 4060 AOE/COE examination, but once the case is denied, defendant cannot request a Labor Code section 4060 AOE/COE examination and only the injured worker can request a Panel QME for a 4060 examination.

- Defendant cannot request a Panel QME for medical treatment disputes. Pursuant to the Supreme Court ruling in the Sandhagen case, utilization review is the exclusive method to resolve disputes on treatment for the injured worker.

- When sending a letter to the applicant's attorney's office to initiate the Panel QME process, at least one doctor must be offered by name, and will need to submit a copy of the AME offer letter, with your request for a Panel QME.

- If the parties agree to use one of the three Panel QMEs as an AME, the QME will be paid at the AME rate, and designated Agreed Panel QME.

- QME must schedule an appointment within 60 days unless waived and is then extended to 90 days. The Panel QME may be replaced if unable to schedule an examination within 60 days.

- There can be no ex parte communication with the AME, Agreed Panel QME, or QME. All communication must be in writing and sent simultaneously to the opposing party.

- 20 days or more before an examination, you must serve the opposing party with all medical reports and other documents that will be sent to the evaluator.

- In both unrepresented and represented cases, the claims administrator shall attach a log to the front of the records and information being sent to the opposing party that identifies each record or other information to be sent to the evaluator and lists each item in the order it is attached to or appears on the log.

- The claims administrator shall include a cover letter or other document when providing such information to the employee which shall clearly and conspicuously include the following language: "Please look carefully at the enclosed information. It may be used by the doctor who is evaluating your medical condition as it relates to your workers' compensation claim. If you do not want the doctor to see this information, you must let me know within 10 days."

- If the opposing party objects within 10 days to any non-medical records or information proposed to be sent to an evaluator, those records and that information shall not be provided to the evaluator unless so ordered by a WCJ.

- An AME, agreed Panel QME, or QME shall not cancel the examination less than 6 business days before appointment without good cause, and must give the parties written notification of the reason for cancellation. Agreed Panel QME or QME must reschedule within 30 days of the date of cancellation and no more than 60 days from the date of the initial appointment request unless the parties agree in writing to accept another date.

- AME who cancels must reschedule within 60 days of cancellation unless the parties agree to no more than 30 days beyond the 60 day limit.

- The parties shall not cancel or reschedule an appointment with an AME, Agreed Panel QME, or QME less than 6 business days before appointment date, except for good cause.

- Cancellation must be made in writing stating the reason for the cancellation and served on the parties.

- The AME, agreed Panel QME, or QME must make themselves available for a deposition within 120 days of notice.

- The report of the AME, agreed Panel QME, or QME is due 30 days from the date of the commencement of the examination unless an extension is approved by the Medical Director.

- The evaluator must request an extension on QME Form 112, 5 days before the end of the 30 day period.

- If doctor does not timely request an extension, or if there is no valid extension, a party can object to the issuance of the report, and ask for another AME/PQME. If a party objects to the lateness of a report, the objection must be made prior to the report being received. In other words, one cannot wait until after they have received and reviewed the report and then, if they don't like it, object on the grounds that it was late.

QME Regulation Update

Suzanne Honor-Vangerov

Manager, DWC Medical Unit

Suzanne Marria

Attorney, DWC Legal Unit

1

Finding the New Regulations and Forms

- Title 8, Cal. Code Regs., §§ 1 – 159
  (8 CCR § 1 - 159)
  Effective date 2/17/2009
  Posted on line at:
    - Regulations
      http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm
    - Forms http://www.dir.ca.gov/dwc/forms.html

  Most forms used by QMEs and parties requesting panels will be posted as fillable, online.

Overview of Presentation

- Panel Request forms 105 and 106 – what's new
- Panel Request Procedures
- QME availability – time limit for scheduling exam
- QME exam appointment notices
- Cancelling (6 day rule) and Re-scheduling exams
- Information sent to QME or AME and *ex parte* communications
- Discovery and Depositions
- Time limits for Reports
- Serving the report

Overview of Presentation, cont.

- Contents of report
- Requests for supplemental reports in unrepresented cases with PD dispute
- Additional panels and consultations
- QME Panel replacements
- Panel selection issues
- Conflicts of Interest and significant financial interests
- Other changes (new definitions, QME exams, ethics, discipline)

New Sections on Panel Request Forms

QME forms 105 and 106

- Identifier information (required)
  - Request date
  - Date of injury
  - Claim number
  - Specialty requested by code
  - Requesting party
- Claim status and MPN related questions
  - Claim denied; date of denial; copy of notice
  - MPN involved:
    - Continuity or transfer of care dispute
    - PD, future medical treatment dispute, UR denial
    - Diagnosis or treatment dispute

New Sections on Panel Request Forms, cont.

- Prior QME panel information
  - Has Employee ever received panel before? (Y/N/Unknown)
  - Did Employee see QME from panel?
  - Did that claim settled or get resolved?
  - Previous QME:
    - name; specialty; date of injury; body part(s); date of exam; panel no.; QME still available

Panel Request Forms, cont.

- Form 106 - Represented cases
  - Added sections for each party's attorney's identifying information including EAMS firm number.
- Required attachments with panel request
  - Form 105
    - Claims administrator's notice and correspondence sent to Injured Employee with panel request form.
  - Form 106
    - First written proposal identifying disputed issue and naming at least one physician to be AME.

    (LC § 4062.2(b); 8 CCR §§ 30(b) and 106)

QME Specialty Codes

- Specialty boards recognized by AD
  - All specialty boards recognized by CA licensing boards. (8 CCR § 12)
  - To be listed as QME in specialty, physician's licensing board must recognize the designated specialty board. (8 CCR § 13)
- Changes in specialty code lists on Panel Request forms
  - MHH Hand (Ortho. Surg.-Hand; Plastic Surg.-Hand; Surgery-Hand)
  - MNB Spine (Ortho. Surg.-Spine; Neuro. Surg.-Spine)
  - MPA Pain Medicine (Anesthes.-Pain Med; Neuro.-Pain Med; Phys. Med. & Rehab.-Pain Med.; Psychiatry-Pain Med.; Pain Medicine)
  - MTT Toxicology (Emerg. Med-Toxicol.; General Prev. Med.-Toxicol.; Occ. Med.-Toxicol.)
  - 'Other than' categories (X other than Spine; Pain Med; Hand)
  - DCN (for all doctors of chiropractic; post-graduate training will be listed under education on panel request form)

Panel Request Forms, cont.

- Grounds to request a panel – May only select one
  - **§ 4060** (compensability exam)
  - **§ 4061** (permanent impairment or disability dispute)
  - **§ 4062** Injured employee only (med treatment, UR, other 4062)
  - **§ 4062** Claims administrator only (non treatment medical determination or non-UR reason under 4062)
  - **§§ 4061 and 4062** (medical treatment and permanent impairment or disability)

Represented cases with dates of injury pre-1/1/2005

- Each party selects own QME from QME database; **or**
- Represented parties may agree in writing to use QME panel per LC § 4062.2.
- Once panel is issued, parties are bound by the timelines and process in LC § 4062.2. (8 CCR § 30(b))
- If no written agreement, each party must select own QME without use of panel process.

LC § 4060 - When Can a QME Panel Be Requested?

- ***To determine compensability during 90 day period after claim form filed (e.g. before <u>claim</u> denied)***
  - Represented IW case

    Must follow AME/QME process in LC § 4062.2. (LC § 4060(c))
  - Unrepresented IW case

    Must follow LC §§ 4060(d) and 4062.1
    - Employer/claims administrator must notify unrepresented injured worker either:
      - Employer is requesting an evaluation to determine compensability, or
      - Employer has not accepted liability and the IW employee may request a QME panel to determine compensability
      - *Remember* LC § 5402 presumption and IW is not *required* by LC § 4060(d) to request panel when Er does not
    - Obtain QME panel only through process in LC § 4062.1

11

When Can a QME Panel Be Requested, cont. ?

- ***After*** a dispute exists
  - If any body part accepted, LC § 4060 does not apply. (see, LC § 4060(a)) Therefore once claims administrator <u>accepts</u> any part of claim, defendant *can only request QME panel by objecting under LC § 4061 or § 4062.* (8 CCR 30(d)(2))
  - Once *claim* is *denied entirely*, only IW may request panel under LC § 4060. (8 CCR 30(d)(3))
  - After LC 5402(b) presumption applies, request by claims administrator for panel under LC 4060 will be issued *only* when present finding by WCALJ that presumption was rebutted and WCALJ order for panel on compensability. (8 CCR 30(d)(4))
  - Dispute permanent impairment or disability opinion. (LC § 4061)
  - Injured worker may dispute UR denial, delay or modification. (LC § 4062) Per <u>*Sandhagen,*</u> only IW may request panel under LC § 4062 on medical treatment disputes.
  - Defendant panel under LC 4062: only non-UR, non-treatment dispute. Must state reason on form. (8 CCR 105 and 106)

12

SB 899, Sandhagen and the AME/QME Process

- SB 899 reforms added LC § 5402(c);clarified LC § 4610
- LC § 5402(c): Within 1 business day of receipt of the claim form, "the employer *shall* authorize" all treatment consistent with MTUS (medical treatment authorization schedule)...and "*shall* continue to provide the treatment until the date that liability for the *claim* is accepted or rejected." Until accept or reject the claim, liability for treatment is limited to $ 10,000.
- Applies to *all dates of injury*
- Per *Sandhagen*, must do UR; even approvals are part of UR. [*SCIF v WCAB (Sandhagen)* CA Supreme Court (2008) 44 Cal. 4th 230; 73 Cal. Comp. Case 981]
- Per LC § 4610(e) and 8 CCR § 9792.9(f), only a *physician* may review and delay, deny or modify a request for authorization.

UR, Sandhagen and the AME/QME Process

- "In light of the comprehensive nature of section 4610 and the goals the Legislature sought to accomplish, we conclude *the Legislature intended for the utilization review process to be employers' only avenue* for resolving an employee's request for treatment.

  We also conclude that *section 4062 is not available to employers as an alternative avenue for disputing employees' requests for treatment*.....i.e. the plain language of section 4062 establishes that only employees may use section 4062 to resolve disputes over treatment....

  Accordingly, in light of the clear statutory language and the Legislature's purpose in enacting the utilization review process in section 4610, we conclude the Legislature intended to require employers to conduct utilization review when considering employees' requests for medical treatment. Employers may not use section 4062 as an alternative method for disputing employees' treatment requests." (emphasis added)

SB 899, Sandhagen and the AME/QME Process, cont.

- Employer options in first 90 days
  - Use UR to resolve treatment requests while deciding whether to accept/deny *claim*
    - Physician reviewer must address medical necessity.
    - Non-physician (claims adjuster or nurse) delay, denial or modification: $ 25,000 UR penalty (8 CCR § 9792.12(a)(7)).
    - If not medically necessary per UR physician, only IW can request panel under LC § 4062.
  - OR, initiate LC § 4060 evaluation. If IW unrepresented, must send notice per LC § 4060(d):
    - Employer requests evaluation 'to determine compensability', send IW panel request form and request IW to file.

SB 899, Sandhagen and the AME/QME Process, cont.

- Accepted *claim*, receive request for authorization (RFA) for new body part
  - Employer cannot get LC § 4060 exam because per LC § 4060(a), "this section shall not apply where injury to any part or parts of body is accepted as compensable."
  - Per *Sandhagen*, must do UR anyway
  - "Responses regarding decisions to modify, delay or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity."(LC § 4610(g)(4); see also 8 CCR § 9792.9(j))

SB 899, Sandhagen and the AME/QME Process (con't.)

- "Utilization review does not include determinations of the work-relatedness of injury or disease..." (8 CCR § 9792.6(s))
- Ask requesting physician how requested treatment relates to claimed injury OR
- Use *Simmons* approach and request LC § 4062 panel for dispute on PTP's medical determination regarding work-relatedness

§ 4060 (compensability exam)

Who and When?

- Defendant [claims administrator]:
  - Before accepting or rejecting a claim; **and**
    (Once claim denied, defendant has no dispute that needs compensability exam to resolve)
  - Within 90 days of date claim form filed; **and**
  - Upon compliance with LC § 4060(d) [notice] and § 4062.1(b) [provide form to IW to select specialty; allow 10 days]
- Applicant
  - Any time until claim accepted

When Causation is Raised in UR on Accepted Claim

- Problem: How avoid UR penalties and get admissible medical-legal report?
  - Issuing denial in UR based on causation without medical necessity determination from UR physician – violates 8 CCR §§ 9792.6(s) & 9792.9(j), and per *Simmons en banc* WCAB decision, UR reviewer opinion not admissible on causation dispute; **and**
  - Denial by adjuster or RN case manager is contrary to LC §§ 4610(e) & 4610(a), 8 CCR § 9792.6(s) and *Simmons*, and will result in a mandatory $ 25,000 UR penalty as a denial by a non-physician. (see, 8 CCR § 9792.12(a)(7))

When Causation is Raised in UR on Accepted Claim, cont.

- Solution:
  - UR reviewing physician must use two step analysis:
    - Is requested treatment medically necessary per MTUS? If no, deny.
    - If yes requested treatment is medically necessary, then may question or add comment on causal connection to claimed injury.
  - Send UR report to claims adjuster, not requesting physician.
  - Claims adjuster must, *within UR timelines*:
    - Deny request for authorization *in reliance on attached UR reviewing physician report*, and
    - Object under LC § 4062(a) on requesting physician's causation determination. (See, *Simmons v State of CA, SCIF* (2005) WCAB *en banc* at 70 Cal Comp Cases 866 and DWC UR webpage FAQs)
- Simpler solution: Within 5 business days of receipt of RFA (request for authorization) ask requesting physician how new body part is related to existing claim.

§ 4061 (permanent impairment or disability dispute)

Who and When?

- Unrepresented case:
  - Defendant [claims administrator]:
    - After give IW notice per LC § 4061(a); **and**
    - Provide QME panel request form per LC § 4062.1(b); **and**
    - More than 10 days but IW (injured worker) has not requested panel and selected specialty.
  - Applicant:
    - Upon objecting to opinion of PTP.
- Represented case with DOI on or after 1/1/2005 (either party):
  - After objection to PTP opinion on permanent disability issue; **and**
  - More than 10 days after first written AME offer naming at least one physician per LC § 4062.2.

§ 4062 Dispute

Who and When?

- Applicant:
  - After UR delay, denial or modification (LC § 4062(a); *Sandhagen*
  - For any medical treatment dispute or other dispute under LC § 4062 (see below).
- Claims administrator:
  - *Must* use UR to dispute need for treatment or extent and scope of medical treatment *Sandhagen.*
  - *If* select LC § 4062 on panel request form, must explain reason for request on line provided.
  - *May* be for non-UR reason - P&S date; medical determination on work restrictions/capabilities; new and further disability determination; compensable consequence determination; PTP medical determination that need for treatment was caused by claimed injury. (LC § 4062(a); *Sandhagen)*

QME Availability - Scheduling Exams

- 60 days unless waived to 90 days
  - QME may be replaced if unable to schedule exam within 60 days of call, unless party with legal right to schedule waives 60 day time limit to accept appointment within 90 days of call.

    (8 CCR §§ 31.5(a)(2); 33(e))
  - To accept appointment more than 90 days from call, both parties must agree in writing to waive the 90 day time limit.

    (8 CCR § 31.5(a)(2); 33(e))

Exam Appointment Notices - § 34

- QME must use Form 110.
- Must be postmarked or faxed within 5 business days of date appointment made.
- Must send to parties' attorneys, if any, as well as IW and claims administrator.
- For IW convenience only and upon written request, may move to other DWC certified office of that QME. (8 CCR § 34(b))
- When QME arranges consultation, must advise parties with QME form 110. (8 CCR § 32(d))

Evaluators - Cancelling and Rescheduling Appointments - § 34

- AME, Agreed Panel QME and QME shall not cancel less than 6 business days before scheduled appointment, except for good cause. (8 CCR 34(d))
- Must give parties written reason for cancellation.
- Agreed Panel QME and QME must reschedule 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 CCR 34(e))
- 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))
- Unilateral re-scheduling panel QME exam more than 2 times is violation of ethical requirements. (8 CCR 41(a)(7))

Parties - Cancelling and Rescheduling Appointments - § 34(h)

- Applies to party and party's attorney.
- Shall not cancel or reschedule appointment with AME, Agreed Panel QME or QME less than 6 business days before appointment date, except for good cause.
- Cancellation must always be made in writing, state reason for cancellation and be served on other party.
- Oral cancellations - within 24 hours must mail or fax written cancellation.
- If for good cause, IW not liable for missed appointment fee; WCAB jurisdiction on disputes.

Information Sent to QME, Agreed panel QME or AME - § 35

- No *ex parte* with AME, Agreed panel QME or QME - All communications must be written and sent simultaneously to opposing party; (§ 35(b)(1)
  - Specified exceptions in 35(c) [HSC 123115(b)], (k) [IW oral or written in course of exam or by request of evaluator], (l) [pre-1/1/05 represented cases].
- With AME or Agreed panel QME, represented parties must agree on what is sent. (§ 35(b)(2))
- Claims administrator must, and injured employee may, provide PTP *relevant* medical records, UR records if treatment disputed.
- Claims administrator must *attach log to front* of records provided, *listing in order as attached;* (§ 35(c))

Information Sent to QME, Agreed panel QME or AME - § 35, cont.

- 20 days advance service on opposing party still applies.
- Upon objection within 10 days, disputed record must not be provided to evaluator until WCALJ rules. (§ 35(d))
- **MUST NOT SEND**: medical/legal report rejected by party as untimely per LC § 4062.5; any evaluation or consulting report by physician other than PTP, secondary TP or *LC §§ 4060- 4062 evaluator that addresses impairment, PD or apportionment*, unless WCALJ has first ruled report admissible; report if stricken, found inadequate, or found inadmissible by WCALJ or by law.
- Appeals Board to resolve disputes over records objected to and alleged *ex parte* communication.

Discovery and Depositions

- Either party may use discovery to establish the accuracy or authenticity of non-medical records or information prior to the evaluation. (8 CCR § 35(f))
- Unless WCAB or WCALJ orders otherwise, whenever party is legally entitled to depose evaluator, evaluator must make self available within at least 120 days of notice of deposition; **and**
- When unrepresented IW requests and is consistent with LC § 5710, deposition must be held at either location of evaluation exam or at a facility or office chosen by deposing party that is no more than 20 miles from evaluation location. (8 CCR § 35.5(f))

Report Time Limits and Extensions

- Initial and Follow up Evaluation Reports
  - 30 days from date exam commenced, unless have extension approved by Medical Director. (LC § 4062.5; 8 CCR § 38(a))
  - Applies to AMEs, Agreed Panel QMEs, QMEs.
- Request for Extension
  - Request extension of 30 days on QME Form 112 five days before end of 30 day period; 15 day extension in extraordinary circumstances.
  - If Medical Director denies extension, parties receive QME Form 113 to state whether the party requests a new evaluator or will accept the late report; per LC 4062.5 both must agree.
  - No extension because relevant medical records or DEU form not received.

Report Time Limits and Extensions, cont.

- Delayed consultation report
  - Must either serve medical-legal report on time and issue supplemental upon late receipt of consultant report, **or** timely request and get extension approval by Medical Director.
  - See 8 CCR § 32(f).
  - Must serve supplemental report within 15 days of receipt of consultant's report.
- Supplemental Reports
  - 60 days from date of request for supplemental.
  - May be extended by 30 days if parties agree, and in such case no need to request extension from Medical Director. (8 CCR 38(h))
  - If no agreement on extension, timely request extension from Medical Director.

Consequences of Late Reports

- No party has liability for payment unless both parties waive right to new evaluation in writing.
  (LC § 4062.5; 8 CCR § 30(a))
- Agreed Panel QMEs and QMEs may be replaced if report late and party requesting replacement objected to report due to lateness prior to date report was served.
  (8 CCR § 31.5(a)(12))
- May be grounds for denial of reappointment.
  (8 CCR § 38(i))

Serving the Report

§§ 36, 36.5, 121 and 122

- Unrepresented case report addressing PD-Serve DEU
  - EAMS document cover sheet, DWC-CA Form 10232.1 (8 CCR § 36(c); 10232.1)
  - DWC-AD Form 100 DEU (Employee Disability Quest.)[8 CCR § 36(c); 10160, 10161)
  - EAMS separator sheet DWC-CA Form 10232.2 [8 CCR § 36(c); 10232.2)
  - DWC-AD Form 101 DEU (Request for Summary Rating Determination) [8 CCR § 36(c); 10160, 10161)
  - Use QME Form 111 (Findings Summary Form)
  - Proof of Service (PoS) is part of pages 2 - 3 of QME Form 111
  - Must also serve at least report, PoS and QME Form 111 on parties
- All other reports - Use QME Form 122 (AME or QME declaration of service of medical-legal report)

Psych Report Special Issues

- Voluntary Alternate Service - Unrepresented Cases only. (8 CCR § 36.5(a); Form 120)
  - Evaluator must advise IW of options - serve IW's copy of report on IW or on physician designated by IW to review and discuss report.
  - IW must designate in writing on QME form 120 before leaves evaluator's office.
  - Designated physician may be, but is not required to be, the PTP in the WC claim.
  - Employer must pay for one office visit with designated physician. (§ 36.5(f))

Psych Report Special Issues, cont.

- HSC §123115(b) findings as described in 8 CCR § 36.5 and on QME Form 121
  - Medical determination made by evaluator.
  - Basis: Substantial risk of significant adverse or detrimental medical consequences to IW from seeing or receiving a copy of part or all of report per CA Health & Safety Code § 123115(b).
  - Evaluator advises IW that report may only be served on physician IW designates on QME Form 121, or if none designated, on the IW's attorney if represented, or if unrepresented on the PTP.

Psych Report Special Issues, cont.

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

Contents of Report

- 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))
- 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))
- List all records received and summarize all records reviewed. (8 CCR § 41 (c)(2))

Contents of Report, cont.

- 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))
- PD discussion
  - 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))
  - 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))
  - Psychiatric disability (8 CCR §§ 43(a) and (b))
    - 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.
    - Not subject to 2005 PD schedule: use IMC psychiatric protocol and 1997 PD Schedule.

Contents of Report, cont.

- Apportionment discussion
  - Consistent with LC §§ 4663 and 4664.
- Date of Exam and street address of exam must be stated. (8 CCR § 35.5(b))
- If sign report on any date other than exam date, must enter date of signature next to signature. (8 CCR § 35.5(b))
- Attachments –
  - Proof of service (PoS) 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

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

- 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.
- 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.

QME Panel Replacements

- Party with legal right (PwLR) to request panel.
- QME on panel doesn't practice in specialty requested.
- QME on panel cannot schedule an exam within 60 days of initial request for an appointment or within 90 days of initial request if PwLR waives 60 day time limit per 8 CCR § 33(e).
- Injured worker (IW) moved residence since panel was issued and prior to the date of exam.
- Physicians are members of same group practice per LC § 139.3.
- QME unavailable per 8 CCR § 33.
- Evaluator who already reported in cases is no longer available.

QME Panel Replacements, cont.

- QME on panel currently is or has been the IW's PTP or secondary physician *for the injury currently in dispute*.
- Submit written agreement of claims administrator and IW to get panel in area of workplace for IW's convenience only.
- 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.
- 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.

QME Panel Replacements, cont.

- Disqualifying conflict of interest per 8 CCR § 41.5.
- AD rating recon order for new QME.
- 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.
- QME panel list was issued more than 24 months before request received and none of the QMEs on the panel have examined the IW.
- When Medical Director replaces a QME per § 31.5(a), times in LC §§ 4062.1(c) and 4062.2(c) are tolled until the date the replacement panel is issued.

Panel Selection Issues in Represented Cases

- Rep. 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))
- When panel requests received same day from each represented party list different specialties, procedure to select specialty: (8 CCR § 31.1(a))
  - Request for QME in same specialty as PTP will be filled;
  - If neither party asked for same specialty as PTP, Medical Director will determine appropriate specialty for disputed issue;
- 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))

Additional Panels – Different Specialty

- Evaluator must address all contested medical issues from all injuries on one or more claim forms prior to appointment. (8 CCR § 35.5(c))
- 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))

Additional Panel - Different Specialty, cont.

- Evaluator Notice of need for other specialty.

  (8 CCR § 35.5(d))
  - 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.

Additional Panel - Different Specialty, cont.

- "Good cause" for an additional QME panel in a different specialty
  (8 CCR § 31.7):
  - Order by WCALJ that also designates party to select specialty or states specialty and residential or employment-based zip code area.
  - 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.

Additional Panel - Different Specialty, cont.

- Represented parties reach written agreement on the need for an additional medical legal report by an evaluator in a different specialty, that attempts to select an AME have failed and the specialty that the parties have agreed upon.
- In 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.

Consultations - § 32

- Acupuncturist QME
  - Must obtain consultation from QME who can evaluate disability
  - If requests panel from Medical Director, L.Ac. shall select the specialty
- No QME may obtain a consultation to address permanent disability and apportionment consistent with LC §§ 4660 - 4664 and AMA guides.
- For post-1/1/1994 DOI, QME may obtain from any physician as reasonable and necessary per LC § 4064(a)
- Referring QME must complete report on time; when receive consulting report later, issue supplemental report within 15 calendar days.
- All party communications to consultant must be written, **and** *sent through referring QME*

Consultations - § 32, cont.

- Agreed Panel QME or QME who decides needs consultation becomes 'referring' physician.
- Referring QME must:
  - Arrange appointment and advise parties using QME form 110 of time, date, place.
  - Parties must communicate with consulting physician through referring physician.
  - Consulting physician serves report on referring QME.
  - Referring QME must, upon receipt of consulting report, review, attach and incorporate consulting report by reference, comment on whether and how the findings in the consulting report change h/h opinions, list all reports and information received from the parties for the consulting physician and whether it was forwarded to consulting or reason not forwarded.

Specified Financial Interests and Conflicts of Interest

Conceptual Framework:

- Two concepts; sound alike
- Different definitions
- Different effect on QME process

"Specified Financial Interest" – §§ 1(dd); 29; QME Form 124

- Shared financial interest that must be disclosed on QME form 124 when filing QME 100, 104 or paying QME fees.
- Disclose by filing QME form 124.
- Medical Unit uses information to avoid placing QMEs with shared specified interests on same panel list (8 CCR §§ 29; 30(f); and QME form 124); if have, can get replacement.

Conflicts of Interest

- Evaluator shall not request or accept any compensation or other thing of value that does or could create a conflict with duties as an evaluator.
  (LC § 139.2(o); 8 CCR § 41.5(a))
- 'Conflict with duties of evaluator' means having disqualifying conflict and failing to disclose.
  - Must disclose 'disqualifying conflict' when become aware.
    (8 CCR §§ 41.5 and 41.6; QME Form 123)
  - Must be replaced in all unrepresented cases.
  - Replaced in represented case unless P's waive conflict in writing per 8 CCR § 41.6

53

Conflicts of Interest, cont.

- 'Disqualifying conflict' includes
  - Familial relationship, fiancé or cohabitant
  - Significant disqualifying financial interest
  - Professional affiliation (same medical group or other business entity comprised of medical evaluators who specialize in WC medical-legal evaluations)
  - 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
- AME or QME may disqualify self, and must disclose to parties within 5 business days of becoming aware of conflict
- Notice at minimum: that disqualifying conflict exists; party or entity arises with; category of conflict (familial, significant financial [amount not disclosed], professional, other)

54

New Definitions – § 1(a) - 1 (gg)

- Agreed Panel QME
  - Selected by represented parties from QME panel letter
  - Entitled to payment at AME rate. (8 CCR § 1(d))
- Mental health record - treatment or evaluation record created or reviewed in course of treating mental disorder.
- Physician's Office - bona fide office facility identified by street address and suite or room number which contains usual and customary equipment for evaluation and treatment appropriate to physician's specialty or practice.
- Significant Financial Interest or Affiliation held by Faculty.

QME Competency Exams and Disability Report Writing

- QME competency examination for acupuncturists added.
  - Questions not pertinent to disability determinations.
- Cheating on either QME competency exam.
  - For good cause, test administrator may disqualify from exam.
  - Upon finding of cheating, 5 year bar to retaking exam . (8 CCR § 11(f)(8))
- Disability Report Writing Course (8 CCR § 11.5)
  - Topics updated to include MTUS, ACOEM, AMA guides (5th Ed.), SB 899 apportionment.
  - To fulfill requirement, each physician enrollee must draft at least one practice written medical/legal report based on a sample case library of materials and the report must be critiqued with notations by the course provider. (8 CCR § 11.5(i)(8))

Ethical Requirements - § 41

- Refrain from treating or soliciting to treat or provide medical supplies or devices
- Violation of conflicts of interest regulation
- Unilaterally reschedules panel QME exam more than twice
- Evaluator cancels QME exam in less than 6 business days without good cause and without providing new appointment per 8 CCR § 34
- No *ex parte* communication in any QME panel case
  - Note: Doesn't apply in pre-1/1/2005 DOI and a party selected QME from list as own QME

57

Ethical Requirements - § 41, cont.

- Report must list and summarize all medical and non-medical records reviewed as part of evaluation.
- Serve report at same time on all parties.
- Refrain from unnecessary physical contact with IW.
- AMEs cannot make IW wait more than one hour.

58

Discipline – §§ 60 - 62 and 65

- New provisions (§ 60):
  - Failure to disclose significant financial interest or disqualifying conflict of interest.
  - AD delegated powers to conduct investigations, issue subpoenas and interrogatories, receive pleadings and arrange hearings to Medical Director.
  - Sanction guidelines (terms of possible discipline to be imposed) now adopted in regulation § 65.

More Information

- DWC Medical Unit: Phone # 1-510-286-3700
- Information for QMEs:
  - 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

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
MAILING ADDRESS:
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR IF YOU DO NOT HAVE AN ATTORNEY (Attachment to Form 105)

Use QME Form 105 when there is a dispute over a medical decision or medical opinion of the primary treating physician or utilization review. Read these instructions to know what you must do and the time limits for making decisions. You must have given your employer or the claims administrator a claim form before you may get a QME or any benefits.

Answer all of the questions on QME form 105, sign the form and mail it to the DWC Medical Unit.

The DWC Medical Unit will use the information on the form to issue a "QME panel". A "QME panel" is a list of three physicians who are certified as Qualified Medical Evaluators ("QME"). One physician from the list must be selected. The QME selected will do a medical examination and write a report. This QME report provides an independent, second medical opinion on all of the disputed and unresolved issues in the case that need a medical opinion.

How to Get a QME Panel – Send QME Form 105 to the DWC Medical Unit

You, the injured worker, will have the first opportunity to choose the specialty of physician to perform the exam.

You must do so within ten (10) days of the date the claims administrator sent you the QME Form 105. Within the 10-day time limit, fill out the form, write in the three letter code for the specialty you have picked, sign the form and mail it to the DWC Medical Unit. If you do not return the form, the claims administrator may gain the legal right to select the specialty of the QME instead.

All three physicians on the "QME panel" will have the same specialty. The names are selected randomly within the general geographic area of your home. Sometimes it is necessary to travel far to see a QME in the specialty you select. Your employer must pay all reasonable transportation expenses to attend the exam, including lodging if needed. If you and the claims administrator agree in writing for your convenience to have the panel issued in the area of your workplace, attach that written agreement including the street address and zip code of your workplace to the panel request form.

If the DWC Medical Unit does not send you and the claims administrator a "QME panel" within fifteen (15) business days of receiving the request, you may select any QME to do the evaluation. If this happens, call your Information and Assistance Officer at 1-800-736-7401 or the Medical Unit at 1-800-794-6900. The QME database, listing all QMEs by specialty and location, can be found on the internet at http://www.dir.ca.gov/databases/dwc/qmestartnew.asp.

How to Complete the Form

"Request Date": Write the date you sign this form.

"Requesting Party": Check the box for the person who selects the QME specialty and signs the form at the bottom.

Answer the questions, about whether any part of the claim has been accepted, whether the claim has been denied; and about the wording of the notice from the claims administrator to you about the need to get a QME report, by checking the box that answers each question.

Selecting a Reason for Requesting the QME Panel

Select "§ 4060 (compensability exam)" whenever: 1) during the 90 days since you gave the employer your claim form, the claims administrator says the employer requests a QME report to determine whether to accept your claim and asks you to complete the form and select the specialty for the QME; or 2) when the claim is denied altogether and the claims administrator has refused to provide or has stopped all benefits including medical treatment; or 3) if the treating physician writes that your injury was not caused by work and you disagree with that opinion. If the claims administrator has accepted any body part in the claim, select a different reason. If the notice from the claims examiner during the only

says the employer has not accepted liability and you *may* request a panel, you are not required by law to send the panel request form to the Medical Unit. Call the Information and Assistance officer 1-800-736-7401 to discuss your options.

Select "§ 4061 (permanent impairment or disability dispute)" if there is a dispute about temporary disability or whether you have any permanent impairment permanent disability, or you disagree over the amount or percentage of permanent impairment or permanent disability.

Select "§ 4062 (injured employee only - medical treatment or UR dispute or other 4062 reason)" if treatment, that your treating physician has recommended, has been denied, delayed or modified based on a decision by utilization review or the claims administrator; or, whenever there is a dispute over the amount or frequency or type of treatment that you need now or will need in the future. Select this reason also if the dispute is about 'permanent and stationary' status.

Select "§ 4062 (claims administrator only – other non-treatment, non-UR reason under § 4062)" if you are the claims administrator who has objected to some other medical determination or issue under Labor Code § 4062. However, the requesting claims administrator must state the reason on the line provided. Examples may include medical determinations on new and further disability, medical eligibility for vocational rehabilitation, the permanent and stationary date, MPN continuity of care or transfer of care, that a new body part needing treatment is causally connected to the claimed injury.

If you are covered for medical treatment in an MPN and you disagree over the MPN physician's diagnosis or treatment you do not need a QME. Call the Information and Assistance officer 1-800-736-7401 to discuss how to get another MPN physician or an MPN second opinion. You may request a QME panel and select § 4062 for disputes over a treating physician's opinion about whether you qualify for continuity of care (care by the same treating physician after your MPN physician left or is terminated by the MPN) or transfer of care (whether your condition or treatment qualifies for your claims administrator to transfer your care to an MPN physician).

Select "§§ 4061 and 4062 issues" if currently there are disagreements about both permanent disability and medical determinations. The claims administrator may not select this reason if the only disputes under § 4062 are because of a denial, delay or modification of your medical treatment by a utilization review physician.

Prior QME Panel List or Examination

Answer the questions about any QME panel lists you have received in the past. This information is needed to avoid delays in issuing the QME panel list you are requesting now.

Select the Medical Specialty, Sign and Mail the Form

Use the list on the back of QME Form 105 to select a medical specialty. If necessary, request help from your treating physician to choose the specialty. Write the 3 letter code for the medical specialty you select on the front of Form 105. Also, sign the form and print your name below the signature.

What if I pick the wrong medical specialty and wish to change the medical specialty?

You may request a change of medical specialty if you have not had the QME evaluation yet and you and the claims administrator agree in writing to the change of medical specialty. Please include the QME panel number on your request.

What if there is a need for another QME report in a different specialty?

Sometimes, there may be a need for an additional examination and report by a QME in a different specialty. Generally this will occur only if the first QME states in the report that an exam by a physician in another specialty is necessary, or if a Workers' Compensation Judge orders the additional report, or if the parties meet with Information and Assistance Officer who determines that the conditions for obtaining an additional report are met.

Your rights to an attorney

You are entitled to be represented by an attorney at any stage of your workers' compensation claim. However, after you have had an evaluation by a QME, you are not entitled to a new QME evaluation. Should you decide to be represented by

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
MAILING ADDRESS:
P.O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

an attorney, you may or may not receive a larger award, but unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Other questions?

For other questions about the QME process, please call the DWC Medical Unit at 1-800-794-6900. For general questions about your workers' compensation claim and benefits, please call the Information and Assistance Officer at the Division of Workers' Compensation 1-800-736-7401 or look on our website at http://www.dir.ca.gov/dwc/InjuredWorker.htm.

State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1
UNREPRESENTED

(Please print or type)

Request date (Required): _____ Date of Injury (Required): _____ Claim Number (Required): _____

Specialty Requested *(Required):*

_____

(use 3 letter code only)

Requesting party *(Check one box only)*:

☐ Unrepresented Injured Employee

☐ Claims Administrator, if none, Employer

☐ Defense Attorney

Reason QME panel is being requested *(Check one box only)*:

☐ § 4060 (compensability exam)

☐ § 4061 (permanent impairment or disability dispute)

☐ § 4062 Injured employee only (medical treatment determination, UR dispute or other 4062 reason)

☐ § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)

☐ §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request:

_____

Answer each question below:

Has this claim been denied? ☐ Yes ☐ No Has any body part in this claim been accepted? ☐ Yes ☐ No

If yes, indicate the date of the denial _____

Did notice to injured employee state employer requests an evaluation to determine compensability?*(Attach copy of notice)* ☐ Yes ☐ No

Does dispute involve an MPN : ☐ Continuity or Transfer of Care ☐ Permanent Disability, Future Medical, UR decision ☐ Diagnosis/Treatment ?

Employee Information

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address : _____

City: _____ State: _____ Zip Code: _____ Daytime Phone No: _____

If you now live out of state, list the California city and zip code of your residence when injured: _____

If you never resided in California, list the California zip code in which you would like to be evaluated: _____

Employer and Claims Administrator Information

Employer: _____

Claims Administrator Name: _____

Adjustor name: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ Phone No. _____

(Continue form on next page)

Claim Number: _____

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received a QME panel before? ☐ Yes ☐ No ☐ Unknown

If yes, did the employee ever see any QME from that panel? ☐ Yes ☐ No ☐ Unknown

If yes, has that claim been settled or resolved? ☐ Yes ☐ No ☐ Unknown

If yes, name of QME seen: _____ Specialty: _____

Date of Injury: _____ Body parts _____ Date of Exam: _____

Panel Number (If known): _____ Is that QME available now: ☐Yes ☐No ☐Unknown

The completed form must be mailed to:
Division of Workers' Compensation-Medical Unit
P.O. Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date: _____

_____ _____

Print Name of Requestor Signature of Injured Employee

Note: Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form

For Use with the QME Panel Request Form 105

MD/DO SPECIALTY CODES

MAI	Allergy and Immunology
MDE	Dermatology
MEM	Emergency Medicine
MFP	Family Practice
MPM	General Preventive Medicine
MHH	Hand
MMM	Internal Medicine
MM V	Internal Medicine - Cardiovascular Disease
MME	Internal Medicine – Endocrinology Diabetes and Metabolism
MMG	Internal Medicine - Gastroenterology
MMH	Internal Medicine - Hematology
MMI	Internal Medicine - Infectious Disease
MMN	Internal Medicine - Nephrology
MMP	Internal Medicine - Pulmonary Disease
MMR	Internal Medicine - Rheumatology
MNB	Spine
MPN	Neurology
MNS	Neurological Surgery *(other than Spine)*
MOG	Obstetrics and Gynecology
MPO	Occupational Medicine
MMO	Oncology – Orthopaedic Surgery Internal Medicine or Radiology
MOP	Ophthalmology
MOS	Orthopaedic Surgery *(other than Spine or Hand)*
MTO	Otolaryngology
MPA	Pain Medicine
MHA	Pathology
MPR	Physical Medicine & Rehabilitation
MPS	Plastic Surgery *(other than Hand)*
MPD	Psychiatry *(other than Pain Medicine)*
MSY	Surgery *(other than Spine or Hand)*
MSG	Surgery - General Vascular
MTS	Thoracic Surgery
MTT	Toxicology
MUU	Urology

NON-MD/DO SPECIALTY CODES

ACA	Acupuncture
DCH	Chiropractic
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology
PSN	Psychology - Clinical Neuropsychology

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR IN A REPRESENTED CASE (Attachment to Form 106)

Use QME Form 106 only in cases in which the injured employee is represented by an attorney. To request a panel of three QMEs in a represented case, the parties first must have attempted to agree on an Agreed Medical Evaluator to resolve a disputed issue as provided by Labor Code Section 4062.2. Once ten (10) days have passed from the date of the first written proposal to use an AME that names one or more physicians, either party may request a panel on QME Form 106. Complete form 106, specify the specialty requested, attach a copy of the first written AME proposal, and send your request by first class U.S. mail to the DWC – Medical Unit address on the bottom of the form. You must serve a copy of your panel request on the other party. If the panel request form is not fully completed, it will be returned.

Completing the form:

"Request Date": Write the date you sign this form.
"Requesting Party": Check the box that describes the person or party with the legal right to request a panel who is signing the form at the bottom.
Answer the questions, about whether any part of the claim has been accepted, whether the claim has been denied; and about attaching a copy of the earliest written AME offer that identifies a disputed issue and names one or more physicians to be the AME.

Selecting the reason for requesting a QME panel:

Select "§ 4060 (compensability exam)" if the claims administrator advises within ninety (90) days of receipt of the claim form that a QME report is needed to determine whether to accept the claim; or if there is a dispute over the treating physician's opinion that the claimed injury was not caused by work. If the claims administrator has accepted any part of the claim, such as accepting one body part or injury, select a different reason (Lab. Code § 4060(a).) If the ninety (90) day period has passed since the claim form was received, a request from a claims administrator or employer for a QME panel for this reason will not be filled until the conditions in section 30(d)(4) of Title 8 of the California Code of Regulations have been satisfied.

Select "§ 4061 (permanent impairment or disability dispute)" if there is a dispute about temporary or permanent impairment or disability, or you disagree over the amount or percentage of permanent impairment or permanent disability.

Select "§ 4062 (injured employee only - medical treatment or UR dispute or other 4062 reason)" if treatment has been denied, delayed or modified by a utilization review physician or the claims administrator; or if there is a dispute over the amount or frequency or type of treatment that the injured employee needs now or will need in the future. Select this reason also if the dispute is about 'permanent and stationary' status. The claims administrator may not select this after treatment has been denied, delayed or modified in utilization review.

Select "§ 4062 (claims administrator only – other non-treatment, non-UR reason under § 4062)" whenever the claims administrator, or if none the employer, objects to some other medical determination or issue under Labor Code § 4062. The requesting claims administrator must state the reason on the line provided. Examples may include medical determinations on new and further disability, medical eligibility for vocational rehabilitation, the permanent and stationary date, MPN continuity of care or transfer of care, that a new body part needing treatment is causally connected to the claimed injury.

If the injured employee is covered for medical treatment by an MPN and the parties disagree over the MPN physician's diagnosis or treatment, you do not need a QME. The parties must follow the MPN second opinion process set out in Labor Code section 4614.3 and section 9767.7 of Title 8 of the California Code of Regulations.

Select "§§ 4061 and 4062" if currently there are disputes about both permanent disability and medical determinations.

Selecting the medical specialty:

Enter the 3 letter code from the reverse side of QME Form 106 for the medical specialty requested. If known, also state the medical specialty of the treating physician and the specialty preferred by the opposing party. If you are requesting a specialty that is different than the medical specialty of the primary treating physician, it is strongly recommended that you submit additional, relevant medical documentation in support of the requested specialty and an explanation of the reasons you believe the specialty being selected is more appropriate for review by the Medical Director of DWC. Such additional medical documentation may include, but is not limited to, copies of the most recent primary treating physician's progress report (DWC Form PR-2), the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021), a consulting physician's report, etc. . It is not necessary to send copies of all medical records in the case. (See sections 31.1 and 31.5 of Title 8 of the California Code of Regulations.)

The DWC-MU uses a random selection program to assign three QMEs to the panel. If there are too few QMEs of the specialty requested in the geographic area of the injured worker's residence, the system will pick QMEs from other geographic areas and the employer is responsible for paying for necessary travel costs incurred. The non-requesting party will receive a copy of the panel letter when it is issued. If the Medical Unit does not issue a panel within thirty (30) calendar days of receiving the request in a represented case, either party may seek an order from a Workers' Compensation Administrative Law Judge to obtain a QME panel.

The AME or QME selection process in represented cases:

Upon receipt of the QME panel list, the parties in a represented case are required to confer and attempt to agree on an Agreed Panel QME from the panel list provided. (See, Labor Code section 4062.2(c).) If the parties have not agreed on an Agreed Panel QME by the 10th day after the panel is issued, each party may then strike one name from the panel. The remaining QME shall serve as the medical evaluator. If a represented party fails to exercise the right to strike a name from the panel within three business days of gaining the right to do so, the other party may select any QME who remains on the panel to serve as the medical evaluator. (Labor Code §4062.2(c)).

Requests returned for additional information and replacement evaluators:

If a QME panel was previously issued for this injured worker and there is insufficient information on the form 106 to process the request, the request will be returned by the Medical Unit with a request for necessary information. The time periods for selecting an Agreed Panel QME and for striking QME names are tolled during this period. (See, 8 Cal. Code Regs. §§ 30(c), 31.5)

Scheduling the evaluation appointment:

The represented employee is responsible for arranging the appointment for the examination. Upon his or her failure to inform the employer/insurer of the appointment within 10 business days after the medical evaluator has been selected, the employer/insurer may arrange the appointment and notify the employee of the arrangements.

How long will it take to have the examination and to get the QME's report?

If the QME selected is unable to schedule the exam within 60 calendar days of the initial call, the party with the legal right to schedule may either waive the 60 day limit, as long as an appointment within 90 days of the initial scheduling call is available, or request a replacement QME. If no appointment is available within 90 days of the initial request, either party may request a replacement QME or QME panel. You are entitled to an evaluation report within 30 calendar days of the commencement of the exam by an Agreed Panel QME or QME. At times, an AME or QME may request the Medical

Director to extend the deadline for completing the report (for example if the evaluator has not received test results or a consulting physician's report or for legal 'good cause'). The evaluator must notify the DWC-Medical Unit and you of the request for approval of an extension of time to complete the report. You will be notified of the decision. If the evaluator selected cannot complete the report within 30 days or the extension of time approved by the Medical Director, the parties may agree in writing (on QME Form 113 or 116) to wait until the physician can complete the report, or either party may request a replacement panel of QMEs. If this occurs, you must go through the selection process again.

Obtaining a QME in a different specialty:

As provided in section 31.7(b) of Title 8 of the California Code of Regulations, parties in a represented case may obtain an additional QME panel in a different specialty under certain circumstances. All such requests for an additional QME panel must be written and submitted with supporting information or documentation showing how the conditions in § 31.7 are being met.

Other questions?

For questions about the QME process, please call the DWC-MU at 1-800-794-6900. For questions about the workers' compensation claim dispute resolution process, call an Information and Assistance officer at the Division of Workers' Compensation office listed in your phone book, or look on our website at http://www.dir.ca.gov/dwc.

State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT
REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.2
REPRESENTED

(Please print or type)

Request date (Required): _____ Date of Injury (Required): _____ **Specialty Requested** *(3 letter code required):* _____ **Claim Number** (Required): _____

Specialty of treating physician: _____ Opposing party's specialty preference: _____

Requesting party *(Check one box only)*

☐ Applicant's Attorney(or injured employee)

☐ Defense Attorney /Claims Administrator

Reason QME panel is being requested (*Read attachment, 'How to Request a QME') (Check one box only)*:

☐ § 4060 (compensability exam)

☐ § 4061 (permanent impairment or disability dispute)

☐ § 4062 Injured employee only (medical treatment determination, UR dispute or other 4062 reason)

☐ § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)

☐ §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the claims administrator is requesting a 4062 panel explain the reason for the request below:

_____

You must attach a copy of your written proposal identifying a disputed issue and naming one or more physicians to be an AME.

Answer each question below:

Has this claim been denied? ☐ Yes ☐ No Has any body part in this claim been accepted? ☐ Yes ☐ No

If yes, indicate the date of the denial _____

Does dispute involve an MPN : ☐ Continuity or Transfer of Care ☐ Permanent Disability, Future Medical, UR decision ☐ Diagnosis/Treatment ?

Employee Information

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address : _____

City: _____ State: _____ Zip Code: _____ Daytime Phone No: _____

If currently living outside of state, enter the California city and zip code on date of injury: _____

If never resided in state, enter the California city and zip code for evaluation: _____

Employee's Attorney

First Name _____ Last Name _____ Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____ Phone No _____

(Continue form on next page)

Claim Number: _____

Employer and Claims Administrator Information

Employer: _____

Claims Administrator Name: _____

Adjustor name: _____

Street Address or P.O. Box: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

Defendant's Attorney

_____ _____ _____
First Name Last Name Firm Number

_____
Law Firm Name

_____
Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____ _____
City State Zip Code Phone Number

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received a QME panel before? ☐ Yes ☐ No ☐ Unknown

If yes, did the employee ever see any QME from that panel? ☐ Yes ☐ No ☐ Unknown

If yes, has that claim been settled or resolved? ☐ Yes ☐ No ☐ Unknown

If yes, name of QME seen: _____ Specialty: _____

Date of Injury: _____ Body parts: _____ Date of Exam: _____

Panel Number (If known): _____ Is that QME available now: ☐ Yes ☐ No ☐ Unknown

The completed form must be mailed to:
Division of Workers' Compensation-Medical Unit
P.O. Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date: _____

Print Name of Requestor: _____ _____
Signature

Note: The party submitting this form must attach a copy of the written proposal identifying a disputed issue and naming one or more physicians to be a AME.

For Use with the QME Panel Request Form 106

MD/DO SPECIALTY CODES

MAI	Allergy and Immunology
MDE	Dermatology
MEM	Emergency Medicine
MFP	Family Practice
MPM	General Preventive Medicine
MHH	Hand
MMM	Internal Medicine
MMV	Internal Medicine - Cardiovascular Disease
MME	Internal Medicine – Endocrinology Diabetes and Metabolism
MMG	Internal Medicine - Gastroenterology
MMH	Internal Medicine - Hematology
MMI	Internal Medicine - Infectious Disease
MMN	Internal Medicine - Nephrology
MMP	Internal Medicine - Pulmonary Disease
MMR	Internal Medicine - Rheumatology
MNB	Spine
MPN	Neurology
MNS	Neurological Surgery *(other than Spine)*
MOG	Obstetrics and Gynecology
MPO	Occupational Medicine
MMO	Oncology – Orthopaedic Surgery Internal Medicine or Radiology
MOP	Ophthalmology
MOS	Orthopaedic Surgery *(other than Spine or Hand)*
MTO	Otolaryngology
MPA	Pain Medicine
MHA	Pathology
MPR	Physical Medicine & Rehabilitation
MPS	Plastic Surgery *(other than Hand)*
MPD	Psychiatry *(other than Pain Medicine)*
MSY	Surgery *(other than Spine or Hand)*
MSG	Surgery - General Vascular
MTS	Thoracic Surgery
MTT	Toxicology
MUU	Urology

NON-MD/DO SPECIALTY CODES

ACA	Acupuncture
DCH	Chiropractic
DEN	Dentistry
OPT	Optometry
POD	Podiatry
PSY	Psychology
PSN	Psychology - Clinical Neuropsychology

STATE OF CALIFORNIA
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or (800) 794-6900

QUALIFIED MEDICAL EVALUATOR'S FINDINGS SUMMARY FORM
UNREPRESENTED INJURED EMPLOYEE CASES ONLY

EMPLOYEE

1. Employee Name (First, Middle, Last) | 2. Social Sec. No. (Optional) | 3. Date of Injury

4. Street Address | City | Zip | 5. Phone

CLAIMS ADMINISTRATOR *(if none, enter Employer information)*

6. Name

7. Street Address | City | Zip | 8. Phone

EVENT DATES

9. Date of Appointment Call | 10. Initial Examination Date | 11. Date of Referral for Medical Testing/Consultation

12a. Date QME Report Served on all Parties | 12b. Date(s) of all prior report(s) served by this QME?

DISPUTED MEDICAL ISSUES AND CONCLUSIONS

13. The following medical issues will be used to determine the injured employee's eligibility for workers' compensation benefits.

	(Check the appropriate box) Yes	No	Pending or Info. Not Sent
a. Has the condition reached permanent and stationary status or maximum medical improvement?	☐	☐	☐
b. Is there permanent impairment/disability?	☐	☐	☐
c. Did work cause or contribute to the injury or illness?	☐	☐	☐
d. If permanent disability exists, is apportionment warranted?	☐	☐	☐
e. Is there a need for current or future medical care?	☐	☐	☐

f. Can this employee now return to his/her usual job? ☐ Yes ☐ No

If yes:

i. Without restrictions ☐ Yes ☐ No, If YES, Date: _____

ii. With restrictions ☐ Yes ☐ No, If YES, Date: _____

BASIS FOR CONCLUSIONS

	(Check the appropriate box) Yes	No	Pending or Info. Not Sent
14. Are there subjective complaints?	☐	☐	☐
15. Are there any abnormal physical or psychological examination findings?	☐	☐	☐
16. Are impairments described and measured using:			
(For non-psyche injuries) the AMA Guides?	☐	☐	☐
(For psyche injuries) the GAF and 2005 PD Schedule?	☐	☐	☐

	Yes	No	Pending or Info. Not Sent
17. If the AMA Guides are used, are percentages of impairment stated?	☐	☐	☐
18. Are there any relevant diagnostic test results (x-ray/laboratory)?	☐	☐	☐
19. What are the diagnoses? (List) _____			
20. Were medical records reviewed?	☐	☐	☐
21. Were other physicians consulted?	☐	☐	
22. Are there any unresolved disputed issues beyond the scope of your licensure or clinical competence that should be addressed by an evaluator in a different specialty?	☐	☐	

23. If the answer to # 22 is yes, what disputed issue(s)?_____

24. Based on the answer in # 23, what specialty (or specialties)?_____

QME

22. Signature:_____ Date:_____

23. Name:_____ Specialty:_____

24. Street Address:_____ City:_____ Zip:_____

25. Phone:_____ Cal. License No.:_____

Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

I, _____, declare:
(Print Name)

1. I am over the age of 18 and I am not a party to this case.
2. My business address is :_____

3. On the date shown below, I served this QME Findings Summary Form with the original, or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A — depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.

B — placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C — placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D — placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E — personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, Enter A – E as appropriate)*	Date:	Addressee and Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When report addresses PD:

_____ _____ Disability Evaluation Unit, DWC,_____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date Signed: _____

_____ _____

(Signature of Declarant) *(Print Name)*

INSTRUCTIONS FOR QME FORM 111

USE THIS FORM ONLY WHEN THE INJURED EMPLOYEE IS UNREPRESENTED

To the QME: You are required by Labor Code section 4062.3(i) to summarize the medical findings from your comprehensive medical-legal evaluation on the form prescribed by the Administrative Director. Please complete the form in its entirety.

Employee Information: Fill in the employee's full name, address, telephone number and date of injury.

Event Dates: Complete dates that patient called for an appointment, date of initial examination, date referred for consultation(s), if any, and date(s) report(s) served on all parties. Supplying these dates is a legal requirement.

Disputed Medical Issues and Conclusions: Complete this section by checking appropriate box and stating what page(s) or section of the medical legal report contain the narrative for details. If diagnostic or laboratory tests have been ordered and the results or a medical records request is pending, check that box. If you cannot render opinions because of pending information, please complete and serve the report to comply with the 30-day time requirement and state what issues could not be evaluated.

Basis for Conclusions: Check appropriate box for each question on form. For diagnoses, please briefly summarize the diagnoses in lay terms where possible, except when you deem that not advisable in disputed claims involving injury to the psyche. Also, list the name and specialty for other physicians who provided information used in the medical legal report.

Need for Additional Evaluation in Another Specialty: Labor Code section 4062.3 directs each evaluator to address all contested medical issues arising from all injuries reported on one or more claim forms prior to the evaluator's initial evaluation. Each evaluator is expected to address permanent impairment consistent with the AMA guides for the evaluator's specialty, or for disputed injuries to the psyche consistent with the global assessment of functioning (GAF) as directed in the 2005 Permanent Disability Schedule adopted by the Administrative Director effective 1/1/2005. In the event there are contested medical issues outside of the scope of your licensure or clinical competence that require evaluation by a physician in a different specialty, complete the information required in questions 22 through 24, and serve a copy of your report on the Medical Unit of DWC.

QME Signature: Remember under the Labor Code, all your reports must be signed under the penalty of perjury. You are required to serve the medical legal report and this form on the employee (unless the claim involves a disputed injury to the psyche and section 36.5 of Title 8 of the California Code of Regulations applies and provides for a different method of service), the claims administrator (if none, the employer) and whenever the report finds permanent impairment and permanent disability, on the Disability Evaluation Unit (DEU) having jurisdiction over the employee's area of residence.

Declaration of Service of Medical – Legal reports: Labor Code sections 139.2(j)(1)(A) and 4062.3 (i) and section 38 of Title 8 of the California Code of Regulations require the QME to serve the medical-legal report and this form on the claims administrator, or if none the employer, and the injured worker (except when section 36.5 of Title 8 of the California Code of Regulations applies) within 30 days from the commencement of the examination, unless certain conditions are met. Please complete the proof of service to show the date the report was served on the parties and the Disability Evaluation Unit.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
MAILING ADDRESS:
P. O. Box 71010
Oakland, CA 946123
(510) 286-3700 or (800) 794-6900 Fax: (510) 622-3467

VOLUNTARY DIRECTIVE FOR ALTERNATE SERVICE OF MEDICAL-LEGAL EVALUATION REPORT ON DISPUTED INJURY TO PSYCHE
(Unrepresented Employees Only)

Injured Employee Name: _____

Date of Injury: _____

Claim No.: _____

WCAB Case No.: _____

Claims Administrator: _____

Name of QME: _____

Date of Evaluation Exam: _____

I, _____,
(print name of injured employee)

understand I have a right to be served with a copy of the medical-legal evaluation report written about my case by the QME physician named above, at the same time as a copy of the report is sent to the claims administrator and/or the Disability Evaluation Unit.

By signing below, I hereby direct that the QME serve my copy of the medical/legal report in the following manner:

(Check one)

☐ **By sending my copy to the following physician who will review it with me and will be paid for an office visit for this purpose by the claims administrator, or if none by my employer. The physician I name below may be my primary treating physician in this case or any other physician I wish to designate. At the end of that visit, the physician named below will give me my copy of the report:**

Physician Name: _____

Address: _____

City: _____ **Zip:** _____

Phone: _____

☐ **Only by sending a copy to me at my address on file. I do not wish to designate a physician to review it with me.**

I am signing this directive voluntarily and of my own free will:

_____ _____
(Signature of Injured Employee) *Date*

Original of this signed form – attach to original medical-legal report
Copies of this signed form – to injured employee, claims administrator, reviewing physician, QME

State of California
DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

DECLARATION REGARDING PROTECTION OF MENTAL HEALTH RECORD

(Health and Safety Code § 123115(b) and § 36.5, Title 8, California Code of Regulations)

NOTE: THE MENTAL HEALTH RECORD(S) ATTACHED TO THIS DECLARATION MUST NOT BE SEEN BY OR COPIED BY _____ FOR THE REASONS STATED BELOW:
(Print name of injured employee)

I, _____, declare as follows:
(Print your name)

1. I am licensed in the state of California as a _____, license number _____.
(Type of license)

2 The attached medical record pertains to:

Employee name:

Address: Phone:

W.C. Claim number:

W. C. Claims administrator: Phone:

3: In my professional medical judgment and pursuant to Health and Safety Code § 123115(b), the attached mental health record, or the portions of this record designated below and on the face of the record, if seen or copied by the employee named above, will or is likely to result in a substantial risk of significant adverse or detrimental medical consequences to the employee, including but not limited to, (describe medical basis for conclusion):

_____

_____

_____

_____

4. On _____ 20____, I was asked by the above named employee, or I was required by law, to serve a copy of this medical record on the employee.

5. On that same date, I advised the employee that the record only could be inspected by, copied or provided to a licensed physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, on behalf of the employee, and that the employee must use that mechanism to obtain the record.

6. The employee has designated the following physician, within the definition of Labor Code § 3209.3 or a health care provider as defined in Health and Safety Code § 123105, for alternate service of the employee's copy of this record:

Name:

Address:

Phone and fax:

Medical license no. (CA, if known):

Date of employee designation of this physician or health care provider (MM/DD/YYYY):

7. For the above reasons, in response to the employee's request of (date MM/DD/YYYY) for a copy of the record, I responded in the following manner: *(Check one below, as appropriate.)*

_____I declined to allow the employee to personally inspect or receive a copy of the record.

_____ I declined to allow the employee to personally inspect, receive a copy or to be served personally with a copy of the record. However, at the employee's request, I did provide to, or serve a copy of the record on, the physician or health care provider designated by the employee as noted below:

Name:

Address:

Phone and fax:

Date of Service:

Manner of Service: (mail, overnight mail, courier, fax)

8. From this time forward, I shall note in the medical file for this employee each time any licensed physician, within the definition of Labor Code 3209.3 or a health care provider as defined in Health and Safety Code § 123105, requests to inspect or copy this record on behalf of the employee.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date signed: _____

_____ _____

(Signature) (Print name)

Address: Phone:

File record of requests for copies of the attached record made subsequent to the declaration date above:

Date	Person	License type and License number

State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: _____ v. _____
(employee name) *(claims administrator name, or if none employer)*

Claim No.: _____

WCAB Case No. (*if any*): _____

I, _____, declare:
(Print Name)

1. I am over the age of 18 and not a party to this action.

2. My business address is:

3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: _____

_____ _____
(signature of declarant) *(print name)*

STATE OF CALIFORNIA
Division of Workers' Compensation – Medical Unit
P.O. Box 71010, Oakland, CA 94612
(510) 286-3700 or 1 (800) 794-6900

QME or AME Conflict of Interest Disclosure Form

QME/AME Name: _____

Injured Employee Name: _____

Claims Administrator: _____

Claim No.: _____ **WCAB Case No. (if known)** _____

QME Panel No. (if applicable): _____

Date Scheduled for Medical/Legal Examination: _____

NOTICE TO THE PARTIES: (check appropriate box)

☐ **I, the undersigned evaluator, have determined I have a disqualifying conflict of interest as defined in section 41.5 of the QME regulations (8 Cal. Code Regs.) in this case.**

Person/Entity with whom conflict exists:

_____

Category of Conflict: (check one or more)

_____ **familial**
_____ **professional**
_____ **significant financial**
_____ **other (describe):**
_____

☐ **I have reviewed the information sent by** _____ **regarding an alleged conflict of interest. I do not believe that any disqualifying conflict of interest, as defined in 8 Cal. Code Regs. § 41.5, exists.**

I declare under penalty of perjury of the laws of California that the foregoing is true and correct to the best of my knowledge. Signed this day : _____
(MM/DD/YYYY)

_____ _____
(Print Name) (Signature)

Objection or Waiver By Represented Parties

I wish to (check one):

_____ **Object to the Evaluator due to the conflict**

_____ **Waive the conflict and continue using the QME/AME in this case in spite of this conflict.**

_____
(Date signed)

_____ _____
(Print Name of Party or Attorney Signing) (Signature)

If form signed by attorney, name of party: _____

.....over/

INSTRUCTIONS FOR QME FORM 123

To the Evaluator:

A QME or AME who knows, or should know, that he or she has a disqualifying conflict of interest as defined in section 41.5 of Title 8 of the California Code of Regulations, with any person or entity listed in subdivision 41.5(c), that also is involved in the case the evaluator is handling, must notify the parties in writing of the conflict of interest. Use this form to do so. A QME or AME may disqualify himself or herself also for conflict of interest whenever the evaluator has a relationship with a person or entity in the case that causes the evaluator to decide it would be unethical to perform a comprehensive medical-legal evaluation in the case. (8 Cal. Code Regs. § 41.5(e).)

Notice of a disqualifying conflict of interest is given by an evaluator by signing and mailing QME Form 123 (QME/AME Conflict of Interest Disclosure and Objection or Waiver by Represented Parties Form) to the parties. (8 Cal. Code Regs. §§ 41.5 and 123.) The evaluator's notice must be sent within five (5) business days of becoming aware of the conflict. If the injured employee is not represented, the evaluator also must fax a copy of this form to the Medical Unit of the Division of Workers' Compensation at 510-622-3467. (8 Cal. Code Regs. § 41.5(f).)

Upon notice from any party in a case that the party believes the evaluator has a disqualifying conflict of interest, the evaluator must review the information submitted and advise the parties within five (5) business days of receipt of the notice whether the evaluator believes that a conflict of interest exists. Use this form to either disclose any conflict or to indicate no conflict exists.

As used in section 41.5 of Title 8 of the California Code of Regulations, the following definitions apply:
Persons and entities considered:
-Injured employee and his or her attorney, if any
-Employer and employer's attorney, if any
-Claims adjuster, insurer or third party administrator, and their attorney, respectively
-Any primary treating physician or secondary physician, only if treatment by that physician is disputed
-Utilization review physician reviewer or expert reviewer, or utilization review organization, only if the UR decision is disputed
-Surgical center where surgery performed or is proposed, only if the need for surgery is disputed
- Other purveyor of medical goods or medical services, only if the medical necessity for using such goods/services is disputed
"Disqualifying Conflict of Interest" which must be disclosed means:
A familial relationship (parent, child, grandparent, grandchild, sibling, uncle, aunt, niece, nephew, spouse, fiancée or cohabitant)
Significant financial interest including
-Employment or a promise of employment
-An interest of five (5) % or more in the fair market value of any form of business entity involved in workers' compensation matters, or of private real property or personal property, or in a leasehold interest
-Five (5) % or more of income of the undersigned is received from direct referrals by or from one or more contracts with a person or entity listed above, except that contracts to participate in an MPN are excluded
-A financial interest a defined in Labor Code section 139.3 that would preclude referral by the evaluator to such a person or entity;
-A financial interest as defined under the Physician ownership and Referral Act of 1993 (PORA) set out in Business and Professions Code sections 650.01 and 650.02 that would preclude referral by the evaluator to such a person or entity
Professional affiliation which means the undersigned performs services in the same medical group or other business entity comprised of medical evaluators who specialize in workers' compensation medical-legal evaluations
Any other relationship or interest not addressed above 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

To Parties in a Represented Case:

Within five (5) business days of receipt of a notice of conflict from an evaluator on QME Form 123, each party must complete the bottom of the form to indicate whether the party objects to the evaluator or wishes to waive the disclosed conflict and use the evaluator. Serve the completed form on the evaluator and the opposing party. If you are objecting to the evaluator, *also* mail this form to the Medical Unit of the Division of Workers' Compensation with a request for a replacement QME.

State of California
Division of Workers' Compensation Medical Unit
P.O. Box 71010
Oakland, CA 94612

QME DISCLOSURE OF SPECIFIED FINANCIAL INTERESTS ("SFI Form 124" Attachment to QME Form 100, 103 & 104)

Name	Professional License No.

Business Address	QME No. (if applicable)

Business Telephone No.	Fax No.

PARTNERSHIP INTERESTS* (Attached continuation sheets of needed)

Name of Business Entity in which have limited or full partnership interest:

Address of Business Entity:

Names of partners who are physicians at same location (MD, DO, DC, OD, DPM, DDS, PhD or L.Ac.):

INTERESTS OF 5% OR MORE IN MEDICAL PRACTICE, MEDICAL GROUP OR OTHER MEDICAL OR MEDICAL/LEGAL BUSINESS ENTITY IN CALIFORNIA WORKERS' COMPENSATION SYSTEM*

Name of Medical Practice/Group/Business Entity:

Address of Business Entity:

Names of participating physicians at same location (MD, DO, DC, OD, DPM, DDS, PhD or L.Ac.):

RECEIPT OF 5% OR MORE OF PROFITS FROM MEDICAL PRACTICE, MEDICAL GROUP OR OTHER MEDICAL OR MEDICAL/LEGAL BUSINESS ENTITY IN CALIFORNIA WORKERS' COMPENSATION SYSTEM*

Name of Medical Practice/Group/Business Entity:

Address of Business Entity:

Names of participating physicians at same location (MD, DO, DC, OD, DPM, DDS, PhD or L.Ac.):

I declare under penalty of perjury that the foregoing information is current, complete and accurate to the best of my knowledge. Signed this _____ day of _____, 20____ at _____, California.

Print name_____ **Signature:**_____

* "Specified Financial Interests" means being a general partner or limited partner in, or having an interest of 5 percent or more, or receiving or being legally entitled to receive a share of 5 % or more of the profits from, any medical practice, group practice, medical group, professional corporation, limited liability corporation, clinic or other entity that provides treatment or medical evaluation, goods or services for use in the California workers' compensation system. (8 Cal. Code Regs. § 29 (b).)

ADDITIONAL LEGAL UPDATES

Vocational Rehabilitation

As of January 1, 2009, Labor Code section 139.5 pertaining to vocational rehabilitation was repealed. Consequently, as of January 1, 2009, there is no legal basis for vocational rehabilitation, and the Rehabilitation Unit has been abolished.

However, there are thousands of cases involving vocational rehabilitation issues, pending before the WCAB.

Presently, a hearing is scheduled before Judge Mark Kahn, for March 27, 2009 at 9:00 a.m. in Los Angeles, to consider the potential consolidation of vocational rehabilitation issues. The issues that Judge Kahn will consider at the hearing on March 27, 2009, include:

1. Whether California workers' compensation cases involving the common issue of the effect of the repeal of Labor Code section 139.5 on an injured workers' entitlement to vocational rehabilitation benefits and services for injuries occurring prior to January 1, 2004, should be consolidated for hearing;

2. Whether all or a limited number of such cases should be consolidated;

3. Assuming a consolidation is ordered, whether an Order should issue staying action on all other cases statewide in which the common issue of the issue of the effect of the repeal on Labor Code section 139.5 is presented pending a final determination on the consolidated matter.

NEW MEDICARE REPORTING REQUIREMENTS

Effective July 1, 2009

As of July 1, 2009, workers' compensation insurers, self-insureds, and TPA's will be required to report settlements with Medicare-eligible beneficiaries once each quarter. Medicare has not yet established the new reporting system.

A Medicare-eligible beneficiary is defined as an individual who is eligible for Medicare, or will become eligible for Medicare within one year. Therefore, it will need to be determined whether an injured worker is 64 years old, since that individual will become eligible for Medicare within one year, or whether the applicant has drawn Social Security disability benefits for a year, due to the fact that claimants become Medicare-eligible after receiving disability payments for two consecutive years.

These regulations are part of the Medicare Second Payer Act, by which Medicare seeks to identify claims where the insurer is liable for the costs of medical care and treatment, and not the tax payers. Although this has been law for a number of years, Medicare is implementing these new requirements.

COMMENT

Claims personnel will need to start identifying Medicare-eligible persons, so that the reporting requirement can be satisfied.