# Qualified Medical Evaluators: Updating Trends in Evaluations, Availability, and Equity

Report to the Commission on Health and Safety and Workers' Compensation

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## Executive Summary

The Qualified Medical Examiner (QME) process is at the heart of the California workers' compensation dispute resolution process. The current process is the result of a series of reforms over the past 15 years that were meant to improve the delivery of medical-legal evaluations expeditiously and equitably for both parties.

This QME report updates the original 2010 review of the QME process for the Commission. This update was requested by Senate Committee on Labor and Industrial Relations Chair Tony Mendoza on October 17, 2016 and was approved by the Commission on December 9, 2016. The report examines how the QME process has changed over the past decade (2007-2017), with special attention on the issues raised in the previous report.

We used extensive electronic administrative data made available by the Division of Workers' Compensation (DWC) Medical Unit and Disability Evaluation Unit (DEU), supplemented with summary data from several sources. The study covers the period from 2007 through 2017. This period covers much of the evolution after the 2004 reforms which introduced utilization and treatment guidelines, a new permanent disability rating schedule based on the AMA *Guides*, and changes to the manner parties in represented cases can select QMEs. Subsequently, SB 863 made additional important changes, including the Independent Medical Review (IMR) process that was anticipated to replace the need for medical-legal exams to decide treatment issues. SB 863 also imposed restrictions on the number of locations at which QMEs could schedule exams.

### Key Findings in This Study

- The number of providers registered as QMEs continues to decline (17% since 2007), but less rapidly than it did prior to 2007.
- The number of requests for QME panels has increased rapidly, 87% since 2007.
- The decline in QMEs and increase in panel requests means that the number of requests per QME has doubled (+101%).
- Coupled with a continuing increase in the average paid amount for QME reports, the average QME earns 240% more from panel reports now than in 2007.
- All the increase in panel requests is from represented track cases, up 400% despite the elimination of panels for most medical treatment issues (replaced by the IMR process). This increase was equally driven by requests from both parties, applicant and defense.
- Panel requests for unrepresented cases declined 55%, entirely driven by a decline in requests from injured workers. The number of requests by claims administrators in unrepresented cases changed little.
- The DWC began collecting the reasons for panel requests on represented cases in 2015. Those data show that the primary reasons for panels are: (1) Compensability (42.5%), Permanent disability (21.4%), and Permanent & Stationary (P&S) status (11.4%).

In response to the earlier study, SB 863 placed limits on the number of locations (10) at which QMEs can be registered. This has had the effect of distributing QME panels more evenly and widely among registered providers.

- Very-high-volume QMEs (with 11-100+ registered locations) have been eliminated.

- However, a high proportion of panel assignments (55%-60%) are still assigned to the busiest 10% of QMEs, nearly all of whom have exactly 10 offices and are in orthopedic specialties.
- Unlike the very-high-volume QMEs studied earlier, the top 10% and 5% of QMEs by number of panels in the current system produce reports that show less bias. Even the top 5% of QMEs by volume rate only slightly more conservatively than average.

Access to QMEs does not appear to be an important current problem, but there are signs that delays in getting an evaluation may be developing.

- Orthopedic specialties are under-represented among registered QMEs relative to requests.
- The number of panels where a subsequent panel is requested because the QME was not available within 60 days (a measure of access), while still low, has increased from 1% to 2.8% for unrepresented cases and 0.7% to 4.7% for represented cases. Almost all of this increase is in the past 3 years (2013-2016).

The DWC has made an effort to eliminate from the workers' compensation system providers who are accused or convicted of fraudulent activity or violations of professional standards. This study examined the activity of these doctors in the QME process and how their suspension may impact QME evaluations. We found:

- Of providers suspended or restricted under Labor Code sections 139.21 & 4615, 41 were registered as QMEs at least one year between 2007 and 2016.
- They represented a small minority of all QMEs (1.6%) and were assigned to a minority of all 3-doctor panels (4.6%).
- While these percentages are small overall, there were some areas where problem providers appear to be concentrated and represent a special issue. The "Pain" specialties (PAP, MAA, & MPP), stood out, with 40% -50% of QME panels including at least one restricted or suspended provider.
- The more general "pain" category (MPA) that is more commonly used now, as well as the Physical Medicine and Rehabilitation (MPR) and Internal Medicine--Hematology (MMH) had 15% - 17% of panels include a restricted or suspended provider.
- Overall, the restricted and suspended doctors gave much more generous evaluations to injured workers than the average QME: higher ratings, less frequent use of apportionment and more frequent "Almaraz" ratings.

## Recommendations for possible modifications in the QME process and future monitoring

- The DWC could use QME registration data linked with WCIS medical-legal payment data to examine whether the increases observed in average cost of medical-legal reports is driven primarily by providers acting through aggregators.
- The very high concentration of restricted and suspended doctors in the 'Pain" specialties suggests the DWC could examine the cost-benefit of maintaining separate pain specialties in the QME system. If the specialties are retained, the DWC might concentrate special monitoring and outreach to this community of providers and related professional associations. This could involve additional testing and/or other restrictions on registering for these specialties
- The number of QMEs not available in the 60 day period is still small, but the recent increase suggests continued close monitoring by the DWC, with special attention to the orthopedic specialties.
- DWC should consider eliminating the requirement that the unrepresented worker serve the claims administrator with notice and confirm proof of service under penalty of perjury. This may be intimidating workers and reducing their use of the QME process when challenging the PTPs findings. DWC could supply notice to the claims administrator and eliminate the need for the worker to submit "Proof of Service" documentation.

<u>Advancing the Division of Workers' Compensation research efforts</u>

The Division is hampered in evaluating how efficient and equitable the QME system is in evaluating issues of compensability, permanent disability, and future medical because there are substantial gaps in the data on which claimants are evaluated by QMEs and which of those evaluations are rated by the DEU.

- The DWC should consider drawing a random sample of initial workers' compensation first reports and examine how they are resolved including issues of compensability and permanent disability. Key questions could be:
    - What are the characteristics of claims and claimants using the QME process vs. resolving disputes based on the PTP report?
    - What are the characteristics of PD claims and claimants who are rated by the DEU vs. other sources like the claims administrator in unrepresented cases and private raters or the parties in represented cases.?
- The DWC should consider identifying more information about the operation of aggregators managing the QME location and appointment process. The consolidation of QMEs under a small number of aggregators with substantial fractions of the market may be having an impact on the system..
- DWC should collect electronically the reason for panel requests in unrepresented cases, similar to the data collected on represented cases. The main reasons for requesting a QME panel are already included on the documentation submitted by workers and claims administrators.

## Acknowledgments

This report would not have been possible without the assistance of the Department of Industrial Relations. Particular thanks go to Sandra Abranches, Jeff Seeman, and John Gordon, who were incredibly helpful in assembling the data and adding context to the legislative and regulatory changes. This study would also not be possible without the leadership of Christine Baker, Director of the Department of Industrial Relations; Eduardo Enz, Executive Officer of the Commission on Health and Safety and Workers' Compensation; and the Commissioners who requested the study.

## Contents

## Introduction

The Qualified Medical Examiner (QME) process is at the heart of the California workers' compensation dispute resolution process. The current process is the result of a series of reforms over the past 15 years, which were meant to improve the delivery of medical-legal evaluations expeditiously and equitably for both parties.

In 2010, this author reviewed the QME process for the Commission on Health and Safety and Workers' Compensation (CSHWC). That report identified several important issues regarding the equity and efficiency of the process. Most notably,

- A few high-volume QMEs were conducting a unusually high proportion of the evaluations.
- These high-volume evaluators were substantially more conservative in the ratings they gave injured workers.
- The number of registered QMEs was declining, and some specialties had especially high ratios of requests for registered evaluators, suggesting possible future access issues.

This report examines how the QME process has changed over the past decade (2007-2017) with special attention on the issues raised in the previous report.

We used extensive electronic administrative data made available by the Division of Workers' Compensation (DWC) Medical Unit and Disability Evaluation Unit (DEU), supplemented with summary data from several sources. The study covers the period from 2007 through 2017, which covers much of the evolution after the 2004 reforms that introduced utilization and treatment guidelines, a new permanent disability rating schedule based on the AMA *Guides*, and changes in how parties in represented cases can select QMEs. Subsequently, SB 863 made additional important changes, including the Independent Medical Review (IMR) process, which was anticipated to replace the need for medical-legal exams to address treatment issues. SB 863 also imposed restrictions on the number of locations at which QMEs could schedule exams.

Panels are assigned by identifying all QMEs registered in the specialty requested and a location near the injured worker's residence, then by selecting randomly from those within a prescribed radius. QMEs can increase their probability of assignment by registering at more locations and, to a lesser extent, by registering under more specialties.

## Trend in the Number of Registered QMEs

The number of registered QMEs has been steadily declining. An earlier study (Neuhauser, 2010) identified this trend as steeply declining in 2005, and since then it has declined more slowly. In 2012, restrictions were placed on the number of different locations QMEs could list as sites for performing evaluations. One might have expected that reducing the high-volume QMEs (those with an exceptionally large number of office locations) would encourage more doctors to register as QMEs because it would increase their opportunities for referrals. However, the statutory restriction on office locations did not significantly affect the number of doctors registering as QMEs. Moreover, as we shall see below, the expectation of being included on more panels did not encourage more doctors with a single location or a very small number of locations to register as QMEs.

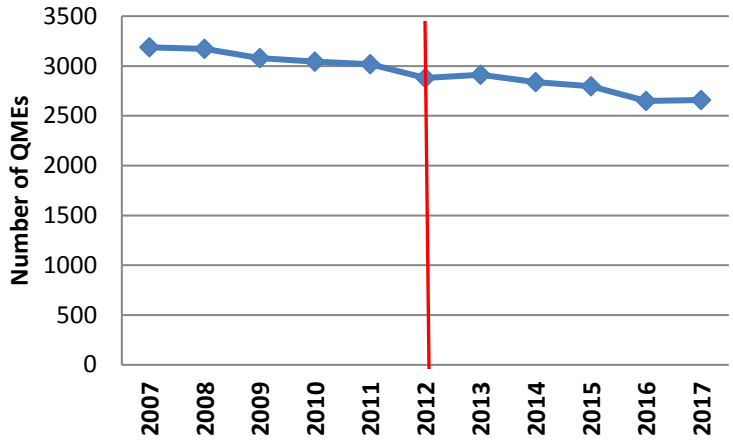


**Figure 1. Trend in QME Registrations**

The number of doctors willing to participate as registered QMEs has continued to decline despite a dramatic increase in the number of panel referrals and total income from evaluations.

## Trend in the Number of QME Requests

Over the decade under study, the number of panels issued by the DWC has rapidly increased (by 85%), albeit with a large decline in 2013.[1] The surge in panels has been particularly marked since a low point in 2013, increasing about 17% annually from 2013 to 2016.

This increase in panels occurred even though the number of permanent disability (PD) claims has remained relatively constant.[2] In addition, changes in statutes should have reduced the number of panels after 2012. In particular, the shift to the IMR process legislated under SB 863 eliminated most of the need to issue panels to address medical treatment issues.[3]

[1] The decline in panels in 2013 was likely driven by changes in the way unrepresented worker requests were processed (discussed later in this study). The greater processing time for unrepresented panel requests and changes under SB 863 to the represented panel process may have slowed the issuing of represented panels.
[2] The number of permanent disability (PD) claims for insured employers, measured at first report, was 40,481 in 2007 and 45,488 in 2014, the last year for which these data are available (WCIRB Losses and Expenses Reports, 2009-2016).
[3] Unfortunately, we do not have data on the proportion of QME requests that involved medical treatment issues prior to 2012. The DWC began to collect data on the "reason" for a panel request in late 2015, and then only for represented cases.

### Table 1. Average Number of Panel Assignments per QME

| Year | # Unique QMEs | Panel requests | Avg. Panel requests/QME | Avg. Unreplaced panels/QME [a] | $/ML report[b] |
|---|---|---|---|---|---|
| 2007 | 3,187 | 70,730 | 22.2 | 20.1 | $979 |
| 2008 | 3,171 | 82,592 | 26.0 | 23.5 | $1,067 |
| 2009 | 3,078 | 76,747 | 24.9 | 22.3 | $1,196 |
| 2010 | 3,044 | 98,771 | 32.4 | 28.6 | $1,274 |
| 2011 | 3,018 | 102,886 | 34.1 | 30.6 | $1,364 |
| 2012 | 2,879 | 117,177 | 40.7 | 36.4 | $1,447 |
| 2013 | 2,912 | 81,679 | 28.0 | 24.9 | $1,514 |
| 2014 | 2,839 | 105,955 | 37.3 | 31.5 | $1,624 |
| 2015 | 2,795 | 120,845 | 43.2 | 35.8 | $1,652 |
| 2016 | 2,649 | 131,106 | 49.5 | 40.5 | $1,654 |
| 2017 | 2,657 | N/A | N/A | N/A | N/A |

[a] Panels are sometimes replaced by a second panel, usually in the unrepresented track. This is based on only final panels.
[b] Assumes QME panels cost, on average, same as all medical-legal reports.

The decline in the number of registered QMEs, along with the surge in panel requests, means that doctors have greater opportunity to be randomly assigned to a panel. Slightly more than twice as many panels, per registered QME, were issued annually in 2016 (40.5) than in 2007 (20.1).

## Trends in Average Reimbursement/Medical-Legal Report

There was a big increase in reimbursement for medical-legal reports in 2006 driven by Medical-Legal Fee Schedule revisions effective July 1, 2006.[4] Those revisions included an increase in the basic reimbursement multiplier by 25%. The average cost of medical-legal reports has been increasing steadily since that change, even absent changes to the fee schedule. The data on medical-legal report cost, available from several sources (DWC, WCIRB, CWCI ) do not allow us to isolate QME panels from other medical-legal reports, for example, agreed medical evaluators (AMEs) and certain treating physician reports. However, it is likely that the upward trend in average cost per medical-legal report is reflected in QME panel reports, similar to the average for all reports. Combined with the increase in the average number of evaluations performed by each QME, provider income from panel referrals increased greatly over the period of study.

[4] 8 C.C.R. §§Medical-Legal Fee Schedule Regulation, May 2006.

## Total Impact of Trends on QME Income and System Costs

### Table 2. Changes in QME Income and Total Cost of Reports, 2007-2016

| | % Change |
|---|---|
| Number of QMEs | -17% |
| Average $/Report [a] | +69% |
| Average Unreplaced Referrals/QME [b] | +101% |
| Average QME Income from Reports [a] | +240% |
| Total Cost QME Reports [a] | +182% |

[a] Assumes that average cost increase for QME reports is similar to cost increase observed for all medical-legal reports

[b] Panels are sometimes replaced by a second panel, usually in the represented track. These data are based only on final panels.

## Trends in the Sources of QME Panel Requests

The DWC segregates panel requests into two tracks, depending upon whether the worker is represented by an attorney. Representation status determines the set of rules under which a particular request will operate, including how the evaluating QME will be chosen from among the three on the panel. Also, considerably more information is collected by the DWC on the nature of the dispute underlying the panel request when the worker is represented.

The separate tracking of represented and unrepresented cases allows us to examine the source or sources of the large increase we observe in the number of QME panel requests.

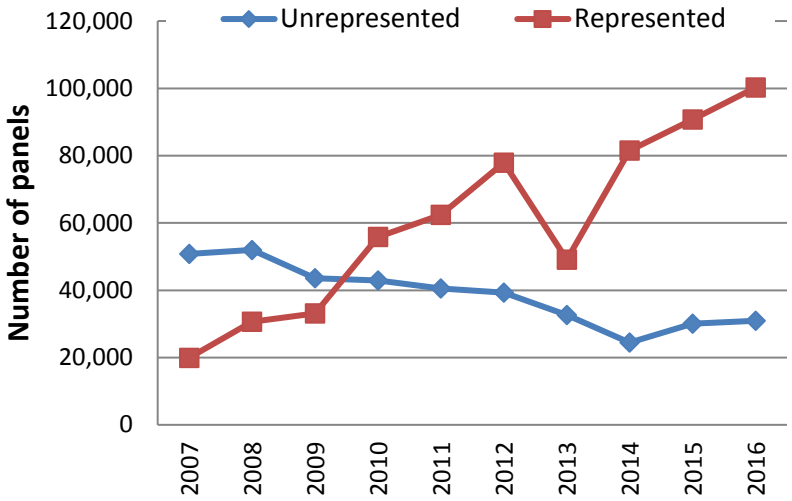


**Figure 2. QME Panel Request by Track**

The growth in the number of panels issued was driven entirely by represented cases. Between 2007 and 2015, the number of unrepresented track panels declined by 20,000, or about 40%. During this period, represented track panels increased by 80,000 or 400%. The number of underlying workers' compensation claims declined from 2007 to 2009 and remained constant from 2009 to 2015, the latest data available.[5] Note that the claim counts are based on the date of injury, which will precede the date that a QME panel is issued, often by 18 months or substantially more. So, trends in panels will lag trends in injury rates. However, when the underlying claim rate is stable, trends observed in the panels can be interpreted as being driven by causes other than the underlying number of injuries.

For the unrepresented track, the decline in panel requests is driven entirely by a decline in requests from workers. Worker requests dropped nearly 70% from 2007 to 2014 before rebounding slightly to a decline of 55% through 2016. Claims administrator filings for the unrepresented track were flat over most of the period.

[5] http://www.dir.ca.gov/dwc/wcis/WCIS_tables/AggregateFROISROIData/AggregateFROISROIData.html.

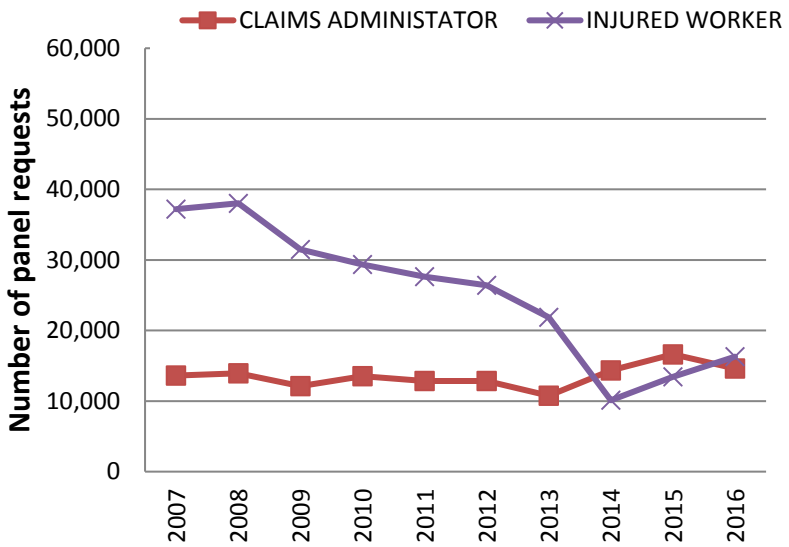


**Figure 3. Requesting Party: Unrepresented Track**

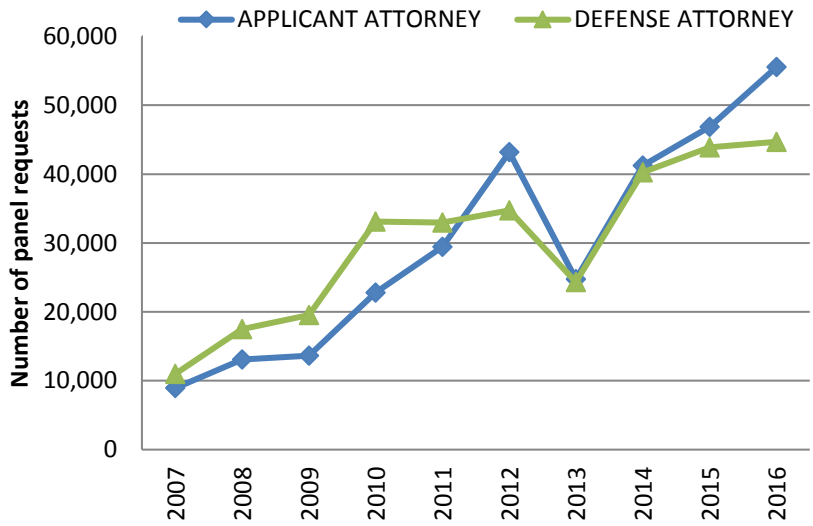


**Figure 4. Requesting Party: Represented Track**

A gradual shift toward a higher percentage of cases in the represented track occurred during this period because of the increasing use of attorneys on claims. Trends in the data on attorney representation are notoriously hard to identify because such data are not consistently collected on claims. Possibly the best source of published data on representation of PD claims is the WCIRB's annual survey of PD claims. For the period 2009-2013, a substantial rise occurred in representation, from 61.6% to 72.7% in Northern California and a smaller rise from 79.1% to

83.4% in Southern California, evaluated at approximately three years post injury.[6] Statewide, the increase was from 73.2% to 79.8%, a rise of 6.5 percentage points. The impact on unrepresented cases is larger in percentage terms because of the smaller proportion of PD cases without representation. The 6.5-percentage-point drop in unrepresented PD cases is almost a 25% decline in the proportion of PD cases that do not involve an attorney (from 26.8% to 20.2%) over the six-year period. The shift to representation on PD claims could account for a substantial proportion of the decline we observe in QME panel requests in the unrepresented track.

For the represented track, the rapid increase in panel requests is similar across both requesting parties. The increase in applicant attorney requests is somewhat steeper in the later period, but the trend lines match very closely. It is likely that the underlying driver is similar for both parties. SB 863 eliminated the requirement that both parties in represented cases attempt to settle on an AME prior to requesting a panel and eliminated the prohibition on agreeing on an AME after this initial period.

The proportion of represented DEU ratings that were based on AME reports dropped from 52% before the legislative change to 42% after the change. Nearly all of the shift from AME reports seems to have been picked up by the panel QME reports for represented cases, not from an increase in the proportion of ratings based on PTP reports. At the same time, a large increase in ratings based on PTP reports was seen for unrepresented cases rated in the DEU.

[6] WCIRB, Claims Working Group, March 30, 2017. Exhibit E7.

### Table 3. DEU Reports by Medical Evaluator Type (in percent)

| | Unrepresented | | Represented | | |
|---|---|---|---|---|---|
| Year | PTP | QME | PTP | QME | AME |
| 2007 | 35.7% | 64.3% | 29.9% | 25.2% | 44.9% |
| 2008 | 34.5% | 65.5% | 24.2% | 24.4% | 51.4% |
| 2009 | 32.3% | 67.7% | 15.4% | 23.7% | 61.0% |
| 2010 | 34.8% | 65.2% | 21.2% | 24.2% | 54.5% |
| 2011 | 33.5% | 66.5% | 20.9% | 28.8% | 50.3% |
| 2012 | 33.4% | 66.6% | 20.6% | 27.3% | 52.1% |
| 2013 | 36.5% | 63.5% | 21.0% | 28.6% | 50.4% |
| 2014 | 40.5% | 59.5% | 21.3% | 29.3% | 49.4% |
| 2015 | 46.1% | 53.9% | 19.7% | 32.8% | 47.5% |
| 2016 | 43.7% | 56.3% | 21.1% | 36.9% | 41.9% |

Note: DEU ratings data based on the date of rating

## Issues Generating Panel Requests

The data on the issues generating panel requests have been gathered exclusively electronically since October 1, 2015, and only for represented cases. Table 4 examines the distribution of issues driving represented QME panel requests. Parties are given the opportunity to enter only a single reason. Consequently, if they list multiple reasons, the more important ones may obscure those that are less important. For example, future medical is likely an issue in many, if not most, claims involving the issue of permanent partial disability (PPD), but it may be seen as the dominant issue and listed as the reason for the request. Similarly, multiple issues may be resolved by the QME in disputes that include "compensability" when no part of the claim is accepted.

### Table 4. Reason for Panel Request, 2015-2016 (Only Represented Track & 2015+)

| Description | Code | 2015 | 2016 |
|---|---|---|---|
| Compensability Dispute (where no part of the claim is accepted) | 001 | 40.2% | 42.5% |
| Permanent Disability | 002 | 24.6% | 21.4% |
| Future Medical Treatment | 003 | 3.8% | 4.2% |
| Temporary Disability | 004 | 7.8% | 6.8% |
| Permanent and Stationary Status | 005 | 11.0% | 11.4% |
| Work Restriction | 006 | 2.1% | 2.2% |
| Ability to Return to Work | 007 | 1.3% | 1.6% |
| Apportionment | 008 | 0.5% | 0.4% |
| Diagnosis | 009 | 5.0% | 6.4% |
| Causation (involving an additional body part); new and further injury; compensability consequence | 010 | 3.7% | 3.3% |

Note: The DWC collects only one dispute code for each represented QME request. If multiple issues are in dispute, we do not take note of the other reasons. A reasonable assumption is that the most important reason is the one listed, but this is not necessarily the case in all situations.

Although the DWC does not track the reason for unrepresented track panel requests, we can gain some insight into the composition by comparing the number of requests for panels to the number of ratings issued by the DWC's DEU based on QME reports in unrepresented cases. All unrepresented track QME reports involving PD are required to be submitted to the DEU for determination of a PD rating and apportionment, if any, between industrial and non-industrial causes. Consequently, the proportion of QME panels submitted to the DEU should be a reasonably accurate estimate of the proportion of unrepresented track panels that involve determinations of PPD, as shown in Table 5.

### Table 5. Unrepresented Track QMEs: Estimated Proportion for PD

| Year | QME Panel requests | DEU-QME rating reports | % of Unrepresented Track QME Panels submitted to DEU |
|---|---|---|---|
| 2007 | 50,803 | 12,430 | 24.5% |
| 2008 | 51,980 | 11,098 | 21.4% |
| 2009 | 43,594 | 11,927 | 27.4% |
| 2010 | 42,890 | 13,801 | 32.2% |
| 2011 | 40,487 | 11,047 | 27.3% |
| 2012 | 39,275 | 8,703 | 22.2% |
| 2013 | 32,620 | 7,432 | 22.8% |
| 2014 | 24,438 | 6,321 | 25.9% |
| 2015 | 30,074 | 5,009 | 16.7% |
| 2016 | 30,881 | 6,013* | 19.5% |

QME panel dates based on the date of request for panel DEU ratings data are based on the date of rating.
*2016 data are through September 2016. Final numbers for 2016 are likely estimated based on 4,010 through September 30, 2016.

We observe that approximately a quarter of QME unrepresented track panels issued resulted in a rating by the DEU. Interestingly, this is close to the proportion that we observe for represented track panels. The most recent years (2015 and 2016) in this series have lower proportions submitted to the DEU, but this decline might be driven by the timing of PPD or delays between when the panel is issued and DEU resolution.

## Impact of SB 863 Restrictions on the Number of Locations for Any Single QME

QMEs can perform evaluations at more than one location. Each QME-location combination is assigned a unique number. Because panels are drawn randomly from all QME locations that meet the requirements for a panel request, QMEs with more locations are assigned panels more often. Figure 5 shows that the average number of locations per QME has been increasing since at least 2007, with a temporary dip between 2011 and 2014.

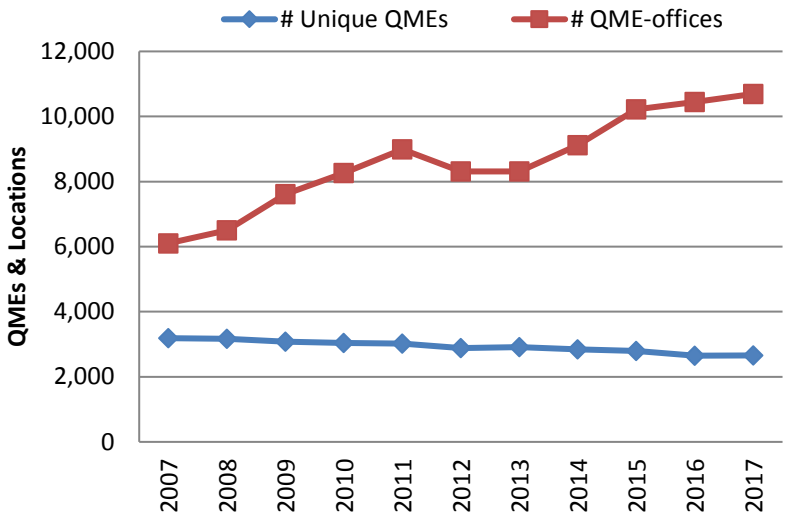


**Figure 5. Trend in the Number of QME Locations**

Table 6 lists the number of QME-by-office combinations each year.

**Table 6. Trend in Average Locations/QME**

| Year | Number of QMEs | Number of QME Office Locations | Average Locations/QME |
|---|---|---|---|
| 2007 | 3,187 | 6,103 | 1.9 |
| 2008 | 3,171 | 6,500 | 2.0 |
| 2009 | 3,078 | 7,611 | 2.5 |
| 2010 | 3,044 | 8,263 | 2.7 |
| 2011 | 3,018 | 8,992 | 3.0 |
| 2012 | 2,879 | 7,342 | 2.6 |
| 2013 | 2,912 | 8,307 | 2.9 |
| 2014 | 2,839 | 9,115 | 3.2 |
| 2015 | 2,795 | 10,219 | 3.7 |
| 2016 | 2,649 | 10,441 | 3.9 |
| 2017 | 2,657 | 10,694 | 4.0 |

SB 863 limited to 10 the number of locations at which an individual QME could schedule examinations. This restriction was in response to a prior study by Neuhauser for CHSWC that revealed that a small number of QMEs was being assigned a disproportionate number of panels by listing a large number of locations for exams. Some QMEs listed more than 100 different locations.

The restriction to 10 offices went into effect in 2012. The number of registered doctor-office combinations dropped by 18.3%, in 2012 but rebounded in 2013 and continued to increase thereafter, exceeding the number of combinations in 2011 by 2014.

The impact of the statutory change was to dramatically reduce the extreme examples. The proportion of doctors with 11 or more offices reached 5% in 2011, but declined to near zero in 2012 and continues at this very low rate. In addition, the exceptions to the 10-location rule involve just a couple doctors with 11–14 offices probably representing geographic exceptions in underserved areas.

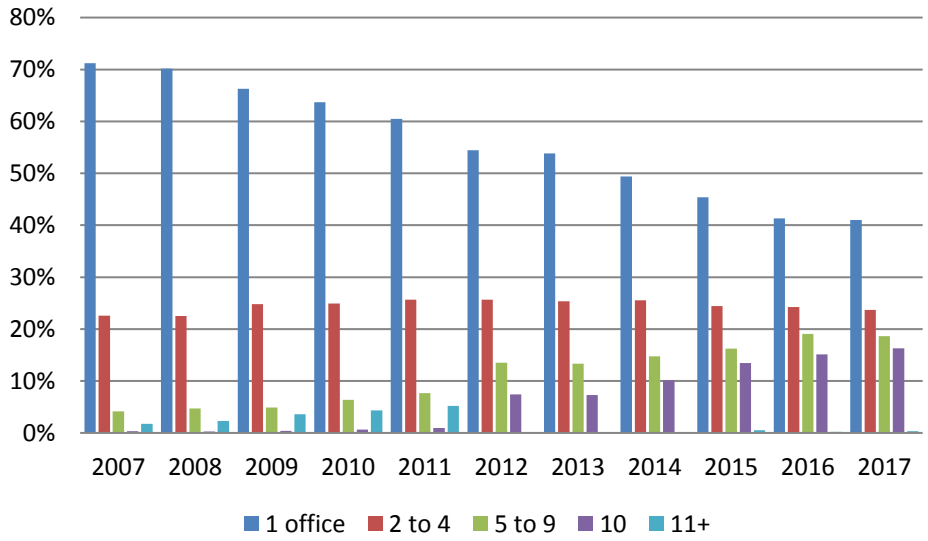


**Figure 6. Trend in Distribution of QMEs by Number of Offices Listed**

At the same time, the number of doctors with a single office also declined, from just over 70% in 2007 to just over 40% in 2017. This was accompanied by an increase in the proportion of doctors with 5 or more offices, particularly doctors with the maximum of 10 locations. While the number of doctors with exactly 10 locations was nominal in 2007, 15% of QMEs had exactly 10 locations in 2017.

SB 863 was passed in September 2012, and the limit on locations became effective as of January 1, 2013. It appears that the industry anticipated the restrictions and reacted in 2012. The industry is dominated by a few large aggregators that act as agents for QMEs. These aggregators may be quite agile in responding to regulatory and economic pressure.

The rapid rise in the average number of panels per active QME masks substantial variation across QMEs. The variation is driven primarily by two factors: the number of office location a QME lists and the specialty or specialties of the QME.

Figure 7 shows that although the extreme examples of a few QMEs dominating panel assignments until 2011 has moderated, the top 10% of QMEs have consistently accounted for 55% or more of all panel assignments, before and after the limitations placed on locations by SB 863. This is a consequence of the proportion of providers with exactly 10 offices and the proportion of those

providers in high-volume specialties, such as orthopedics. Meanwhile, a substantial proportion of QMEs (the bottom 25% by volume of assignments) receive only a small proportion of assignments. Again, this is driven by having one or two office locations and being in infrequently requested specialties.

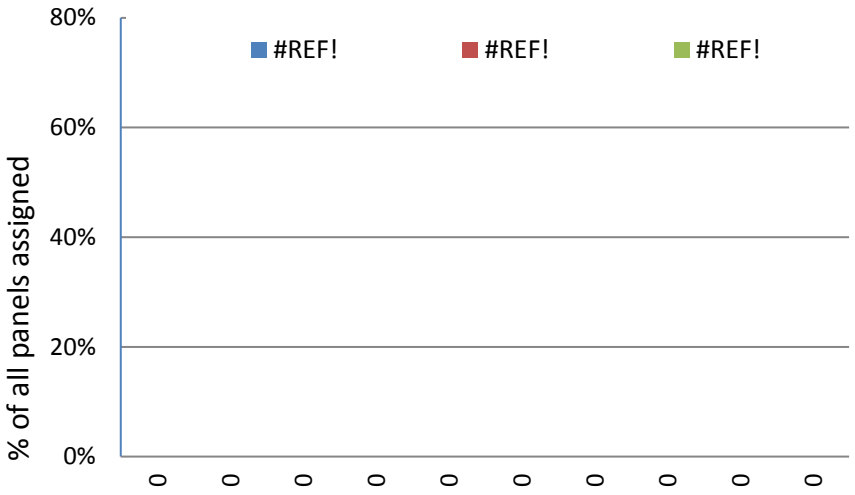


**Figure 7. Trend in Distribution of Panel Assignments among QMEs**

## Availability of QMEs

We highlighted above the continuing decline in the number of registered QMEs at the same time that the number of requests for QME panels has been increasing. Now, the number of panel requests per QME is slightly more than twice as many on average as 10 years earlier. Although the number of locations at which QMEs see workers has increased, this affects only convenience, not availability. Consequently, the decline in QMEs can raise concerns that their availability is becoming problematic. One important dimension of this availability issue is whether particular specialties might be underrepresented, causing additional challenges in scheduling.

In the comparisons below regarding the number of specialists and number of requests, we combine the Orthopedic Surgery (MOS) and Spine (MNB) specialties because virtually all QMEs in one of these specialties is also registered in the other. Therefore, it is useful to consider the number of requests in both specialties relative to the number of unique QMEs registered in the specialties.

The ratio of the rate of requests to the rate of specialists is at least one indicator of potential access issues related to specialties. When the ratio is very high for a specialty, relative to the average for all specialties, one might expect to find that workers, claims administrators, and attorneys have more difficulty scheduling appointments and moving the case to conclusion. Figure 8 gives the ratios for the primary specialties by the proportion of requests. Other specialties account for only very small proportions of requests, less than 1%.

The ratio is highest for the orthopedic specialties, which account for 52% of the requests but only 22% of the specialists available. Only pain medicine specialists have a ratio of requests/specialists that is above average for all specialties. If there is an availability issue, we would expect it to show up most intensely in orthopedic and pain specialties.

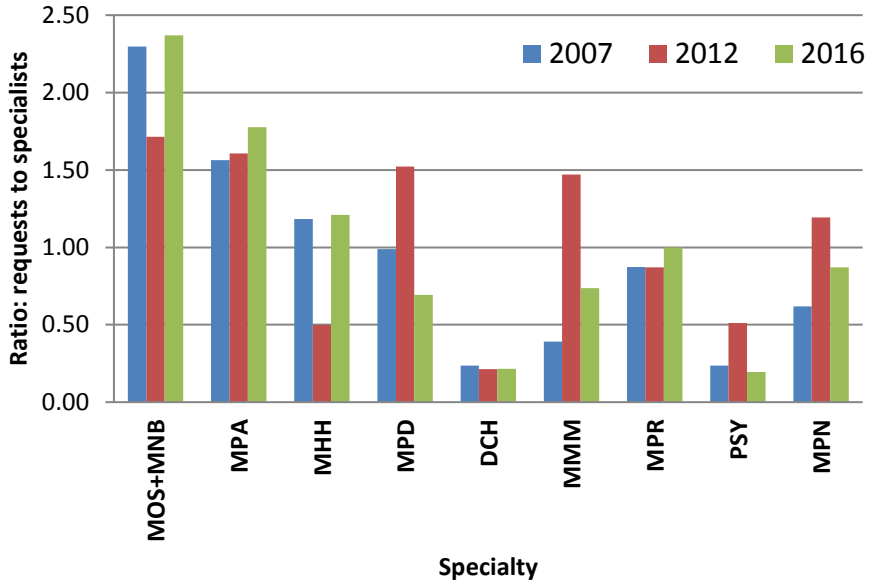


**Figure 8. Trend in Specialties' Availability, 2007-2016 ((% specialty requests)/(% specialists))**

## Table 7. Distribution of Specialties Requested and Specialties Registered

| | | % as of 2016 | |
|---|---|---|---|
| | Description | Requests | Specialists |
| MOS | Orthopedic Surgery (other than Spine or Hand) | 43.9 | 20.2 |
| MNB | Spine | 8.4 | 13.7 |
| MOS+MNB | | 52.3 | 22.1 |
| MPA | Pain Medicine | 7.4 | 4.2 |
| MHH | Hand | 5.5 | 4.6 |
| MPD | Psychiatry (other than Pain Medicine) | 5.2 | 7.6 |
| DCH | Chiropractic | 5.0 | 23.1 |
| MMM | Internal Medicine | 4.2 | 5.7 |
| MPR | Physical Medicine & Rehabilitation | 4.1 | 4.1 |
| PSY | Psychology | 3.3 | 16.9 |
| MPN | Neurology | 3.0 | 3.5 |

One way to evaluate the issue of availability is to examine how often the parties have difficulty in scheduling an appointment. When a panel is replaced, the DWC records the reason for requesting a second panel. One of the reasons that can be given is "QME not available within 60 days." This

could indicate an access issue. We examined the proportion of panels replaced each year because the QME was not available in the statutory timeframe. We evaluated this separately for the represented and unrepresented tracks, because they use different selection processes.

As can be seen in Table 8, the proportion of cases replaced because of a lack of availability is small, 1%-5%, but increasing. This trend suggests the potential for future problems.

### Table 8. Percent of Panels with "QME Not Available" by Track (subsequent request: Reason = QME not available > 60 days)

| | Unrepresented | Represented |
|---|---|---|
| 2007 | 1.0% | 0.7% |
| 2008 | 1.3% | 1.1% |
| 2009 | 1.0% | 1.3% |
| 2010 | 1.1% | 1.7% |
| 2011 | 1.0% | 1.4% |
| 2012 | 1.0% | 1.5% |
| 2013 | 1.3% | 1.8% |
| 2014 | 1.5% | 2.9% |
| 2015 | 2.0% | 4.0% |
| 2016 | 2.8% | 4.7% |

Based on first requests for panels.

Interestingly, we do not find that the availability issue is closely correlated to the volume of panel requests per QME for a given specialty or the ratio for each specialty of requests to registered QMEs. The proportion of cases in which a second panel is requested because of the 60-day delay is similar across specialties, including orthopedics. This suggests that the high volume of requests for orthopedic specialties is not generating any unique problems in access for orthopedics relative to nearly all other specialties. However, the proportion of cases for which "60 days" is the reason for a second panel is three times as high for the pain medicine specialty. Something unique is occurring with the pain medicine specialty that may be driving delays in resolving disputes through the QME process.

## Testing for Bias among High-Volume QMEs

One of the remarkable findings of the previous study was that the small number of extremely high-volume QMEs had a substantial and significant bias in their evaluations of PD. Specifically, very-high-volume QMEs, on average, gave substantially lower PD ratings that the other 99% of

evaluators. This bias extended across their role (PTP, QME, and AME) as well as the pre-2005 PDRS and the AMA *Guides* based PDRS adopted in 2005. The report concluded that workers using the QME process were at risk of having their PD awards unfairly reduced, simply based on the chance assignment of these few conservative evaluators.
We evaluated the impact of the SB 863 reforms that limited the number of locations a QME could list by examining whether workers were likely to be subject to the same bias under the new rules.

### Table 9. Comparing High-Volume QME Ratings to Average Ratings before and after the Limitation to 10 Office Locations (Comparison of DEU Ratings by Top 5% of QMEs, by Number of QME Panel Assignments, to All Other Evaluating Physicians)

| | Coefficient | Std. Error | Significance | | Approximate difference in rating (in %) |
|---|---|---|---|---|---|
| Average Rating | | | | | |
| Before | -0.498 | 0.054 | 0.000 | | -3.2% |
| After | -0.651 | 0.107 | 0.000 | | -3.1% |

| | Coefficient | Std. Error | Significance | Exp(B) | Approximate difference in finding of apportionment (in percentage points) |
|---|---|---|---|---|---|
| Probability of apportionment | | | | | |
| Before | 0.171 | 0.012 | 0.000 | 1.187 | +4.2 |
| After | 0.080 | 0.018 | 0.000 | 1.084 | +2.6 |

Overall, high-volume QMEs (the top 5%) are still conservative in their evaluations of workers for PD relative to all other evaluators. This conservative impact extended to both the underlying rating (lower) and the application of apportionment (more frequent) Over all types of evaluations submitted to the DEU (AME, QME, and PTP for both represented and unrepresented cases), high-volume QMEs give ratings that are, on average, 3.1% to 3.2% lower. This translates to 0.5 to 0.7 percentage points of final rating. However, this is a much smaller difference than observed for the very-high-volume QMEs who targeted by SB 863. In the prior study, we observed that the very-high-volume QMEs gave ratings that were 7% to 18% lower for claims rated under the 2005 PDRS. That difference was three to five times higher than observed in this study.

## Restricted and Suspended QMEs

The Department of Industrial Relations classifies two sets of providers who have been restricted or suspended.

- Physicians, practitioners, and providers issued a notice of suspension under Labor Code section 129.21(a)
- Criminally charged providers whose liens are stayed under Labor Code section 4615.

Of those on one or both lists, 41 providers were also registered as QMEs between 2007 and 2017. During that period, restricted/suspended providers offered QME examinations at 266 locations.

Because these providers had a high average number of locations/QME, they received somewhat proportionately more assignments than the average QME.
In total, restricted or suspended QMEs were assigned to panels 46,616 times, but that represented only a minority of QME assignments (1.6%) during this period. Among the three doctor lists, 45,176 panels (4.6%) had at least one restricted or suspended QME.

However, in some specialties the frequency with which a three-QME panel included a restricted or suspended provider was much higher than average. Table 10 lists the percentage, by specialty, of three-QME panels that included at least one restricted or suspended QME. Three "pain" specialties (MAP, MAA, and MPP)[7] stand out as particularly troubling, with 40%-50% of the panels for these specialties including at least one problem provider. The fourth specialty, Pain Medicine (MPA), had 16% of panels with problem providers, three to four times the average.

These pain specialties have fewer registered QMEs than nearly all other major specialties, ranked by the number of requests. Consequently a substantial number of suspended providers can have a large impact on access.

[7] The Pain Management–Anesthesiology (MAP) and Pain Management–Pain Medicine (MPP) specialties were eliminated in September 2015.

## Table 10. QME Panels with Suspended/Restricted Provider (% by Specialty)

| Specialty requested | % of panels with at least one suspended/restricted provider |
|---|---|
| MAP (Pain Management–Anesthesiology) | 49.6% |
| MAA (Anesthesiology) | 49.2% |
| MPP (Pain Management–Pain Medicine) | 41.4% |
| MPA (Pain Medicine) | 16.7% |
| MPR (Physical Medicine & Rehabilitation) | 16.3% |
| MMH (Internal Medicine–Hematology) | 15.2% |
| MME (Internal Medicine–Endocrinology, Diabetes, and Metabolism) | 11.0% |
| MTO (Otolaryngology) | 8.8% |
| MPN (Neurology) | 8.1% |
| MMN (Internal Medicine–Nephrology) | 7.8% |
| MMI (Internal Medicine–Infectious Disease) | 7.1% |
| MMG (Internal Medicine–Gastroenterology) | 5.9% |
| MMR (Internal Medicine–Rheumatology) | 5.8% |
| POD (Podiatry) | 5.7% |
| MMP (Internal Medicine–Pulmonary Disease) | 5.5% |
| MMV (Internal Medicine–Cardiovascular Disease) | 5.0% |
| MOB (Orthopedic Surgery–Including Back) | 4.5% |
| MPD (Psychiatry) | 3.9% |
| MNB (Spine) | 3.1% |
| MMM (Internal Medicine) | 3.0% |
| MOS (Orthopedic Surgery) | 3.0% |
| MNS (Neurological Surgery) | 2.9% |
| DCH (Chiropractic) | 1.9% |
| MOH (Hand–Orthopedic Surgery) | 0.8% |
| MHH (Hand) | 0.6% |
| PSY (Psychology) | 0.1% |

Average for all panels was 4.6%.

Interestingly, these restricted/suspended doctors, while representing relatively "high volume" because of their multiple locations, differ substantially from the very-high-volume QMEs whom SB 863 sought to restrict. As detailed earlier, the very-high-volume QMEs, both before and after SB 863, are on average "conservative." That is, they tend to give lower than average PPD ratings than QMEs with the same specialty and similar workers and impairments. In contrast, restricted/suspended QMEs offer very "liberal" ratings, that have a high percentage of impairment, high use of Almaraz, and low application of apportionment to non-industrial causes. This generosity exists even after the specialty, year of rating, worker characteristics, impairment type(s), and region are controlled for.

These findings are detailed in Table 11. The restricted/suspended QMEs rate impairments 5.3% higher than the average QME under the AMA *Guides*. They are also 43% more likely to offer a rating under Almaraz, which almost always results in a rating substantially higher than the AMA *Guides*.[8] Similarly, restricted/suspended QMEs are 6.7% less likely to apportion any disability to non-industrial causes.

### Table 11. Comparing Suspended/Restricted QME ratings to All Other Ratings (Comparison of DEU Ratings by Top 5% of QMEs, by Number of QME Panel Assignments, to All Other Evaluating Physicians)

| | Coefficient | Std. Error | Significance | | Approximate difference in rating (in %) |
|---|---|---|---|---|---|
| Average Rating | 0.898 | 0.183 | 0.000 | | +5.3% |
| | | | | | |
| | Coefficient | Std. Error | Significance | Exp(B) | Approximate difference in the finding of apportionment (in percentage points) |
| Probability of apportionment | -0.076 | 0.036 | 0.036 | 0.927 | -1.9 |
| Probability of Alamaraz | 0.358 | 0.050 | 0.000 | 1.431 | +4.3 |

[8] It is difficult to identify the exact impact of the higher use of Almaraz type ratings. The DEU did not, until recently, calculate Almaraz ratings for unrepresented cases, only indicating the existence of an alternative rating. Almaraz ratings on represented cases are found to be substantially higher than those that adhere strictly to the AMA *Guides*. Also, the existence of an Almaraz alternative does not guarantee that the alternative rating will be used. The choice between the AMA *Guides*–based rating and the Almaraz–based alternative is still subject to legal questions.

# Discussion

## Declining Number of QMEs

The number of registered QMEs continues to decline despite a dramatic increase in the average number of panel assignments per QME and an even more dramatic increase in average income for QMEs from writing reports. Even the limit on the number of evaluation locations per provider has not reversed this trend. A relatively small proportion (10%) of QMEs continues to account for the majority (55%-60%) of panel assignments.

This continued concentration of QME assignments among a small number of high-volume QMEs can pose problems but may also provide benefits. Below, we discuss some of the potential problems (e.g., access for workers and barriers to entry by providers). On the positive side, concentration of evaluations among a limited number of QMEs may result in a highly skilled group of specialists and a more consistent rating process for workers and employers.

We saw in the 2010 QME study that problems can arise if the concentration of assignments results in a small group of evaluators who exhibit bias against one party. Or if a small group exhibits other problems, such as high variance in their ratings for similar workers and impairments. We do not observe this type of bias in the current system, despite a lower, but still substantial amount of concentration. The DWC should use data resources to constantly monitor QMEs on dimensions such as the time from panel issue to submission to parties, average rating, fraction apportioned, and the proportion with Almaraz ratings. The data resources and the concentration of reports among a limited number of QMEs make continuous monitoring possible. Outliers could be subject to additional training or additional requirements and restrictions. Evaluation should extend to their role as PTPs and AMEs as well.

## Driving the Decline in QME Requests by Unrepresented Workers

The number of unrepresented injured worker requests for panels has declined for several potential reasons. The requirements for workers filing a request changed. Prior to SB 863, requests by workers required minimal documentation. SB 863 adds some requirements, which may have imposed enough of an additional burden that workers may perceive that the value of objecting to the claims administrator's conclusion is not worth the effort.

The decline in unrepresented worker requests may also be driven by changes in the underlying PD evaluation process preceding any QME panel. The greater use of medical provider networks (MPNs) may have led to more uniform PTP reports involving compensability, P&S status, and PD. Because of greater MPN use, a larger proportion of PTPs may be willing to write reports, resulting in fewer automatic requirements for QME panel.

If the difference between the PTP's evaluation and a QME's evaluation is minor, then the decline in QME requests by unrepresented workers is a net positive for both parties. Any impact on evaluations would be small, and both parties would gain from speeding up resolution of the case by avoiding the QME process.

However, to the extent that workers are not objecting to PTP reports, and claims administrators' offers based on those reports, because of the burden of pursuing an objection, workers may be

receiving lower PD ratings and less frequent rulings in favor of compensability. The data in Table 3 suggest that a growing proportion of unrepresented workers' PD decisions are based on PTP reports, rather than QME reports. This trend became more pronounced after SB 863 added more requirements to unrepresented worker requests.

Before SB 863, an unrepresented injured worker had to submit just a panel request form. Staff who joined the panel could look over the form to ensure that required fields were filled out and then issue the panel. After SB 863, the unrepresented injured worker had to attach a copy of the objection letter with the panel request form and a proof of service on the claims administrator. The extra burden of attaching the claims administrator objection, serving the claims administrator with the QME panel request, and supplying the proof of service statement to the DWC should be expected to deter some workers, possibly a substantial number of them, from submitting a request.

Workers may be confused about which of the many communications they likely received from the claims administrator was the denial letter and/or request for an evaluation. "Service" simply consists of the worker mailing a copy of the panel request to the claims administrator. However, "proof of service" is a legal concept and might be confusing for workers who might believe that simply mailing a copy to the claims administrator constitutes "service." Finally, the "penalty of perjury" language may be seen by the DWC as a legal necessity (nicety?), but the reality is that perjury is never going to be pursued, and this phrase can easily intimidate workers unnecessarily.

Table 12 shows that, with respect to PD, among reports that are rated by the DEU, a larger proportion of unrepresented workers have their ratings based on PTPs, rather than QMEs. This swing has been substantial. At the same time, a similar change has not been seen for represented workers, for whom the proportion of PTP evaluations has remained reasonably consistent.

### Table 12. Trends in Evaluator Type: DEU Reports, 2007-2016 (by Type of Medical Evaluator: PTP, QME, or AME)

| | Unrepresented | | Represented | | |
|---|---|---|---|---|---|
| Year | PTP | QME | PTP | QME | AME |
| 2007 | 35.7% | 64.3% | 29.9% | 25.2% | 44.9% |
| 2008 | 34.5% | 65.5% | 24.2% | 24.4% | 51.4% |
| 2009 | 32.3% | 67.7% | 15.4% | 23.7% | 61.0% |
| 2010 | 34.8% | 65.2% | 21.2% | 24.2% | 54.5% |
| 2011 | 33.5% | 66.5% | 20.9% | 28.8% | 50.3% |
| 2012 | 33.4% | 66.6% | 20.6% | 27.3% | 52.1% |
| 2013 | 36.5% | 63.5% | 21.0% | 28.6% | 50.4% |
| 2014 | 40.5% | 59.5% | 21.3% | 29.3% | 49.4% |
| 2015 | 46.1% | 53.9% | 19.7% | 32.8% | 47.5% |
| 2016 | 43.7% | 56.3% | 21.1% | 36.9% | 41.9% |

DEU ratings data based on date of rating.

At a minimum, the DWC should drop the requirements for proof of service under penalty of perjury. Even having the worker notify the claims administrator is likely unnecessary, because the worker supplies all necessary information to the DWC for this notification, and the DWC does the notification as part of the QME process. (The Proof of Service and QME Form 105 are included in the appendix.)

In addition, the DWC should consider drawing a sample of claims with both a PTP and QME evaluation of PD. Then the DWC could examine whether the findings of both providers are consistent or divergent. This would allow stakeholders to determine whether the trend away from QME requests by unrepresented workers imposes meaningfully lower compensation on injured workers.

Another explanation for the changing composition of evaluating physicians' submitting reports to the DEU for rating may be that workers, pre-SB 863, who would have remained unrepresented and requested a QME now choose to be represented. We see a decline in the proportion of unrepresented track DEU ratings based on QME reports and an increase in the proportion of represented track DEU ratings based on QME reports. This might suggest that the additional

demands on unrepresented workers requesting a QME exam may be causing some workers to seek the assistance of an attorney.

It is very difficult to reach firm conclusions, especially about what causes shifts in representation status and evaluator choice. Most important, a substantial proportion of unrepresented and, especially, represented cases are not submitted to the DEU for rating. Often, the ratings are done by the insurer, one or both parties to a case, or a private rater requested by one or both parties. Second, the volume of ratings has been trending downward, steeply for the unrepresented track and less steeply for the represented track. Consequently, it is very difficult to separate out all the factors that may influence the distribution of ratings among different evaluating provider types and represented vs. unrepresented workers.

The DWC should draw a random sample of initial workers' compensation cases and examine how they are resolved, including issues of compensability and PD. Who is using the QME process, and which evaluations are being rated by the DEU?

The DWC should also increase the data collected on QME requests on unrepresented claims. In particular, the DWC collects the reasons for represented claim QME requests, but does not collect the same data on unrepresented cases. The additional data are included on the unrepresented workers' and claims administrators' QME request forms, but not electronically tracked by the DWC. These data could help the DWC improve its understanding of the drivers behind trends in unrepresented worker claims.

### Increase in QME Requests on Represented Cases

Another trend we observed is the rapid increase in the number of QME requests in represented cases. This is visible in the QME panel request data, in which the increase in requests for the represented track have soared. And we observe a substantial increase in the proportion of consult ratings in the DEU that are based on QME reports.

It is not clear whether this is driven by the shift of previously unrepresented cases into the represented track or whether the elimination under SB 863 of the requirement for the parties to initially seek an AME is increasing QME requests at the expense of AME evaluations.

Because the increase in QME requests in represented claims is so large (+400% since 2007), the DWC should consider convening stakeholders to explore the reasons that parties are increasingly unable to reach agreements more economically and quickly based on the original physicians' opinions.

### Concentration of Assignments among a Limited Proportion of High-Volume QMEs

We observed that, although the restriction to 10 locations eliminated the very-high-volume QMEs, a high proportion of assignments remain concentrated among a limited proportion of QMEs. This does not necessarily represent a problem if the result is highly skilled evaluators primarily responsible for evaluations. And our analysis does not find that the current high-volume QMEs are outliers. However, if the concentration of assignments means that fewer providers are willing to register as QMEs, then the barriers to entry may result in access problems down the line.

Consider two related reasons that more providers may not register as QMEs despite the substantial increase in gross income from evaluations. First, providers with only one or two locations are at a substantial disadvantage against providers with a maximum of 10 locations. Initial registration as a QME requires a significant investment of time and resources. Hence, pursuing registration may remain unprofitable, at least initially, posing a significant barrier to entry for new QMEs.

Second, many, if not most, high-volume QMEs operate though "aggregators" who set up the multiple office locations and field and schedule appointments through a central number. Several private equity funds have entered this field, either funding independent aggregators or buying them outright. How much of the gross payments are split with the aggregators is unknown, as well as whether these payments discourage new entrants. In addition, an open question is whether the market control by aggregators is affecting the dramatic increase in QME requests and/or the rise in average charges per medical-legal report.

The DWC should consider convening stakeholders to identify more information about the operation of aggregators and their impact on the system. Aggregators may offer a valuable service, improving the efficiency of the system and ease of operation for providers. But the concentration of market share may also lead to trends that increase system costs. The DWC could also use QME registration data linked with WCIS medical-legal payment data to examine whether the increases observed in the average cost of medical-legal reports is driven primarily by providers acting through aggregators. This, in turn, would suggest closer monitoring and regulating of the operation of medical-legal aggregators.

## Access and Restricted and Suspended Providers

Providers who have been suspended or restricted by the DWC under Labor Code sections 139.21 and 4615 represent only as small proportion of QMEs. However, they represent a very large proportion of providers in several specialties, particularly pain-related specialties. This suggests two related issues and directions for the DWC.

First, the extraordinarily high concentration of problematic providers in the pain specialties and several other areas indicates a need for the DWC to focus special monitoring and outreach on this community of providers and related professional associations. This could involve additional testing and/or other restrictions on registering for these specialties. The professional associations responsible for certification in these specialties should be included in a process to better vet providers acting as QMEs and more generally as treating physicians.

Second, access concerns may be on the rise. The increase has had a moderate impact across all specialties, suggesting that the DWC continue to monitor this development. In addition, the pain specialties have had a much higher proportion of QME panels replaced because the QME was not available in 60 days. One reason for this concentration may be that the number of QMEs in the pain specialties is relatively small, and the Labor Code sections 139.21 and 4615 restrictions have had a large impact on this group. The DWC should monitor this area particularly closely for access problems.

## Recommendations for Possible Modifications to the QME Process and Future Monitoring

- The very high concentration of restricted and suspended doctors in the pain specialties suggests that the DWC focus special monitoring and outreach on this community of providers and related professional associations. This could involve additional testing and/or other restrictions on registering for these specialties.
- Access should be monitored carefully, with special attention to the pain and orthopedic specialties. The elimination of pain specialists under Labor Code sections 139.21 and 4615 may be resulting in special access problems for these panel requests.
- The DWC could evaluate whether small modifications to the panel assignment process would both encourage more providers to participate as QMEs and reduce access concerns. For example, giving some additional weight in the choice process to QMEs with just one or two locations could spread out the assignments more evenly.
- The DWC should consider eliminating the requirement for unrepresented workers to serve the claims administrator with notice and confirm proof of service under penalty of perjury. This may be intimidating workers and reducing their use of the QME process when challenging the PTP's findings. The DWC could supply notice to the claims administrator and eliminate the need for proof of service documentation.
- The DWC should electronically collect the reason for panel requests in unrepresented cases, similar to the data collected on represented cases. The main reasons for requesting a QME panel are already included on the documentation submitted by workers and claims administrators.
- Because the unrepresented track appears to rely much more heavily on PTP evaluations for medical-legal issues, the DWC should examine how this works in more detail. In particular, the DWC might obtain a sample of PTP P&S reports in cases that requested a QME and compare the findings from the two sets of doctors.
- The proportion and nature of cases that request a QME and the proportion and nature of cases that are evaluated by the DEU are both poorly understood. Consequently, it is difficult to monitor the system performance and fairness to both workers and employers. The DWC should perform a random sampling of initial workers' compensation cases and examine how they are resolved, including issues of compensability and PD. Who is using the QME process, and which evaluations are rated by the DEU?
- The DWC should consider convening stakeholders to identify more information about the operation of aggregators managing the QME's location and appointment process and their potential impact on the system.
- The DWC could use QME registration data linked with WCIS medical-legal payment data to examine whether the increases observed in the average cost of medical-legal reports is driven primarily by providers' use of aggregators.

## Appendix 1: Labor Code Sections

**TITLE 8. INDUSTRIAL RELATIONS**
**DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS**
**CHAPTER 1. DIVISION OF WORKERS' COMPENSATION-QUALIFIED MEDICAL EVALUATOR**
**Article 3. Assignment of Qualified Medical Evaluators, Evaluation Procedure**

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**§ 30. QME Panel Requests.**

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(a) Unrepresented cases. Whenever an employee is not represented by an attorney and either the employee or the claims administrator requests a QME panel pursuant to Labor Code section 4062.1, the request shall be submitted on the Request for Qualified Medical Evaluator Panel Form (Unrepresented Employee), QME Form 105, in section 105.
(1) For disputes covered by Labor Code section 4060, the requesting party shall attach the claims administrator's notice that the claim was denied or a copy of the claims administrator's request for an examination to determine compensability to the QME Form 105;
(2) For disputes covered by Labor Code section 4061 or 4062, if the requesting party is the claims administrator, the claims administrator shall attach a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical determination that requires a comprehensive medical-legal report to resolve to the QME Form 105.
(3) The claims administrator (or if none the employer) shall provide QME Form 105 to the unrepresented employee pursuant to Labor Code sections 4060, 4061, and 4062, by means of personal delivery or by first class or certified mailing.
(4) If the form is incomplete, so that a QME panel selection cannot be made, the request form shall be returned to the requesting party with an explanation of why the QME panel selection could not be made. The Medical Director may delay issuing a QME panel until the Medical Director receives additional information, requested from a party or both parties, needed to resolve the panel request.

(b) Represented cases. Effective October 1, 2015, requests for an initial QME panel in a represented case, for all cases with a date of injury on or after January 1, 2005, shall be submitted electronically utilizing the Division of Workers' Compensation internet site at www.dwc.ca.gov. The Medical Unit will not accept or process panel requests on the QME Form 106 postmarked after September 3, 2015, except as to those cases with dates of injury prior to January 1, 2005 where represented parties agree to obtain a panel of Qualified Medical Evaluators pursuant to the process in Labor Code section 4062.2.
(1) The party requesting a QME panel online shall:
(A) Identify the following elements in the appropriate sections:
1. Panel Request Information Section
i. Date of Injury
ii. Claim Number

iii. Requesting Party
iv. Reason QME Panel is being requested
v. Dispute type
vi. Name of primary treating physician
vii. Date of report being objected to
viii. Date of objection communication
ix. Specialty of treating physician
x. QME Specialty Requested
xi. Opposing Party's QME Specialty Preferred (if known)
2. Employee Information Section
i. Employee First Name
ii. Employee Middle Name
iii. Employee Last Name
iv. Mailing Address
v. City
vi. Zip Code
vii. State
3. Applicant's Attorney Information Section
i. First Name
ii. Last Name
iii. Address
iv. City
v. State Zip
vi. Phone Number
vii. Electronic Adjudication Management System (EAMS) Uniform Assigned Names (UAN)
viii. Firm Name
4. Employee and Claims Administrator Information Section
i. Employer Name
ii. Claims Administrator First Name
iii. Claims Administrator Last Name
iv. Claims Administrator Company Name
v. Address
vi. City
vii. State
viii. Zip
ix. Phone Number
x. Electronic Adjudication Management System (EAMS) Uniform Assigned Names (UAN)
5. Defense Attorney Information Section
i. First name
ii. Last name
iii. Defense Attorney Firm Name
iv. Address/P.O. Box
v. City
vi. State Zip
vii. Phone Number
viii. EAMS UAN Number

(B) Scan and upload the following supporting documentation when prompted:
1. a written request for an examination to determine compensability for disputes covered by Labor Code section 4060; or
2. a written objection indicating the identity of the primary treating physician, the date of the primary treating physician's report that is the subject of the objection and a description of the medical determination that requires a comprehensive medical - legal report to resolve, for disputes covered by Labor Code sections 4061 and 4062;
(C) Print and serve a paper copy of the online request, the panel list, and a copy of any supporting documentation that was submitted online, upon the opposing party with a proof of service, within 1 (one) working day after generating the QME panel list. Within 10 (ten) days of service of the panel, each party may strike one name from the panel.
(2) Requests may be made twenty-four hours a day, seven days a week. For determining the timeliness of requests under Labor Code section 4062.2, requests made on Saturday, Sunday or a holiday will be deemed to have been made at 8:00 a.m. on the next business day. Requests made Monday through Friday after 5:00 p.m. and before 12:00 a.m. will be deemed to have been made at 8:00 a.m. on the next business day, and requests made between 12:00 a.m. and 8:00 a.m. will be deemed to have been made at 8:00 a.m. on the same business day.
(3) Upon submission of the request online, the QME panel selection will be generated automatically. After issuance of a panel, any subsequent request on the same claim, whether made on the same day or not, is a duplicate request. In the event of technical difficulties, such that a panel QME selection cannot be generated on-line, the requesting party may contact the Medical Unit and shall reference the error code or message.
(c) If after the issuance of a panel it appears to the satisfaction of the Medical Director that the panel was issued by mistake, misrepresentation of fact contained in the forms or document filed in support of the request, or the parties have agreed to resolve their dispute using an AME or by other agreement, the issued panel may be revoked. Notice of the revocation shall be sent to parties listed on the panel request.
(d)(1) After a claim form has been filed, the claims administrator, or if none the employer, may request a panel of Qualified Medical Evaluators only as provided in Labor Code section 4060, to determine whether to accept or reject a claim within the ninety (90) day period for rejecting liability in Labor Code section 5402(b), and only after providing evidence of compliance with Labor Code Section 4062.1 or 4062.2.
(2) Once the claims administrator, or if none, the employer, has accepted as compensable injury to any body part in the claim, a request for a panel QME may only be filed based on a dispute arising under Labor Code section 4061 or 4062.
(e) If the request is submitted by or on behalf of an employee who does not reside within the state of California, the geographic area of the QME panel selection within the state shall be determined by agreement between the claims administrator, or if none the employer, and the employee. If no agreement can be reached, the geographic area of the QME panel selection shall be determined for an unrepresented employee by the employee's former residence within the state or, if the employee never resided in the state, by the geographic location of the employer's place of business where the employee was employed, and for a represented employee by the office of the employee's attorney.
(f) To compile a panel list of three (3) independent QMEs randomly selected from the specialty designated by the party holding the legal right to request a QME panel, the Medical Director shall exclude from the panel, to the extent feasible, any QME who is listed by another QME as a

business partner or as having a shared specified financial interest, as those terms are defined in sections 1 and 29 of Title 8 of the California Code of Regulations.
(g) The time periods specified in Labor Code sections 4062.1(c) and 4062.2(c), respectively, for selecting an evaluator from a QME panel and for scheduling an appointment, shall be tolled whenever the Medical Director asks a party for additional information needed to resolve the panel request. These time periods shall remain tolled until the date the Medical Director issues either a new QME panel or a decision on the panel request.
NOTE: Forms referred to above are available at no charge by downloading from the web at www.dir.ca.gov/dwc/forms.html or by requesting at 1-800-794-6900.
Note: Authority cited: Sections 133, 139.2, 4061, 4062 and 5307.3, Labor Code. Reference: Sections 139.2, 4060, 4061, 4062, 4062.1, 4062.2, 4062.3, 4064 and 4067, Labor Code.

**HISTORY**
1. New article 3 and section filed 8-1-94; operative 8-31-94 (Register 94, No. 31).
2. Amendment of subsection (b) and new subsections (d)-(e) filed 8-23-96; operative 9-22-96 (Register 96, No. 34).
3. Amendment of subsections (a), (c) and (d)(1) filed 4-14-2000; operative 5-14-2000 (Register 2000, No. 15).
4. Amendment of section and Note filed 1-13-2009; operative 2-17-2009 (Register 2009, No. 3).
5. Amendment of subsection (b)(1), repealer of subsection (b)(2), subsection renumbering, amendment of newly designated subsection (b)(4) and repealer of subsections (d)(3)-(4) filed 12-31-2012 as an emergency; operative 1-1-2013 pursuant to Government Code section 11346.1(d) (Register 2013, No. 1). A Certificate of Compliance must be transmitted to OAL by 7-1-2013 or emergency language will be repealed by operation of law on the following day.
6. Amendment of subsection (b)(1), repealer of subsection (b)(2), subsection renumbering, amendment of newly designated subsection (b)(4) and repealer of subsections (d)(3)-(4) refiled 7-1-2013 as an emergency; operative 7-1-2013 (Register 2013, No. 27). A Certificate of Compliance must be transmitted to OAL by 9-30-2013 or emergency language will be repealed by operation of law on the following day.
7. Certificate of Compliance as to 7-1-2013 order, including further amendment of section, transmitted to OAL 8-2-2013 and filed 9-16-2013; amendments operative 9-16-2013 pursuant to Government Code section 11343.4(b)(3) (Register 2013, No. 38).
8. Amendment of section and Note filed 8-12-2015; operative 9-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2015, No. 33).

**LABOR CODE-LAB**

**DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS [50-176]**

(*Division 1 enacted by Stats. 1937, Ch. 90*)

**CHAPTER 5. Division of Workers' Compensation [110-139.6]**

(*Heading of Chapter 5 amended by Stats. 2002, Ch. 6, Sec. 23.5.*)

**139.21.**

(a) (1) The administrative director shall promptly suspend, pursuant to subdivision (b), any physician, practitioner, or provider from participating in the workers' compensation system as a physician, practitioner, or provider if the individual or entity meets any of the following criteria:

(A) The individual has been convicted of any felony or misdemeanor and that crime comes within any of the following descriptions:

(i) It involves fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient.

(ii) It relates to the conduct of the individual's medical practice as it pertains to patient care.

(iii) It is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system.

(iv) It is otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(B) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.

(C) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(2) The administrative director shall exercise due diligence to identify physicians, practitioners, or providers who have been suspended as described in subdivision (a) by accessing the quarterly updates to the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

(b) (1) The administrative director shall adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the administrative director is required to suspend the physician, practitioner, or provider pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the physician, practitioner, or provider requests a hearing and, in that hearing, the physician, practitioner, or provider provides proof that paragraph (1) of subdivision (a) is not applicable. The physician, practitioner, or provider may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the administrative director finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician, practitioner, or provider.

(3) The administrative director shall have power and jurisdiction to do all things necessary or convenient to conduct the hearings provided for in paragraph (2). The hearings and investigations may be conducted by any designated hearing officer appointed by the administrative director. Any authorized person conducting that hearing or investigation may administer oaths, subpoena and require the attendance of witnesses and the production of books or papers, and cause the depositions of witnesses residing within or

without the state to be taken in the manner prescribed by law for like depositions in civil cases in the superior court of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure.

(c) The administrative director shall promptly notify the physician's, practitioner's, or provider's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the division's qualified medical evaluator and medical provider network databases, as appropriate.

(d) Upon suspension of a physician, practitioner, or provider pursuant to this section, the administrative director shall give notice of the suspension to the chief judge of the division, and the chief judge shall promptly thereafter provide written notification of the suspension to district offices and all workers' compensation judges. The method of notification to all district offices and to all workers' compensation judges shall be in a manner determined by the chief judge in his or her discretion. The administrative director shall also post notification of the suspension on the department's Internet Web site.

(e) The following procedures shall apply for the adjudication of any liens of a physician, practitioner, or provider suspended pursuant to subparagraph (A) of paragraph (1) of subdivision (a), including any liens filed by or on behalf of the physician, practitioner, or provider or any clinic, group or corporation in which the suspended physician, practitioner, or provider has an ownership interest.

(1) If the disposition of the criminal proceeding provides for or requires, whether by plea agreement or by judgment, dismissal of liens and forfeiture of sums claimed therein, as specified in the criminal disposition, all of those liens shall be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding, and orders notifying of those dismissals may and shall be entered by workers' compensation judges.

(2) If the disposition of the criminal proceeding fails to specify the disposition to be made of lien filings in the workers' compensation system as set forth in paragraph (1), all liens pending in any workers' compensation case in any district office within the state shall be consolidated and adjudicated in a special lien proceeding as described in subdivisions (f) to (i), inclusive.

(f) After notice of suspension, pursuant to subdivision (d), and if subdivision (e) applies, the administrative director shall appoint a special lien proceeding attorney, who shall be an attorney employed by the division or by the department. The special lien proceeding attorney shall, based on the information that is available, identify liens subject to disposition pursuant to subdivision (e), and workers' compensation cases in which those liens are pending, and shall notify the chief judge regarding those liens. Based on this information, the chief judge shall identify a district office for a consolidated special lien proceeding to adjudicate those liens, and shall appoint a workers' compensation judge to preside over that proceeding.

(g) It shall be a presumption affecting the burden of proof that all liens to be adjudicated in the special lien proceeding, and all underlying bills for service and claims for compensation asserted therein, arise from the conduct subjecting the physician, practitioner, or provider to suspension, and that payment is not due and should not be made on those liens because they arise from, or are connected to, criminal, fraudulent, or abusive conduct or activity. A lien claimant shall not have the right to payment unless he or she rebuts that presumption by a preponderance of the evidence.

(h) The special lien proceedings shall be governed by the same laws, regulations, and procedures that govern all other matters before the appeals board. The administrative director shall promulgate regulations for the implementation of this section.

(i) If it is determined in a special lien proceeding that a lien does not arise from the conduct subjecting a physician, practitioner, or provider to suspension, the workers' compensation judge shall have the discretion to adjudicate the lien or transfer the lien back to the district office having venue over the case in which the lien was filed.

(j) At any time following suspension, a physician, practitioner, or provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice, which shall constitute a final disposition of the claim for compensation asserted therein.

(k) The provisions of this section shall not affect, amend, alter, or in any way apply to the provisions of Section 139.2.

(*Added by Stats. 2016, Ch. 852, Sec. 1. Effective January 1, 2017.*)

**LABOR CODE-LAB**

**DIVISION 4. WORKERS' COMPENSATION AND INSURANCE [3200-6002]**
(*Heading of Division 4 amended by Stats. 1979, Ch. 373.*)

**PART 2. COMPUTATION OF COMPENSATION [4451-4856]**
(*Part 2 enacted by Stats. 1937, Ch. 90.*)

**CHAPTER 2. Compensation Schedules [4550-4856]**
(*Chapter 2 enacted by Stats. 1937, Ch. 90.*)

**ARTICLE 2. Medical and Hospital Treatment [4600-4615]**
(*Article 2 enacted by Stats. 1937, Ch. 90.*)

**4615.**

(a) Any lien filed by or on behalf of a physician or provider of medical treatment services under Section 4600 or medical-legal services under Section 4621, and any accrual of interest related to the lien, shall be automatically stayed upon the filing of criminal charges against that physician or provider for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the Medicare or Medi-Cal programs. The stay shall be in effect from the time of the filing of the charges until the disposition of the criminal proceedings. The administrative director may promulgate rules for the implementation of this section.

(b) The administrative director shall promptly post on the division's Internet Web site the names of any physician or provider of medical treatment services whose liens were stayed pursuant to this section.

(*Added by Stats. 2016, Ch. 868, Sec. 7. Effective January 1, 2017.*)

## Appendix 2: QME Panel Request Form 105

**State of California, Division of Workers' Compensation**

**REQUEST FOR QUALIFIED MEDICAL EVALUATOR PANEL**

**(Unrepresented Employee)**

TO REQUEST A QUALIFIED MEDICAL EVALUATOR (QME) PANEL FOR AN UNREPRESENTED EMPLOYEE:

1. Complete this form (print or type the information). Sign and date at bottom.
2. If the request is made to determine if the injury is work-related, include a copy of the claims administrator's notice that the claim was denied, or a copy of the claims administrator's request for an evaluation.
3. Complete the attached Proof of Service.
4. For Employee: Mail the completed signed form and Proof of Service to: Division of Workers' Compensation – Medical Unit
   P.O. Box 71010, Oakland, CA 94612 (510)
   286-3700 or (800) 794-6900
5. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.
6. For Claims Administrator/Defense Attorney: Mail the completed signed form, attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.

**Panel Request Information :**

**Date of Injury:**_____ **Claim Number:**_____ **Specialty Requested:**_____

(Select only ONE specialty)

**Requesting Party:** ☐ **Employee** ☐ **Claims Administrator** ☐ **Defense Attorney**

**Reason for QME Panel Request (check one):**

☐ To determine if the injury is work-related (attach claims administrator's notice that claim was denied or a copy of the claims administrator's request for an evaluation).
☐ Objection to Primary Treating Physician's determination regarding temporary disability, permanent disability, or the need for future medical care.
☐ Work injury claim is accepted for one or more body parts, there is a dispute over additional body parts.
☐ Other (specify non-medical treatment dispute): _____

**Employee Information**

First Name:_____ Middle Initial:___ Last Name: _____ Street

Address or P.O. Box:_____ City:_____

_____ State _____ Zip Code:_____

If currently not living in state, enter the California zip code on date of injury:_____

If never resided in state, enter the California zip code agreed on for the evaluation: _____

**Employer/Claims Administrator Information**

Employer:_____Zip Code of Employer:_____

Claims Administrator Company Name:_____Adjuster/Contact Name (if known):_____

Street Address or P.O. Box:_____

City:_____State:_____Zip Code:_____Phone No.:_____

**Requestor Signature**:_____**Date:**_____

# PROOF OF SERVICE

**Instructions:**

**1. Complete the Proof of Service.**

**2. For Employee: Mail the completed signed form and Proof of Service to:**
**Division of Workers' Compensation – Medical Unit**
**P.O. Box 71010, Oakland, CA 94612**
**(510) 286-3700 or (800) 794-6900**

**3. For Employee: Mail or deliver a signed copy of the form and Proof of Service to your Claims Administrator.**

**4. For Claims Administrator/Defense Attorney: Mail the completed signed form attach a copy of the written objection to an opinion of a treating physician, and Proof of Service, to the Medical Unit with a copy served to the Employee.**

I declare that I am a resident of or employed in the county of _____, California; I am over the age of eighteen years.

On _____, I served the attached completed Form 105 on the following parties:

☐ by mail to:

_____
Name of Employee or Claims Administrator

_____
Street Address

_____
City, State, Zip code

☐ by hand delivery to:

_____
Name

_____
Street Address

_____
City, State, Zip code

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

**Executed on _____, at _____, California**

**Type or Print Name: _____ Signature:**

_____

**For Use with the QME Panel Request Form 105**

**MD/DO SPECIALTY CODES**

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

**NON-MD/DO SPECIALTIES CODES**

| | |
|---|---|
| ACA | Acupuncture |
| DCH | Chiropractic |
| DEN | Dentistry |
| OPT | Optometry |
| POD | Podiatry |
| PSY | Psychology |

*Do not file this page with your form!*

**Reference**

WCIRB, Losses and Expenses Reports, 2009-2016.