

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT

Qualified Medical Evaluator

Competency Examination Study Guide

DWC Medical Unit
10/20/2015

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Introduction

The purpose of this guide is to highlight the parts of the California workers' compensation law that will be tested in during the Qualified Medical Evaluator (QME) competency examination. Section I of this guide introduces Labor Code section 139.2 which regulates the accreditation and reaccreditation of qualified medical evaluators. Section II discusses the substantive disputes that are raised by injured workers and claims administrators that are resolved by QMEs. Section III discusses how QMEs are chosen in cases where the injured worker is represented or unrepresented by an attorney. Section IV highlights the QME examination process from the initial scheduling of the appointment, the examination process and post examination procedures.

You will find references throughout this document to workers' compensation case law, en banc decisions, California Labor Code and regulations, a physician's guide and forms used for qualified medical evaluator processes. That information can be found by using the links in the resource in Section V at the end of this guide.

I. QME Accreditation and Reaccreditation

a. Labor Code section 139.2.

In 1991, the legislature enacted Labor Code section 139.2 authorizing the creation of the QME program. Labor Code section 139.2 also sets forth the law regarding appointment, certification, recertification, termination, discipline, continuing education requirements and other matters concerning medical evaluations, and submission of reports. The QME regulations are found at title 8 of the California Code of Regulations, sections 1 through 159 and are sometimes referred to as the QME rules. The statute authorizes the Administrative Director (AD) to appoint physicians, as defined in Labor Code section 3209.3, as evaluators for two year terms. Labor Code section 3209.3 defines the term “physician” to include “physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.” The grouping of the various medical providers under the term “physician” does not mean that optometrists and chiropractors may represent, advertise, or hold themselves out as physicians. (*Lab. Code §§ 3209.4, 3209.6.*)

Regardless of the type of “physician” seeking appointment all QMEs must pass the QME competency examination, complete a 12 hour course in disability evaluation report writing and, with a couple of exceptions, devote at least one-third of their total practice time to providing direct medical treatment or have served as an agreed medical evaluator (AME) on eight or more occasions in the 12 months prior to applying to be appointed as a QME. (*Lab. Code §139.2(b) (1), (b) (2).*)¹ These general appointment requirements are made more specific in other sections of 139.2; the physicians listed in Labor Code section 3209.3 have different paths to appointment which are listed in Labor Code sections 139.2 (b) (3) through 139.2 (b) (5). Additional requirements for appointment, including the requirements for the report writing course, appear at sections 11 and 11.5 of the QME regulations. (*Cal. Code of Regs., tit.8, §§ 11, 11.5.*)

¹ The exception to the 1/3 treatment requirement and its 8 AME alternative is if the physician is appointed under section 15 of the QME regulations that regulates the certification of retired, teaching or disabled physicians as QMEs. (*Cal. Code of Regs., tit. 8, § 15.*)

The AD recognizes physician specialties as “one for which the physician is board certified or, one for which a medical doctor or doctor of osteopathy has completed postgraduate specialty training as defined in section 11(a)(2)(A) or held an appointment as a QME in that specialty on June 30, 2000, pursuant to Labor Code Section 139.2.” (*Cal. Code of Regs., tit.8, §§ 13.*) For a QME to be placed in a specialty “physician's licensing board must recognize the designated specialty board and the applicant for QME status must have provided to the AD documentation from the relevant board of certification or qualification.” (*Cal. Code of Regs., tit.8, §§ 12.*)

At the conclusion of a two year period of appointment a QME may seek reappointment by meeting the original requirements of appointment and by meeting the following additional requirements: be in compliance with all applicable regulations and evaluation guidelines adopted by the AD, completion of at least 12 hours of continuing education in impairment evaluation or workers' compensation-related medical dispute evaluation approved by the AD in the previous 24 months before reappointment, has not had more than five evaluations rejected by a workers' compensation judge while serving as a QME and, finally, has not been terminated, suspended, or placed on probation by their licensing board. (*Lab. Code §139.2(d).*) The failure of an applicant to meet any of the above referenced requirements allows the AD in his or her discretion to reappoint or deny reappointment to an applicant. The AD is prohibited from reappointing a QME whose license to practice has been revoked or terminated by their licensing board.

The AD may in his or her discretion terminate or suspend a QME without a hearing when one of the following events occurs:

1. The QME's license to practice has been suspended so as to preclude practice or the license has been revoked or terminated by their licensing board; or
2. The QME has failed to pay the required fee to become a QME.

Each QME is required to pay a fee upon appointment and yearly thereafter. (*Lab. Code §139.2(n).*) The fee is based on a combination of the number of offices the evaluator uses to evaluate injured workers and the number of evaluations performed by the QME. (*Cal. Code of*

Regs., tit. 8, §§17,18.) The AD may discipline QMEs after a hearing for violating reasons listed in Labor Code section 139.2 (k); discipline includes suspension or termination².

II. Substantive medical disputes resolved by QMEs-Labor Code sections 4060-4062

The sections below describe the general kinds of disputes that a QME sees when evaluating injured workers. The parties raise disputes about medical determinations made by the injured worker's primary treating physician in compliance with the sections below. Different procedures are used depending on how the QME is chosen, which in turn depends on whether the injured worker is represented by an attorney; these procedures will be discussed later.

a. Labor Code section 4060-Disputes Over the compensability of the claim

A dispute over compensability is a dispute over whether work caused an injury recognized under the workers' compensation laws of California. The types and kinds of injuries recognized under California law is discussed on pages 17 to 19 of the 3rd edition of the Industrial Medical Council's Physician's Guide, Medical Practice in the California Workers' Compensation System, Third Edition (Physician's Guide). The Physician's Guide is available in the DWC website and a link to its location is found in Section V of this study guide. The discussion in Chapter 2 of the Physician's Guide is still applicable on the issues of causation of injury, except for the section on lighting up of pre-existing disabilities. You should consult subsequent developments in case law on compensability issues with particular emphasis on psychiatric injuries.

The parties use this section to resolve disputes over compensability at any time after the claim form is filed, but before the claim or any body part has been accepted by the claims administrator. Once the claims administrator has accepted any body part, neither party may request a QME panel based on compensability because Labor Code section 4060 does not apply. For example, an injured worker files a claim form for an injury to the back and the foot. If the claims administrator accepts the injury to the back, the parties may not use Labor Code section 4060 to

² The discipline sections of the QME rules appear at sections 60 to 65 of title 8 of the California Code of Regulations.

determine if the foot injury is a work related injury; instead, the parties must use Labor Code section 4062 to resolve the issue.

If the injured worker is not represented, the claims administrator must either tell the worker that they *request* an examination to determine compensability or must send a worker a notice the claim is denied and the injured worker *may* request a QME for this purpose.

In either case, the injured worker has a right to request an evaluation, and the injured worker always has the first right to submit the QME request form and to specify the specialty of the QME panel.

The only reports admissible before a workers' compensation judge (WCJ) to resolve the issue of compensability is the report of a properly acquired QME and the reports of a primary treating physician. Neither party shall be liable for any comprehensive medical-legal evaluation performed by other than the treating physician, except as provided in Labor Code section 4060.

b. Labor Code section 4061-Permanent Disability Disputes:

An evaluation under Labor Code section 4061 is invoked by the injured worker or the claims administrator objecting to a determination of the primary treating physician about the existence and the extent of permanent disability or whether the injured worker is in need of future medical care. (*Lab. Code §§ 4061(b), (c).*)

The trigger for the permanent disability dispute is the termination of temporary disability, generally caused by a medical report of the primary treating physician that finds the injured worker permanent and stationary (P&S) or has reached maximum medical improvement (MMI) that requires the claims administrator to send certain notices to the injured worker.³

³ Labor Code section 4061(a) contains the required notices that must be sent to the injured worker and reads in full:

“Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the

Like the compensability examination, the procedure for obtaining a panel of QME's depends on how the QME is chosen which depends on whether the injured worker is represented by an attorney. (*Lab. Code §§ 4062.1; 4062.2.*) The only admissible reports before a WCJ on the issue of permanent disability in addition to the report of the QME are an evaluation or evaluations prepared by the treating physician or physicians. (*Lab. Code §§ 4062.1 (i)*)

California has had unique methods to determine disability for decades. Most states have based the evaluation of disability on the American Medical Association's Guides to the Evaluation of Permanent Impairment. California adopted these guides starting on January 1, 2005 to implement a more objective process. Physicians now measure *impairment* by using *The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition)* for both description and percentages of impairment. A rater will change the impairment rating into a disability rating by applying scheduled adjustments such as age and occupation. QMEs are expected to know the basic principles of the AMA Guides. In *Blackledge v. Bank of America (2010) 75 Cal. Comp. Cases 613(en banc)*, the Workers' Compensation Appeals Board noted the role of an evaluator in a permanent disability evaluation is to assess the injured employee's whole person impairment percentage by a report that sets forth facts and reasoning to support its conclusions and that comports with the AMA guides and case law. (*Blackledge, 75 Cal. Comp. Cases at 615.*) It further defines the roles of the WCJ and rater with regards to a formal rating in a workers' compensation proceeding.

Not all injured workers who are evaluated after January 1, 2005 will have reports based on the AMA Guides. For instance, if an injured worker had a permanent and stationary report

determination was made, whether there is need for future medical care, and whether an indemnity payment will be deferred pursuant to paragraph (2) of subdivision (b) of Section 4650.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine whether there will be the need for future medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable."

describing permanent disability completed prior to January 1, 2005, any subsequent report would use a previous permanent disability rating schedule not the permanent disability rating schedule adopted effective January 1, 2005 based on the AMA Guides.⁴ For injuries prior to January 1, 2005 when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice required by Labor Code section 4061 to the injured worker, the worker's reports would be written using the AMA Guides.

If a worker is injured on or after January 1, 2005, he or she will have any impairment rating done using the AMA Guides. A whole person impairment rating based on the body or organ rating system of the AMA Guides may be increased by up to 3% WPI if the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the standard WPI rating for that body part or organ. This extra 1 to 3% rating can only be added if there is a ratable impairment. In most circumstances, the additional rating for pain should not be necessary as the usual impairment ratings already provide for a normal amount of pain for any given injury. Chapter 18 of the AMA Guides explains when this extra rating can be given.

A QME must use his or her clinical judgment in applying the AMA Guides and may utilize any chapter, table, or method in that publication that most accurately reflects the injured employee's impairment within "the four corners" of the guides under the appropriate circumstances. This includes an explanation why a departure from the strict application of the guides may be appropriate for specific circumstances. (*Milpitas Unified School District v. Workers' Comp. Appeals Bd. (Guzman)* (2010) 187 Cal. App 4th 808.) The *Guzman* Court of Appeal decision, just cited, and the appeals board decision found at 74 Cal. Comp. Cases 133 should be reviewed to fully understand this concept.

⁴ The Permanent disability rating schedule (PDRS) has three versions currently in use: January 2005 (used to rate permanent disability for injuries occurring on or after January 1, 2005 or any date of injury when there has been either no comprehensive medical-legal report, or no report of the treating physician indicating the existence of permanent disability or when the employer is not required to provide a notice to the injured worker under Labor Code section 4061), April 1997 (used to rate permanent disability for injuries occurring on or after April 1, 1997) and July 1988 (used to rate permanent disability for injuries occurring on or after July 1, 1988.)

For psychiatric injuries impairment is measured by using the global assessment of function (GAF), not the AMA guides, utilizing the terminology and criteria of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (DSM-III-R)*, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine. (*Lab. Code §§ 139.2(j) (4); 3208.3 (a).*)

If the evaluator declares the injured worker permanent and stationary for the body part evaluated and the evaluator finds that the injury has caused permanent partial disability, the evaluator shall complete the Return-to-Work & Voucher Report and serve it on the claims administrator and the employee together with the medical report. (*DWC-AD Form 10133.36.*)

If the employee's condition is not permanent and stationary or has not reached maximum medical improvement, a permanent disability evaluation cannot be completed because the rating of impairment and apportionment requires the employee's condition to be stationary. (See pg. 38 of the Physician's Guide for a discussion of the concept of P&S status; *Cal. Code of Regs., tit. 8, § 10152; Department of Rehabilitation v. Workers' Comp. Appeals Bd. (2003) 30 Cal.4th 1281,1292.*) However, under certain narrowly proscribed circumstances if an employee's condition is insidious and slowly progressive, the employee's disability may be rated. (*General Foundry Service v. Workers' Comp. Appeals Bd. (1986) 42 Cal.3d 331.*)

Apportionment is a determination that must be made if some portion of an injured employee's permanent disability is due to previous disabilities or some other cause, rather than the current injury, and is an estimate of the approximate percentage of the permanent disability which was caused by a work related injury and the approximate percentage which was caused by other factors. (*Lab. Code §§ 4663, 4664.*) Injured workers are required on request to "disclose all previous permanent disabilities or physical impairments" (*Lab. Code § 4663(d).*)

A discussion of apportionment is required "when a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability." (*Lab. Code § 4663 (b).*) In fact, when a report discusses permanent disability and omits a discussion of apportionment the report is incomplete. (*Lab. Code § 4663(c).*)

Apportionment applies only to permanent disability; it is never appropriate to assess

apportionment on the issue of industrial causation of an injury. (*Escobedo v. Marshalls* (2005) 70 Cal. Comp. Cases 604, 611(en banc).)⁵ The standard for determining apportionment is:

“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.” (*Lab. Code § 4663(c)*.)

An opinion on apportionment must “disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles.” (*Escobedo* 70 Cal. Comp. Cases at 621.) Also a physician cannot make an arbitrary percentage finding simply because it is "fair" in a particular case. To illustrate the point below is an example from the *Escobedo* case:

“For example, if a physician opines that approximately 50% of an employee's back disability is directly caused by the industrial injury, the physician must explain how and why the disability is causally related to the industrial injury (e.g., the industrial injury resulted in surgery which caused vulnerability that necessitates certain restrictions) and how and why the injury is responsible for approximately 50% of the disability. And, if a physician opines that 50% of an employee's back disability is caused by degenerative disc disease, the physician must explain the nature of the degenerative disc disease, how and why it is causing permanent disability at the time of the evaluation, and how and why it is responsible for approximately 50% of the disability.” (*Escobedo* 70 Cal. Comp. Cases at 621.)

If an examiner determines that he or she is unable to make an apportionment determination, then “the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. “ (*Lab. Code § 4663(c)*.) Merely stating an inability to determine apportionment is

⁵ Causation issues for psychiatric injuries under Labor Code § 3208.3 is not apportionment of permanent disability under Labor Code § 4663.

insufficient to meet the requirements of the statute. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Dorsett)* (2011) 201 Cal. App. 4th 443.)

An employer is only liable for “for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.” (*Lab. Code § 4664 (a).*) Prior awards of permanent disability may be used for apportionment. The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee’s lifetime unless the employee’s injury or illness is conclusively presumed to be total in character pursuant to Labor Code section 4662. The regions of the body are the following: hearing; vision; mental and behavioral disorders; the spine; the upper extremities, including the shoulders; the lower extremities, including the hip joints; the head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed above.

Presumptive 100 percent awards under Labor Code section 4662 are:

- a. Loss of both eyes or the sight in both eyes
- b. Loss of both hands or the use of both hands
- c. An injury resulting in practically total paralysis
- d. An injury to the brain resulting in incurable mental incapacity (imbecility) or insanity.

c. Labor Code section 4062-Resolving disputes not covered by Labor Code sections 4060 and 4061

This section is the “catch-all” for any dispute that is not compensability or permanent disability with the need for future medical care. Starting January 1, 2013 for new injuries and as of July 1, 2013 for all injuries, disputes over any current need for medical treatment are no longer among the disputes resolved by QMEs. These disputes instead are resolved through the Independent Medical Review process, which is available to the injured worker after the Utilization Review process (UR) if the treatment requested by the primary treating physician is denied, delayed or modified by the claims administrator. (*Lab. Code §§ 4610, 4610.3, 4610.5; State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Sandhagen)* (2008) 44 Cal.4th 230 [73 Cal. Comp.

Cases 981].) Of course, if UR approves the treatment request there cannot be a medical dispute, and the injured worker must receive the requested treatment.

Unlike Labor Code sections 4060 and 4061, section 4062 contains explicit timeframes in which objections to medical determinations of the treating physician must be made. In represented cases either party may object to a medical determination by the treating physician by notifying the other party in writing within 20 days of receipt of the treating physician's report in represented cases or within 30 days of receipt of the treating physician's report in unrepresented cases. The timeframes to object may be extended by the agreement of the parties.

Disputes that fall into this section as to whether the injured worker is temporarily disabled; whether the injured worker has any work restrictions to facilitate an injured worker's return to work; whether after a judicial determination of permanent disability, there exists new and further disability as a result of the deterioration of the original injury; or whether a new body part added to the claim of injury is a compensable consequence of the industrial injury is another type of new and further disability. (*J.C. Penney Co. v. Workers' Comp. Appeals Bd. (Edwards)* (2009) 175 Cal.App.4th 818 [74 Cal. Comp. Cases 826] (Entitlement to TD); *Simmons v. State of California, Dept. of Mental Health* (2005) 70 Cal. Comp. Cases 866 (en banc) (Compensability issues raised in UR process).) Other disputes under this section include whether the injured worker's medical condition is P&S or MMI, whether the injured worker is temporarily disabled and work restrictions, if any, the injured worker needs to return to work before the injured worker is P&S.

Temporary disability indemnity (TDI) is intended primarily to substitute for the worker's lost wages, in order to maintain a steady stream of income. The employer's obligation to pay TDI to an injured worker ceases when such replacement income is no longer needed. Thus, the obligation to pay TDI ends when the injured employee either returns to work or is deemed able to return to work or when the employee's medical condition achieves P&S status. (*Labor Code § 4653; Huston v. Workers' Comp. Appeals Bd.* (1979) 95 Cal. App. 3d 856, 868).

Temporary work restrictions may become an issue in dispute between the parties; the Physician's Guide, pages 44 to 47, discusses the development of work restrictions. The content of the report should focus on the issues presented by the parties for resolution. The cases mentioned

earlier in this section will give a better idea of how these issues are factually presented for resolution by the QME.

III. QME Selection Process

A QME is selected by the parties from a “panel” or list of QMEs. Employees or employers may request QMEs pursuant to Labor Code sections 4062.1 (unrepresented worker) or 4062.2 (represented worker). Upon request, the DWC Executive Medical Director (hereafter referred to as medical director) randomly assigns three-member panels of QMEs. (*Lab. Code §139.2 (h) (1).*) Requests for QME panels must be submitted following specific directions and forms. QME Form 105 is to be used for unrepresented workers and QME Form 106 for represented workers.

a. Process for Unrepresented Injured Worker: Labor Code 4062.1

Unrepresented injured workers cannot be offered and cannot accept an offer to resolve a medical dispute using an AME. (*Lab. Code § 4062.1(a).*) When the substantive requirements of Labor Code sections 4060 (compensability), 4061 or 4062 are met, either the injured worker or the claims administrator may request a QME panel; however, the injured worker is always given the first opportunity to request the panel. (*Lab. Code § 4062.1(b).*) A claims administrator may not submit the QME form 105⁶ (i.e., request a QME panel) “unless the employee has not submitted the form within 10 days after the employer has furnished the form to the employee and requested the employee to submit the form.” (*Lab. Code § 4062.1(b).*) The party submitting the form 105 is required to designate the specialty of the QME to examine the injured worker. If the request for a panel is not issued within 20 working days in an unrepresented case the employee shall have the right to obtain an evaluation from any QME within a reasonable geographic area. (*Lab. Code § 139.2(h)(1).*)

Within ten (10) days after the panel is issued the injured worker is required to select a physician from the panel, make an appointment for the examination and inform the claims administrator of the selection and the appointment. (*Lab. Code § 4062.1(c).*) If the injured worker does not inform the claims administrator of the physician selected, the claims administrator may

⁶ Request for QME Panel under Labor Code section 4062.1 - Unrepresented (QME form 105)

make the selection. If the injured worker does not inform the claims administrator of the date of the appointment the claims administrator may arrange the appointment.

Finally, if an unrepresented employee has received a comprehensive medical-legal evaluation under Labor Code section 4062.1 (a) and he or she later becomes represented by an attorney; he or she shall not be entitled to an additional evaluation.

b. Process for Represented Injured Worker: Labor Code 4062.2

For represented workers, panel QME evaluations are only available for any dispute arising out of an injury or a claimed injury occurring on or after January 1, 2005. (*Lab. Code § 4062.2(a).*) In represented cases the parties may resolve their disputes at any time by utilizing an AME. However, the parties in a case may not request a QME to resolve a dispute that either has been agreed to be submitted or has been submitted to an AME. (*Lab. Code § 4062.2(f).*)

After a request for a QME to resolve a compensability dispute pursuant to Labor Code section 4060 or an objection to a determination made by the injured worker's primary treating physician pursuant to Labor Code sections 4061 or 4062 that is served on the opposing party, either party may file the QME form 106⁷ and request a panel of QMEs to resolve the dispute. The party filing the QME request must wait to file the form 106 “[n]o earlier than the first working day that is at least 10 days after the date of mailing of a request for a medical evaluation pursuant to Section 4060 or the first working day that is at least 10 days after the date of mailing of an objection pursuant to Sections 4061 or 4062, ...” (*Lab. Code § 4062.2(b).*)

After the assignment of the QME panel by the medical director, there is a ten (10) day period in which each party may strike one name from the panel. (*Lab. Code § 4062.2(c).*) At the conclusion of the striking process, the remaining QME shall serve as the medical evaluator. If a party fails to exercise the right to strike a physician from the panel the other party may exercise the right to strike. (*Lab. Code § 4062.2(c).*) Finally, if a represented employee has received a comprehensive medical-legal evaluation under Labor Code section 4062.2 (a) and he or she later becomes unrepresented; he or she shall not be entitled to an additional evaluation.

⁷ Request for QME Panel under Labor Code section 4062.1 - Represented (QME form 106)

IV. The examination process

a. Scheduling and cancellation of appointments

There are specific timelines to be followed and forms to be used, in connection with the scheduling of a QME appointment whether an employee is represented or not. (*Cal. Code of Regs., tit. 8, § 31.3.*) After the issuance of a panel and selection of a QME as described in the preceding chapter, the selected QME must schedule an appointment to see the employee within 60 days of a request for an appointment. The appointment must be scheduled at the medical office identified on the panel selection form. (*Cal. Code of Regs., tit. 8, §§ 33(e), 34(b).*) An appointment may be scheduled beyond 60 days of a request for an appointment if the party who has the right to schedule the appointment is willing to accept an appointment up to 90 days from the date of the request. (*Cal. Code of Regs., tit. 8, § 33(e).*)

When an appointment has been made the QME must submit the QME Appointment Notification form (Form 110) within 5 business days of making the appointment. The appointment notification form must be served on the employee, the employee's representative (if there is one), the employer or the claims administrator, and the latter's representative. (*Cal. Code of Regs., tit. 8, § 34(a).*) The appointment notification form serves as the notice of an appointment and is also the notice for sending medical records and other information to the QME in connection with the examination. The failure by the QME to serve the appointment notification form is cause for the issuance of a replacement panel. (*Cal. Code of Regs., tit. 8, § 31.5(a) (11).*)

The appointment notification form shall state whether a state certified interpreter is required and specify the language that is necessary. (*Cal. Code of Regs., tit. 8, § 34(c).*) The employer is responsible for arranging for, and paying, the interpreter.

An evaluator may cancel an appointment up to 6 business days prior to the scheduled appointment and must reschedule an appointment within 30 calendar days of the date of cancellation, but not more than 60 calendar days from the date of the initial request for an appointment, unless there is written agreement by the parties to extend the date of a new appointment beyond the 60 day limit. (*Cal. Code of Regs., tit. 8, § 34(f).*)

An appointment may be cancelled in writing, and must be served on the non-cancelling party by one of the parties less than 6 business days before the scheduled appointment that states the reason for cancellation. An oral cancellation must be followed by a written confirmation. It would be prudent for the evaluator to offer to reschedule an appointment if there is reason to do so. (*Cal. Code of Regs., tit. 8, §§ 34(e); 34(h).*)

An evaluator cannot cancel an appointment because of a failure to receive relevant medical records—unless the evaluation is by a psychiatrist or psychologist who states in the evaluation report that receipt of the medical records prior to the evaluation was necessary to conduct a full and fair evaluation. (*Cal. Code of Regs., tit. 8, § 34(g).*)

The evaluator must schedule appointments without regard to whether an employee is represented or not, and cannot refuse to schedule an appointment because a promise to reimburse, or reimbursement is not made prior to the examination. (*Cal. Code of Regs., tit. 8, § 41(a) (2)*)

b. Information to be provided to the QME

All communications prior to an examination by the parties with a QME shall be in writing and served on the QME at the same time as the non-serving party. (*Cal. Code of Regs., tit. 8, § 35(b) (1).*)

It is important for a QME to know the QME regulations because a party could decide not to use the QME's report if the regulations are not followed; especially serving the information on the opposing parties to prevent ex parte communication. Any party may provide to the QME selected from a panel any of the following information:

- (1) All records prepared or maintained by the employee's treating physician or physicians;
- (2) Other medical records, including any previous treatment records or information, which are relevant to determination of the medical issue in dispute;
- (3) A letter outlining the medical determination of the primary treating physician or the compensability issue that the evaluator is requested to address in the evaluation, which shall be served on the opposing party no less than 20 days in advance of the evaluation.

(4) Where the evaluation is for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30, 2013 and the treating physician's recommended medical treatment is disputed, a copy of the treating physician's report recommending the medical treatment with all supporting documents, a copy of claims administrator's, or if none the employer's, decision to approve, delay, deny or modify the disputed treatment with the documents supporting the decision, and all other relevant communications about the disputed treatment exchanged during the utilization review process required by Labor Code section 4610;

(5) Non-medical records, including films and videotapes, which are relevant to determination of medical issue(s) in dispute, after compliance with subdivision 35(c) of title 8 of the California Code of Regulations. (*Lab. Code § 4062.2; Cal. Code of Regs., tit. 8, § 35(a)(3).*)

Information that a party proposes to provide to the QME selected from a panel should be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to sending non-medical records (such as a video tape) within 10 days of receipt of the objection, the records shall not be provided to the evaluator. Either party may take the issue to the appeals board to establish the accuracy or authenticity of non-medical records or whether previously objected to material should be seen by a QME prior to the evaluation.⁸ *In no event should the QME be sent the following information:*

“(1) Any medical/legal report which has been rejected by a party as untimely pursuant to Labor Code section 4062.5;

(2) Any evaluation or consulting report written by any physician other than a treating physician, the primary treating physician or secondary physician, or an evaluator through the medical-legal process in Labor Code sections 4060 through 4062, that addresses permanent impairment, permanent disability or apportionment under California workers' compensation laws, unless that physician's report has first been ruled admissible by a Workers' Compensation Administrative Law Judge; or

⁸ If an agreed medical evaluator is selected, as part of their agreement on an evaluator, the parties must agree on what information is to be provided to the agreed medical evaluator. (*Cal. Code of Regs., tit. 8, § 35(b)(2).*)

(3) Any medical report or record or other information or thing which has been stricken, or found inadequate or inadmissible by a Workers' Compensation Administrative Law Judge or which otherwise has been deemed inadmissible to the evaluator as a matter of law." (*Cal. Code of Regs., tit. 8, § 35(e).*)

In the event that a party fails to provide to the evaluator any relevant medical record which the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health care provider, to obtain such record(s). If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report within 30 days of the evaluation to comply with the statutory time frames under section 38 of title 8 of the California Code of Regulations.⁹ The evaluator shall note in the report that the records were not received within 10 days after the date of the evaluation. Upon request by a party, or the Appeals Board, the evaluator shall complete a supplemental evaluation when the relevant medical records are received. (*Cal. Code of Regs., tit. 8, § 35(i).*)

c. Ex-parte contact

The prohibition against ex-parte contact appears in Labor Code section 4062.3 (g) and is implemented by the provisions of rule 35. This rule is designed to avoid ex parte communication, which is *any* communication--written or oral--by one party, or a party's representative, with the evaluator *outside the presence of the opposing party*. Such communication is forbidden in connection with the qualified medical evaluation of an employee to avoid possible covert influence by one party, or the *suggestion* of covert influence by one party, which would prejudice the impartial, neutral evaluator.

This restriction shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination. (*Labor Code § 4062.3(i).*) The rules are also relaxed in represented cases involving an AME. "Oral or written communications with

⁹ The time frame for a comprehensive medical-legal report is 30 days. (*Cal. Code of Regs., tit. 8, § 38 (a).*) -The time frame for supplemental medical report is 60 days. (*Cal. Code of Reg., tit. 8, § 38 (h).*)

physician staff or, as applicable, with the agreed medical evaluator, relative to nonsubstantial matters such as the scheduling of appointments, missed appointments, the furnishing of records and reports, and the availability of the report, do not constitute ex parte communication in violation of this section unless the appeals board has made a specific finding of an impermissible ex parte communication.” (*Lab. Code § 4062.3(f).*)

If a party communicates with the AME or the QME, or the AME or QME communicates with a party, in violation of subdivision 4062.3(e) (which requires all communication to be written), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from a QME to be selected according to Labor Code sections 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation. (*Lab. Code § 4062.3(g); Alvarez v. Workers’ Comp. Appeals Bd. (SCIF) (2010) 187 Cal.App.4th 575 [75 Cal. Comp. Cases 817].*)

The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the wronged party as a result of the prohibited communication.

d. Conflict of Interest disclosure (*Cal. Code of Regs., tit. 8, §§ 41.5, 41.6.*)

Labor Code section 139.2 (o) provides “an evaluator may not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code.” A conflict of interest exists when an evaluator has a connection of some sort—personal, financial, or otherwise—with any of the parties involved in a dispute, a connection which may interfere with an objective evaluation. (*Cal. Code of Regs., tit. 8, § 41.5.*)

Section 41.5 (c) defines the “persons or entities” with whom a QME may have a disqualifying conflict of interest and Section 41.5 (d) defines a “disqualifying conflict of interest.” An in-depth review of these provisions is beyond the scope of this document, but these provisions should be reviewed prior to the examination.

An evaluator may disqualify himself or herself on the basis of a conflict of interest whenever the evaluator has a relationship with a person or entity in a specific case, including doctor-patient, familial, financial or professional, that causes the evaluator to decide it would be

unethical to perform a comprehensive medical-legal evaluation examination or to write a report in the case. (*Cal. Code of Regs., tit. 8, § 41.5(e).*)

An evaluator who discovers a conflict of interest should disclose the nature of the conflict in writing to the parties within 5 business days of becoming aware of the conflict. (*Cal. Code of Regs., tit. 8, § 41.5(f).*)

In the case of an unrepresented injured worker, the parties are required to obtain a new evaluator by following the procedure provided under section 31.5 of title 8 of the California Code of Regulations and a replacement QME, or when necessary replacement QME panel, shall be issued. (*Cal. Code of Regs., tit. 8, § 41.6(c)(1).*)

In represented cases, the parties have the option of waiving the evaluator's conflict of interest, or, if they do not agree to waive the conflict, to replace the evaluator's name on the panel (if the conflict is discovered early, before any panelist's names have been stricken) or (if the conflict is discovered after an appointment has been made with the evaluator) to request a new panel. Waivers should be written. (*Cal. Code of Regs., tit. 8, § 41.6(c)(2).*)

If the injured worker terminates the examination process based on an alleged violation of section 41.5 of title 8 of the California Code of Regulations and the appeals board later determines that good cause did not exist for the termination, the cost of the evaluation shall be deducted from the injured worker's award. A violation of section 41.5 by the evaluator shall constitute good cause for purposes of an appeals board determination. No party shall be liable for any cost for medical reports or medical services delivered as a result of an exam terminated for good cause. (*Cal. Code of Regs., tit. 8, § 41(g).*)

If the evaluator declines to perform the evaluation because of the conflict of interest, a new QME panel will be issued. If the evaluator does not decline to perform the evaluation, the parties can waive the conflict or object to the evaluator based on the evaluator's conflict. In the latter situation, a new panel will be issued. (*Cal. Code of Regs., tit. 8, § 41.6(c)(3).*) Disputes about whether a conflict of interest may affect the integrity and impartiality of the evaluation, or supplemental reports, will be decided by a Workers' Compensation Administrative Law Judge assigned to the case. (*Cal. Code of Regs., tit. 8, § 41.6(d).*)

e. Examination Disclosures (*Cal. Code of Regs., tit. 8, § 40.*)

A QME at the time of the evaluation shall advise an injured worker before the examination or at the time of the actual evaluation of the following items:

- That he or she is entitled to ask the evaluator and the evaluator shall promptly answer questions about any matter concerning the evaluation process in which the QME and the injured worker are involved;
- The injured worker may discontinue the evaluation based on good cause. Good cause includes: (A) discriminatory conduct by the evaluator towards the worker based on race, sex, national origin, religion, or sexual preference, (B) abusive, hostile or rude behavior including behavior that clearly demonstrates a bias against injured workers, and (C) instances where the evaluator requests the worker to submit to an unnecessary exam or procedure.
- When required as a condition of probation by the Administrative Director or his/her licensing authority, the QME shall disclose his/her probationary status. The QME shall be entitled to explain any circumstances surrounding the probation. If at that time, the injured worker declines to proceed with the evaluation, such termination shall be considered by the Administrative Director to have occurred for good cause.

If the injured worker declines to ask any questions relating to the evaluation procedure as set forth in section 40, and does not otherwise object on the grounds of good cause to the exam proceedings during the exam itself, the injured worker shall have no right to object to the QME comprehensive medical-legal evaluation based on a violation of this section. (*Cal. Code of Regs., tit. 8, § 40(c).*)

If the injured worker terminates the examination process based on an alleged violation of section 40 of title 8 of the California Code of Regulations and the Appeals Board later determines that good cause did not exist for the termination, the cost of the evaluation shall be deducted from the injured worker's award. A violation of section 40 by the evaluator shall constitute good cause for purposes of an Appeals Board determination. No party shall be liable for any cost for medical reports or medical services delivered as a result of an exam terminated for good cause. (*Cal. Code of Regs., tit. 8, § 41(g).*)

f. Ethical obligations of the QME (*Cal. Code of Regs., tit. 8, § 41.*)

The ethical obligations of QMEs are worth noting and are set forth in section 41 of title 8 of the Cal. Code of Regulation and cover a variety of issues including but not limited to office cleanliness, appointment scheduling and report content among others. If the injured worker terminates the examination process based on an alleged violation of the ex-parte contact regulation, rule 35 (k); the QME disclosure requirements, rule 40; the failure to maintain a clean and professional office provision, rule 41 (a); or the conflict of interest regulations, rule 41.5, and the appeals board later determines that good cause did not exist for the termination, the cost of the evaluation shall be deducted from the injured worker's award. A violation of the above referenced sections by the evaluator shall constitute good cause for purposes of an appeals board determination. No party shall be liable for any cost for medical reports or medical services delivered as a result of an exam terminated for good cause. (*Cal. Code of Regs., tit. 8, § 41(g).*)

An evaluator is not required to undertake or continue a comprehensive medical-legal evaluation where the injured worker or his/her representative uses abusive language towards the evaluator or evaluator's staff or deliberately attempts to disrupt the operation of the evaluator's office in any way or where the injured worker is intoxicated or under the influence of any medication which impairs the injured worker's ability to participate in the evaluation process. (*Cal. Code of Regs., tit. 8, § 41(h);41(i).*) In either case, the evaluator shall state under penalty of perjury, the facts supporting the termination of the evaluation process. Upon request, the medical Director shall investigate the facts and make a final determination of the issue. (*Cal. Code of Regs., tit. 8, § 41(h);41(i).*)

g. Evaluation protocols (*Cal. Code of Regs., tit. 8, §§ 43-47.*)

Evaluations for injuries occurring before January 1, 2005 are conducted pursuant to evaluation protocols that appear in sections 43 through 47. Injuries that occurred before January 1, 2005 may be rated using the April 1997 permanent disability rating schedule or an earlier schedule. Protocols exist for the following evaluations:

- Psychiatric evaluations (*Cal. Code of Regs., tit. 8, §§ 43, 9726.*)
- Pulmonary disability evaluations (*Cal. Code of Regs., tit. 8, § 44.*)
- Cardiac disability evaluations (*Cal. Code of Regs., tit. 8, § 45.*)
- Neuromusculoskeletal evaluations (*Cal. Code of Regs., tit. 8, § 46.*)
- Foot and Ankle evaluations (*Cal. Code of Regs., tit. 8, § 46.1.*)
- Immunological evaluations (*Cal. Code of Regs., tit. 8, § 47.*)

For injuries occurring on or after January 1, 2005, the evaluation protocols are contained in the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition and the January 1, 2005 permanent disability rating schedule.

h. Face to Face time (*Cal. Code of Regs., tit. 8, §§ 49-49.9.*)

A QME is required to spend a minimum amount of “face to face” time with the worker as described below. “Face to face time means only that time the evaluator is present with an injured worker. This includes the time in which the evaluator performs such tasks as taking a history, performing a physical examination or discussing the worker’s medical condition with the worker. Face to face time excludes time spent on research, records review and report writing. Any time spent by the injured worker with clinical or clerical staff who perform diagnostic or laboratory tests (including blood tests or x-rays) or time spent by the injured worker in a waiting room or other area outside the evaluation room is not included in face to face time.” (*Cal. Code of Regs., tit. 8, § 49(b).*)

The minimum amount of “face to face” time depends on the nature of the evaluation being conducted and variances below the minimum amount of face to face time stated in the regulation

must be explained in the evaluator's report. All minimum "face to face" time requirements are stated for "uncomplicated evaluations" which is defined to mean "minimal or no review of records, minimal or no diagnostic studies or laboratory testing, minimal or no research, and minimal or no medical history taking." (*Cal. Code of Regs., tit. 8, § 49(h).*)

- Neuromusculoskeletal evaluations- whether a specific or cumulative injury is involved shall not be completed by a QME in fewer than 20 minutes of face to face time. Twenty minutes is the minimum allowable face to face time for an uncomplicated evaluation. (*Cal. Code of Regs., tit. 8, § 49.2.*)

- Cardiovascular evaluations- whether a specific or cumulative injury is involved shall not be completed by a QME in fewer than 30 minutes of face to face time. Thirty minutes is the minimum allowable face to face time for an uncomplicated evaluation. (*Cal. Code of Regs., tit. 8, § 49.4.*)

- Pulmonary evaluations- whether a specific or cumulative injury is involved shall not be completed by a QME in fewer than 30 minutes of face to face time. Thirty minutes is the minimum allowable face to face time for an uncomplicated evaluation. (*Cal. Code of Regs., tit. 8, § 49.6.*)

- Psychiatric evaluations- whether a specific or cumulative injury is involved shall not be completed by a QME in fewer than 60 minutes of face to face time. Sixty minutes is the minimum allowable face to face time for an uncomplicated evaluation. (*Cal. Code of Regs., tit. 8, § 49.8.*)

- Any other evaluations- whether a specific or cumulative injury is involved shall not be completed by a QME in fewer than 30 minutes of face to face time. Thirty minutes is the minimum allowable face to face time for an uncomplicated evaluation. (*Cal. Code of Regs., tit. 8, § 49.9.*)

i. Report Content, Report disclosures, Fraud Reporting, and Substantial evidence

There are several statutes and regulations that govern the content of a medical report. Section 35.5 of the QME regulations covers several of these obligations.

1) Report Content

- First, “each reporting evaluator shall state in the body of the comprehensive medical-legal report the date the examination was completed and the street address at which the examination was performed.” (*Cal. Code of Regs., tit. 8, § 35.5 (b).*) In addition, “if the evaluator signs the report on any date other than the date the examination was completed, the evaluator shall enter the date the report is signed next to or near the signature on the report.” (*Cal. Code of Regs., tit. 8, § 35.5 (b).*)

- Second, the evaluator shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's appointment with the medical evaluator that are issues within the evaluator's scope of practice and areas of clinical competence. The reporting evaluator shall attempt to address each question raised by each party in the issue cover letter sent to the evaluator as provided in subdivision 35(a) (3). (*Cal. Code of Regs., tit. 8, § 35.5 (c).*) Of course, there are legal limitations that must be respected limiting the scope of the opinion being provided by the QME or AME. For example, for all medical treatment requests on or after July 1, 2013 a QME or AME cannot offer an opinion about disputed medical issues, including the type and the amount of the injured worker's current need for medical treatment or an opinion about a current medical treatment dispute.

- Finally, the evaluator should inform the parties of disputed issues that are beyond the evaluator's expertise using the following method “[a]t the evaluator's earliest opportunity and no later than the date the report is served, the evaluator shall advise the parties in writing of any disputed medical issues outside of the evaluator's scope of practice and area of clinical competency in order that the parties may initiate the process for obtaining an additional evaluation pursuant to section 4062.1 or 4062.2 of the Labor Code and these regulations in another specialty. In the case of a QME, the QME evaluator shall send a copy of the written notification provided to the parties to the medical director at the same time.” (*Cal. Code of Regs., tit. 8, § 35.5 (d).*)

2) Report Disclosures

Labor Code section 4628 provides a list of rules concerning who may participate in the preparation of the medical-legal report, the scope of the person’s participation in the preparation of the report, what must be disclosed by the signatory to the report and contains a declaration that is required to be in all medical-legal reports.¹⁰ QMEs are encouraged to review and understand this section of the law.

3) Anti-self referral

Labor Code section 139.3 is the workers’ compensation companion to the anti-self referral provisions in the Business and Professions Code section 650.01 of the Physician Ownership and Referral Act of 1993.¹¹ QMEs are encouraged to review and understand this section of the law.

4) Substantial Evidence

The Appeals Board Regulation 10606 defines the content of a medical report. Regulation 10606, is flexible and the rule explicitly states the items listed in the rule should be included “where applicable.” (*Cal. Code of Regs., tit. 8, § 10606*.) For example, if an evaluation is conducted to determine whether an injury occurred under Labor Code section 4060, it is unnecessary to provide an opinion about apportionment of permanent disability because the worker is not permanent and stationary.

All medical reports from any source are measured by the concept of substantial evidence. The task of the evaluator is to provide a report which constitutes substantial evidence, and can be used to resolve disputes about medical issues. The burden of proof is on the party that is trying to establish some point by a preponderance of the evidence. A preponderance of the evidence means “such evidence as, when weighed with that opposed to it, has more convincing force and the greater probability of truth. When weighing the evidence, the test is not the relative number of witnesses,

¹⁰ QMEs may report suspected fraud to the AD. “Any insurer, self-insured employer, third-party administrator, workers’ compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim to the administrative director.” (*Lab. Code § 3823 (b)*.) The communication is privileged under Labor Code section 3823 (c).

¹¹ Labor Code section 139.32 is similar to Labor Code section 139.3 and requires the disclosure of “any” financial interest” of any interested party providing “services.” QMEs are covered by the statute because the QME provides medical services and is an interested party under the statute.

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but the relative convincing force of the evidence” (*Lab. Code § 3202.5.*) In other words, the party must prove that its position is more likely than not to be correct. The injured worker has the burden of proof to show by a preponderance of evidence that the injury was work-related. This has sometimes been referred to as the burden of "going forward" on an issue. If the employer is asserting that the injury was deliberately self-inflicted, then the employer has the burden of proof to prove this point by a preponderance of evidence on this issue. For example, the employer has the burden of proof on the issue of apportionment. The weight given an evaluation will depend on the quality of reasoning which underlies the conclusions of the report. The standards for determining if a report is substantial evidence are listed below:

- In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability;
- A medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess;
- A medical report is not substantial evidence unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions;
- In the context of apportionment determinations, the medical opinion must “disclose familiarity [knowledge and understanding] with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the Board can determine whether the physician is properly apportioning under correct legal principles.” (*Escobedo v. Marshalls (2005) 70 Cal. Comp. Cases 604, 621 (en banc)*); see also *McAllister v. Workers’ Comp. Appeals Bd., (1968) 69 Cal. 2d 408*; *Heggin v. Workers’ Comp. Appeals Bd., (1971) 4 Cal.3d 162, 169.*)

j. The Types of Reports and Reevaluations

The first evaluation by a QME is defined as a comprehensive medical-legal evaluation. After the original evaluation by a QME, subsequent medical reports, may be necessary after the original medical report was issued to review additional information about the injured worker either

in connection with the original dispute or if a new dispute arises about the medical condition of the injured worker.

The types of medical reports that may be required are defined in section 9793 of the QME regulations and listed below:

- Comprehensive medical-legal evaluation (*Cal. Code of Regs., tit. 8, § 9793(c).*)
- Follow-up medical-legal evaluation (*Cal. Code of Regs., tit. 8, § 9793 (f.)*)
- Supplemental medical-legal evaluation (*Cal. Code of Regs., tit. 8, § 9793 (l).*)

Labor Code sections 4062.3, 4067 and section 35.5 (e) of the QME rules require the parties return to the QME who originally provided a medical opinion in the case if the issue is within the clinical competency of the QME and the QME is available to perform the evaluation. These sections should be reviewed by the QME for a complete understanding of the concepts.

There is a special provision in Labor Code, section 4061(d) that is applicable only to reports involving unrepresented injured workers that determine permanent disability and may require the writing of a supplemental report called a factual correction. Unlike the other supplemental reports, the request for factual correction is confined to a review of the medical records in the possession of the QME at the time of the evaluation. (*Cal. Code of Regs., tit. 8, § 37.*)

k. QME unavailability (*Cal. Code of Regs., tit. 8, § 33.*)

A QME who will be unavailable to schedule or perform comprehensive medical evaluations as a Panel QME for a period of 14 days or up to a maximum of 90 days during a calendar period, for any reason shall notify the medical director at least 30 days before the period of unavailability is to begin. (Notice of Qualified Medical Evaluator Unavailability, QME Form 109.)

If a QME fails to notify the medical director, by submitting the Notice of Qualified Medical Evaluator Unavailability of his or her unavailability at a medical office at least thirty (30) days prior to the period the evaluator becomes unavailable, the medical director may designate the QME to be unavailable at that location for thirty (30) days from the date the medical director learns of the unavailability.

Whenever the medical director is notified by a party seeking an appointment with a QME, or otherwise becomes aware, that the QME is not available and not responding to calls or mail at a location listed for the QME, a certified letter will be sent to the QME by the medical director regarding his/her unavailability. If the medical director does not receive a response within fifteen (15) days of the date the certified letter is mailed, then the QME will be made unavailable at that location. The time a QME is placed on unavailable status pursuant to this subdivision shall count toward the ninety (90) day limit mentioned above.

At the time of requesting unavailable status, the QME shall provide the medical director with a list of any and all comprehensive medical/legal evaluation examinations already scheduled during the time requested for unavailable status and shall indicate whether each such examination is being rescheduled or the QME plans to complete the exam and report while in unavailable status.

It is not an acceptable reason for unavailability that a QME does not intend to perform comprehensive medical-legal evaluations for unrepresented workers.

A QME who has filed notifications for unavailability totaling more than ninety (90) days during the QME calendar year without good cause may be denied reappointment subject to section 52 of title 8 of the California Code of Regulations. Good cause includes, but is not limited to, sabbaticals, or death or serious illness of an immediate family member.

I. Additional, Replacement panels and Consultations

Notwithstanding the general rule that if a subsequent examination is necessary the injured worker is reexamined by the same QME, there may be circumstances because of scope of practice limitations or because of limitations on the clinical competency of the QME to resolve a subsequent dispute, it may become necessary for the injured worker to be examined by a different QME in a different specialty. The parties may request the issuance of an additional QME by agreeing in writing on the need for an additional panel and on the specialty needed to resolve the issue. (*Cal. Code of Regs., tit. 8, § 31.7(b)(1).*) For example, if an acupuncture QME performed the original evaluation, then issues relating to PD require the appointment of an additional QME. (*Cal. Code of Regs., tit. 8, § 31.7(b)(2).*) A workers' compensation administrative law judge may order an additional QME panel where necessary to resolve the issues in the case. (*Cal. Code of*

Regs., tit. 8, § 31.7(b)(3).) Finally, in the case of an unrepresented injured worker, a panel may be issued after an information and assistance officer verifies the need for the evaluation. (*Cal. Code of Regs., tit. 8, § 31.7(b)(4).*)

A QME who examined an injured worker may be replaced by the under the terms of section 31.5 of the QME regulations. (*Cal. Code of Regs., tit. 8, § 31.5.*) Section 31.5 contains 16 reasons why a QME may be replaced and it should be reviewed.

m. Timeframe for service of Reports and timeframe extensions (*Cal. Code of Regs., tit. 8, § 38.*)

The time frame for an initial or a follow-up comprehensive medical-legal evaluation report to be prepared and submitted shall not exceed thirty (30) days after the QME, Agreed Panel QME or AME has seen the employee or otherwise commenced the comprehensive medical-legal evaluation procedure. (*Cal. Code of Regs., tit. 8, § 38(a).*)

If there has been a failure to prepare and serve the initial or follow-up comprehensive medical-legal evaluation report within thirty days and the evaluator has failed to obtain approval from the medical director for an extension of time pursuant to this section, the employee or the employer may request a QME replacement pursuant to section 31.5 of title 8 of the California Code of Regulations.

Supplemental reports shall be completed and served no more than sixty days from the date of a written or electronically transmitted request to the physician by a party. An extension of the sixty-day time frame for completing the supplemental report, of no more than thirty days, may be agreed to by the parties without the need to request an extension from the medical director.

Neither the employee nor the employer shall have any liability for payment for the medical evaluation which was not completed within the timeframes required under this section unless the employee and the employer each waive the right to a new evaluation and elect to accept the original evaluation, in writing or by signing and returning to the medical director either QME Form 113 (Notice of Denial of Request For Time Extension) or QME Form 116 (Notice of Late QME/AME Report – No Extension Requested).

If the injured worker files the Request for Factual Correction of an Unrepresented Panel QME Report (QME form 37), the panel QME shall have ten days after service of the request to review the corrections requested in the form and determine if factual corrections are necessary to ensure the factual accuracy of the comprehensive medical-legal report. If the request for factual correction is filed by the claims administrator or by both parties, the time to review the request for correction shall be extended to fifteen days after the service of the request for correction.

An evaluator may request an extension of time in which to file a medical report. All requests by an evaluator for extensions of time shall be made on form 112 (QME/AME Time Frame Extension Request). If the evaluation will not be completed on the original due date, the evaluator may request an extension from the medical director, not to exceed an additional 30 days. The grounds for timeframe extension appear in subdivision 38 (b) of the QME rules.

n. Service of Reports (*Cal. Code of Regs., tit. 8, § 36.*)

The service of medical reports is governed by whether the worker who is unrepresented or represented by an attorney and if the report makes a determination of the existence of permanent disability. Whenever an injured worker is represented by an attorney, the evaluator shall serve each comprehensive medical-legal evaluation report, follow-up comprehensive medical-legal evaluation report and supplemental evaluation report on the injured worker, his or her attorney and on the claims administrator, or if none the employer, by completing QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report Form) and attaching to the report, unless section 36.5 of title 8 of the California Code of Regulations applies.

Whenever an injured worker is not represented by an attorney, the QME shall serve each comprehensive medical-legal evaluation report, follow-up evaluation report or supplemental report that addresses only disputed issues outside of the scope of Labor Code section 4061, by completing the questions and declaration of service on the QME Form 111 (QME Findings Summary Form), and by serving the report with that form attached, on the injured worker and the claims administrator, or if none on the employer, unless section 36.5 of title 8 of the California Code of Regulations applies.

Whenever the evaluator is serving a medical-legal evaluation report that addresses or describes findings and conclusions pertaining to permanent impairment, permanent disability or apportionment of an unrepresented injured worker, the evaluator shall serve the evaluation report, on the Disability Evaluation Unit office assigned based on the zip code of the injured worker, at the same time as serving the report, QME Form 111, DWC-AD Form 100 (DEU) (Employee's Disability Questionnaire) and DWC-AD Form 101 (DEU) (Request for Summary Rating Determination of Qualified Medical Evaluator's Report)-on the claims administrator, or if none the employer, and on the unrepresented employee within the time frames specified in section 38 of title 8 of the California Code of Regulations, unless section 36.5 of title 8 of the California Code of Regulations applies.

In the case of psychiatric injury, "an injured worker shall be advised by the evaluator that the employee's copy of the comprehensive medical-legal report, and any follow up or supplemental reports, from the evaluation may be served either directly on the injured worker or instead on a physician designated in writing by the injured worker prior to leaving the evaluator's office, for the purpose of reviewing and discussing the evaluation report with the injured worker." (*Cal. Code of Regs., tit. 8, § 36.5.*) The alternative service of the medical report is optional at the discretion of the injured worker. (*Cal. Code of Regs., tit. 8, § 36.5. (f).*)

In certain circumstances in a psychiatric injury case the examiner may make a determination pursuant to Health and Safety Code section 123115(b) that there is a substantial risk of significant adverse or detrimental medical consequences to the injured worker. (*Cal. Code of Regs., tit. 8, § 36.5. (b).*)

o. Retention of reports and return of records (*Cal. Code of Regs., tit. 8, § 39.5.*)

QMEs shall retain a copy of all comprehensive medical-legal reports completed by the QME for a period of five (5) years from the date of each evaluation report. A QME may satisfy this requirement by retaining an electronic copy of the report, as long as the electronic copy retained is a true and correct copy of the original, showing the QME's signature that was served on the parties.

Upon written request, a QME is required to return original radiological films, imaging studies and original medical records to the person who supplied the original records to the QME or to the injured worker. The medical director may request an evaluator submit all comprehensive medical/legal reports performed as a QME, the failure to do so may constitute grounds for discipline.

V. Resources

California case law from the court of appeal and the Supreme Court (free, but registration is required): http://california.lp.findlaw.com/ca00_casecode/index.html

Controlling decisions of the WCAB (en banc decisions) and significant panel decisions (cases of interest to the public): http://www.dir.ca.gov/wcab/wcab_enbanc.htm

Industrial Medical Council's Physician's Guide, Medical Practice in the California Workers' Compensation System, Third Edition (Physician's Guide):
<http://www.dir.ca.gov/dwc/MedicalUnit/toc.pdf>

Qualified medical evaluator (QME) and agreed medical evaluator (AME) forms:
<http://www.dir.ca.gov/dwc/forms.html#QMEForms>

Text of the California Labor Code and regulations:
http://www.dir.ca.gov/DWC/Laws_Regulations.htm