



QME Rules Modified

Council Adopts Sweeping New IMC Regulations

The Industrial Medical Council has enacted new IMC rules which dramatically change the way that physicians are appointed and disciplined as QMEs. The QME process has also been significantly clarified in many respects - from additional reports to requirements for QME supplemental reports and time frame extensions.

The Council has also added Sanction Guidelines which will guide the IMC in imposing various disciplinary actions against QMEs in violation of statutory or regulatory requirements.

"Everyone is aware that the medical-legal process can be difficult for all parties, but the Council strongly believes these new regulations will simplify problem areas for QMEs, injured workers, and employers," said Dr. Allan MacKenzie, Executive Medical Director.

The IMC regulations cover the certification, testing and appointment of physicians as QMEs in the state of California. The regulations also define the QME process by which injured workers obtain QME evaluations, and under what circumstances parties can object to the selection of the physicians or file complaints against QMEs.

Under current statutory law, an injured worker is required to go through the QME process regardless of whether represented by an attorney or not after an objection by a party to a finding by the treating physician is made. Unrepresented workers must navigate through what is commonly referred to as the "panel process" in which the worker selects a specialist to evaluate their injury and write a medical-legal report which serves as expert opinion before the Workers' Compensation Appeals Board and

may serve as the basis for a Judge's finding or for settlement purposes.

Also, the official IMC forms for QMEs and injured workers have all been renumbered and placed together beginning at section 100. Interested persons may request a copy of the forms only from the IMC in addition to downloading them from the IMC web-site at <http://www.dir.ca.gov/imc/imchp.htm>.

A detailed analysis of the new rules is provided on page 9.

QME Criteria Changing For Incoming Physicians

With the passage of AB 776, the legislature has modified the prerequisites for a physician applying for QME certification. The bill makes several significant changes which will take effect January 1, 2001. Among the notable amendments:

- ❖ For physicians seeking their first appointment, beginning after January 1, 2001 they will be required to complete a 12 hour course on medical-legal report writing prior to being appointed as a QME. Current QMEs and physicians becoming QMEs after the Fall 2000 examination are excluded from this requirement.

- ❖ Regardless of board certification status (including failure of a board certification exam) if the physician was an active QME on June 30, 2000 the physician will be "grandfathered" into the QME program. Note that if the physician was actively on the list as a result of providing false information then this provision would not apply.

- ❖ If the MD/DO has completed a residency training program approved by the American College of Graduate Medical Education (or the Osteopathic equivalent) the physician will be qualified to become a QME (provided he or she meets all other criteria). This provision applies even if the physician failed a board certification exam.

- ❖ The new law deletes the requirement that a current QME who is not board certified must gain board certification no later than January 1, 2003. It also deletes the provision that a physician who has failed a board certification examination in his or her specialty after 1985 cannot be appointed in that specialty as a QME.

The QME regulations will be modified immediately to make them consistent with the new law (see accompanying story on the new QME regulations).

RBRVS Proposal To Move Forward

The Council voted July 20 to advertise a request for proposal to hire a consultant to perform the data analysis needed to adopt the Resource Based Relative Value Scale for the Official Medical Fee Schedule.

Richard Gannon, the Administrative Director expressed his appreciation to the IMC for assisting in the study which would be an integral step in the conversion to the RBRVS system.

Gannon has stated that, barring unforeseen problems, he intends to move to an RBRVS based fee schedule in the next revision.

The RFP process is expected to be completed in November, 2000. The Resource Based Relative Value Scale is used by a number of states as the "backbone" for their workers' Compensation medical fee schedules.

The Administrative Director is required to revise the Fee Schedule every two years.



D. Allan MacKenzie, MD, CM, F.A.A.O.S.
Executive Medical Director

No Rest For the Weary

One of the important functions of the IMC is to get out “products” which will facilitate the task of our physicians in treating and evaluating injured workers. IMC staff and Council Members have had a wild ride in the first seven months of the year 2000. Assembly Bills 435, 776, 2301, and many disciplinary issues have slowed our product assembly line. These perturbations notwithstanding, the Council has made some significant advances and we would like to share these developments with our readership.

Disability Management

At the IMC’s annual long range planning meeting, the Council announced its intention of establishing a Disability Management Committee and further, that the IMC should promote disability management throughout the entire WC community – not just to the treating physicians. With that goal in mind, the IMC’s Speaker Bureau has made a specific effort to educate our physicians and stakeholder/constituents on the nuance of these concepts.

OAL Approves IMC Regs

The Office of Administrative Law approved the new IMC regulations, including the Sanction Guidelines, and some new IMC forms. The regulations became effective on May 14 and contain new rules by which QMEs are appointed, classified, and disciplined. We strongly believe that these regulations will provide a better explanation on how the QME process works and what kinds of behavior are prohibited. Recall that the specific purpose of the Sanction Guidelines was to provide a framework for the QME process – a matrix of disciplinary actions for the various violations. Packets of these regs and guidelines were sent to every QME. Recently, the Council announced its intention of ensuring that the QMEs, at the time of appointment or reappointment, declare that they have read *and understood* the most recently published QME regulation changes.

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Telephone # (650) 737-2063 or 1-800-794-6900
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Forms and Course information for doctors **press 1**
Forms for an injured worker **press 2**
Agendas for IMC’s monthly public meetings **press 3**
For a list of approved guidelines **press 4**
For IMC’s Newsletter **press 5**

To receive a directory of availability faxes **press 6**
To reach an operator **press 0**

When calling from outside the 650 area code enter 1
your area code and your fax number
to receive a fax.

Educational Efforts

The ink was barely dry on the new QME regs when the Governor signed AB 776 (Calderon). This bill will have great impact on the appointment of QMEs. The most significant educational feature is the requirement that all QME candidates have completed a med/legal report writing course of *at least* 12 hours prior to being appointed as a QME. IMC members and staff have had extensive discussions on what should comprise the core content of the education material for this course. The bill becomes effective on 1/1/2001 and will directly impact those QME candidates taking the March 2001 QME exam.

Guidelines and Protocols

Recall that when the IMC Treatment Guidelines were completed in 1997-98, the Council agreed to a Continuous Quality Improvement (CQI) initiative whereby all of the guidelines would be reviewed as frequently as was ‘reasonable and necessary.’ With that in mind, the Council has begun discussions on the Continuous Quality Review process and committee work will be ramping up in the fall.

Work is also continuing on the neuromusculoskeletal evaluation (forensic) protocols for the cervical spine. The evaluation protocol for the lumbar spine was completed several years ago. The Council then elected to pause and get feedback from the WC community before continuing to develop more protocols. Our constituents have continued to ask for evaluation protocols for the cervical spine and extremities. The Council’s response is to target November/December as the date for public hearings with the guidelines expected to be in place by the first quarter of the new year.

Disciplinary Activity

Our Complaint Tracking unit has been performing admirably well and along with the Discipline Committee has recently settled several complicated cases under the new Sanction Guidelines. Several more cases are in the accusation phase and will either settle or go to a public hearing in the coming months. Although some in the WC community have doubted the Council’s ability to discipline “their own,” it is without question that in the past several months the Council has sent a clear message that certain acts and conduct will result in the loss of QME status.

Wrap Up

Finally, work has begun in earnest on the third edition of the Physician’s Guide. I am constantly reminded by colleagues in the community that they are looking forward to an updated version and since water flows uphill, I have been repeatedly reminding our IMC staff as well. If we promise it, you will receive it.

We here at the IMC, wish you all a healthy and prosperous summer with continued encouragement and support of your work within our workers’ compensation community.

Court Explains Change of Treater in QME Process

By James D. Fisher, Esq.

When the QME process “officially” begins has been a point of contention for some time in the compensation community. When a defendant disputes the finding of a treating doctor, their only choice is to invoke the QME process under Labor Code sections 4061 & 4062 to resolve disputed issues. Applicants believed that they had a second alternative to the QME process - to change treating physicians under Labor Code section 4600. Recently, in the case of the *Tenet/Centinela Hospital or Medical Center v. WCAB (Rushing)* (2000) 80 Cal.App. 4th 1041, 65 C.C.C. 477, reviewed file June 27, 2000, the Court of Appeal put the brakes on this practice of changing treaters to avoid the QME process.

In *Rushing*, the applicant sustained the injury on July 12, 1995 in the course and scope of her employment as a hospital help care aid. Beginning in August of 1995 through October of 1996, the applicant treated with Dr. Glausman who found the applicant to be permanent and stationary with no work restrictions. In Dr. Glausman’s final report dated January 1998, he declared Rushing’s injury to be permanent and stationary and indicated that the applicant “needed no future medical care at this time.” Dr. Glausman indicated however, that it was medically probable that the applicant would have a flare up of her underlying symptoms and require future physicians visits, attendant anti-inflammatory medications, and possible physical therapy. Finally, the doctor indicated that a future surgery might be warranted if the treatment did not alleviate the applicant’s current pain.

The applicant, acting without an attorney, objected to Dr. Glausman’s permanent disability opinion. The defendant then requested that the IMC provide a three physician panel of QMEs. Instead of selecting a QME, the applicant retained an attorney and began treatment with Dr. Stokes five months after Dr. Glausman’s final report.

At trial, the applicant relied on the medical report of Dr. Stokes and invoked the treaters presumption of correctness under section 4062.9. The hospital objected to Dr. Stokes’ report, noting that under section 9785(b) the regulation precludes the change of treating physician where the primary treating physician has discharged the employee from further treatment and there is a dispute concerning the need for continuing medical care.

The trial judge ruled that Dr. Stokes was the primary treating physician, rationalizing that the applicant was entitled to change treating physicians when future medical care was warranted. The WCJ said that since Dr. Glausman found that there may be some need for future medical treatment, *Rushing* had not been discharged from care.

The hospital filed for reconsideration which was denied by the WCAB. The Board ruled that Labor Code sections 4061 and 4062 were not involved in this decision. The Board further ruled that because Dr. Glausman has recommended some continuance of future medical treat-

ment, that *Rushing* had not been discharged from his care when she exercised her right to change treaters to Dr. Stokes. The hospital then filed the Petition for Writ of Review which was granted by the Court of Appeal. The Court reversed the WCAB.

In reversing, the Court focused on section 9785(b) and whether there was a need for continuing medical treatment. In analyzing Dr. Glausman’s report, the court agreed that his report did not use the term “discharge”. The type of medical treatment discussed in Dr. Glausman’s report however, was not continuing (current) in nature, but was a prediction of possible future medical needs. Based on that analysis, the court concluded that at the time the applicant objected to the report of Dr. Glausman, she should have used the QME process to resolve whatever dispute had arisen.

Interestingly, the Court of Appeal pointed to the case of *Roacho v. WCAB* (1998) 63 C.C.C. 874 (Writ Denied) as an indication that the Board interpreted its own regulations consistent with the Court of Appeals’ view of the case. In *Roacho*, the Court of Appeal pointed out that a doctor who found that there was some form of future medical care that might be needed in the form of short courses of physical therapy upon an exacerbation, was not an ongoing need for treatment. The WCJ in *Roacho* held that the original treating doctor discharged the applicant from his care and the applicant was not entitled to a change of treating physician.

In addition, the *Rushing* Court relied on the fact that Dr. Glausman repeatedly found the applicant’s condition to be permanent and stationary and returned her to work. Furthermore, Dr. Glausman scheduled no additional visits nor prescribed any treatments.

Prior to the decision in *Rushing*, the WCAB in *Krueger v. Republic Indemnity Co. of America* 28 CWCR 44 (March 2000) held that section 9785(b) was unconstitutional because it hindered the applicant’s right to medical treatment under Labor Code section 4600. Interestingly, Dr. Glausman, who was the treater in the *Rushing* case, was also a treating physician in *Krueger*. (In *Krueger*, the issue was whether a lien filed by a treating physician selected after a primary treating physician has found that the applicant had no future need for medical treatment was allowable).

Taken together, *Krueger* and *Rushing* make it clear that the WCAB has taken the position that the ability to change the treating physician is virtually absolute. It seems highly unusual that the WCAB would find a section of the administrative code to be unconstitutional since the Administrative Director is charged with the promulgation of rules and regulations, administering the QME/AME process under Labor Code section 4061.5. The Legislature seems to have anticipated these issues by requiring an expedited hearing process for medical treatment issues, under Labor Code §5502 (b).

The court concluded that at the time the applicant objected to the report of Dr. Glausman that she should used the QME process to resolve whatever dispute had arisen.

AMEs Should Not Replace Credible Treater's Report

By Paul A. Aubin, D.C.

I have been following with great interest your focus on the all-important topic of the treating physician's presumption in recent issues of the IMC's *Medical Examiner*. Arthur Johnson, Esq., an applicant's attorney, described the problem inherent among unrepresented workers whose treating physician fails to adequately fulfill his or her obligation under L.C. 4061.5 to "render opinions on all issues necessary to determine the employee's eligibility for compensation." Dr. Phillip Wagner followed up with the well-reasoned opinion that the repeal of the treater's presumption "would be a disaster."

To be sure, I agree wholeheartedly with Dr. Wagner and I applaud Mr. Johnson's desire to protect the rights of the injured employee. I also agree that the failure of the treating physician to write an adequate closing report often does a disservice to injured workers and may ultimately deny them legitimate benefits to which they may be entitled as result of their injuries. In fact, I believe that the inability of many treating physicians to properly prepare a ratable closing report is one of the factors that led the authors of L.C. 4061.5 to allow the treater to designate another physician to evaluate their patient and prepare this report, a service I have provided for many of my colleagues in recent years.

However, there is a category of patients within the work comp system that is routinely being denied the benefits of the treating physician's presumption as outlined in L.C. 4062.9, and powerfully confirmed in the now famous *Minniear* decision, because for them the treater's closing report is simply being bypassed. I am referring to represented employees who are commonly referred by their attorney and their adjuster to an AME for the purpose of settling their case without so much as contacting the treating physician or attempting to solicit his or her opinion regarding the employee's status. In fact, represented employees' cases are typically settled according to the AME report despite the fact that the treating physician may hold a contrary opinion regarding such things as the patient's permanent and stationary status, permanent disability and the need for future care.

Now I do not profess to be an attorney, nor do I have legal training of any kind, but as a participant in the California Workers' Compensation system, it is incumbent upon me to be able to read, interpret and apply the California Labor Code as it pertains to my practice. As such, I submit that the above described custom completely sidesteps the treating physician's presumption and thereby threatens to negatively impact the employee's benefits by ignoring the principal advantage on which the presumption was established - namely

the treater's familiarity with the case. Moreover, it negates one of the primary purposes of 4062.9 and *Minniear*, which is to reduce confusion and cost by reducing the number of med-legal reports generated on any given case.

In order to appreciate the nuances surrounding this issue, I would like to place it in its proper historical and legal context, as I understand it. Prior to 1994, virtually all issues of permanent disability, future medical care and vocational rehabilitation were decided through either the QME or AME process. However, in 1994 the laws were significantly changed placing more responsibility on the shoulders of the treating physician to properly document and describe any ratable factors of disability that may exist once the patient has been declared permanent and stationary.

Specifically, Labor Code 4061.5 states in part;

"The treating physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician shall, in accordance with rules promulgated by the administrative director, render opinions on all issues necessary to determine eligibility for compensation."

Along with this added responsibility came acknowledgment that the treating physician's opinion, by virtue of the long-standing relationship with the patient and familiarity with the case, was almost certainly the most reliable opinion on which to settle these important issues. Accordingly, Labor Code 4062.9 granted the physician the presumption of correctness where two or more comprehensive reports exist for the same case, except in cases where both parties have selected QME's. Thus, having received a properly documented closing report from the treating physician describing the patient's ratable factors of disability, the carrier is to settle the case based on this report unless a preponderance of the medical evidence can be shown to contradict some important aspect of the report.

Labor Code 4061(c), which governs the use of AME's, unmistakably honors the spirit of these new guidelines. Please read the following excerpt carefully;

"If the parties do not agree to a permanent disability rating based on the treating physician's evaluation or the assessment of need for continuing medical care, and the employee is represented by an attorney, the employer shall seek agreement with the employee on a physician to prepare a comprehensive medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury."

This language is clearly intended to preserve the integrity of the treating physician's presumption by allowing the use of an AME only when the treater's closing report has been found to be either inadequate or ambiguous. In fact, prior to the treating physician rendering "opinions on all issues necessary to determine eligibility for com-

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"The AME process is intended to remedy the absence of a ratable closing report on the part of the treating physician in instances where the employee is represented."

The opinions expressed in Letters and Analysis are those of the authors.

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“pensation” by way of a closing report as required by L.C. 4061.5, there is no basis for making a permanent disability rating. Subsequently, since the AME process as described in 4061(c) is only to be initiated when “*the parties do not agree to a permanent disability rating based on the treating physician’s evaluation,*” then requesting an AME before the treating physician has declared the patient to be permanent and stationary and prepared a closing report, is clearly inappropriate and contrary to the intent of this code. More importantly, it often has the effect of completely overshadowing the presumption established on L.C. 4062.9 and the subsequent *Minniear* decision, and may deny proper benefits to the injured employee.

As I have indicated, the AME process is intended to remedy the absence of a ratable closing report on the part of the treating physician in instances where the employee is represented. Unfortunately, what I (and many of my colleagues) have experienced in practice is that applicant’s attorneys will typically instruct their clients to schedule an AME examination without ever consulting or even contacting the treating physician at all. In many cases, this examination is scheduled despite the treating physician’s well-documented opinion, by way of his or her monthly reports, that the patient is not yet permanent and stationary. Moreover, the employee is usually ignorant of the fact that the outcome of his case relies almost entirely on the report of a doctor whom he will meet only once and that his treating physician’s opinion will be given little more than a passing glance under the heading of “Review of Medical Records.”

By way of illustration, I would like to offer the following example from my own practice. A patient of mine with significant spinal disc injuries was recently referred by his attorney to an AME. The AME in this case predictably found the patient to be permanent and stationary and the case was subsequently settled based on his report. In this particular case, I had been the treating physician of record for several months and my periodic reports clearly indicated that the patient was still some months from being permanent and stationary. Fur-

thermore, the patient had been treated by several medical doctors prior to coming to my office and was very happy with the progress he was making under chiropractic care. As such, I continued treating the patient, submitting periodic reports as required, and when the patient became permanent and stationary I submitted a ratable closing report.

In this particular case, the AME, an orthopedist, had opined that chiropractic care was no longer necessary. Subsequently, the carrier immediately began to object to my billing despite the fact that I continued to be the employee’s properly selected treating physician under L.C. 4600. In addition, the objection was a direct violation of L.C. 9792.6(c) (2) and subsequent case law which require the contrary opinion of a physician with similar training, education and experience on which to base an objection to medical care. Specifically what these cases established, among other things, is that a doctor in one specialty (such as orthopedic medicine) is not qualified to comment on the appropriateness of care within another specialty (such as chi-

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ropractic medicine). Despite these facts, the judge concluded that my opinion as the treating physician was virtually immaterial in the presence of an AME’s report. He further indicated that he would abide by the AME’s opinion on all relevant issues including future treatment, contravening both the Labor Code and case law, as I understand them. The disintegration of my presumption as the treating physician was thus complete. The final blow came in the form of my patient’s shock when he was told that he would no longer be able to see his physician of choice simply because he took the advice of his attorney and/or adjuster in seeking an AME examination.

Now I relate this story to illustrate the extent of the misconception surrounding this issue. It is not indicative of all such cases, but neither is it unusual. In my discussions with other providers, I have learned that this sce-

nario is being played out, with mild variations, on a regular basis throughout the Bay Area and beyond. What I find most disturbing about this practice of bypassing the treating physician is that, in choosing this option, monetary factors tend to outweigh the well being of the patient. The employee’s attorney only gets paid when the case settles and therefore has an interest in settling the case as quickly as possible. Likewise, the carrier is often very eager to settle the case sooner rather than later as this typically saves them money in the long run. Meanwhile, the employee is told that the AME examination is a **necessary** part of the process of settling his or her case. Subsequently, the carrier and the applicant’s attorney “agree” to an AME so that the case can be settled expeditiously, regardless of the patient’s current status as documented by the treating physician.

Clearly the injured employee is just as eager to settle his or her case as any other party already mentioned. However, completely ignoring the treating physician’s opinion for the sake of fiscal expediency may be in conflict with the injured employee’s best long-term interests. Conveying this important point to the employee should be the purview of the employee’s attorney, whose job is to protect his client’s rights. What typically happens in actual practice, however, is that the attorney often presents the AME option as necessary without ever educating the employee on the potential downside of this decision. As such,

this may represent a conflict of interest. These opinions I am expressing are based on discussions I have had with my own represented patients who have been scheduled for AME examinations at the direction of their attorneys, all without my knowledge or input. When I explain to them what I have outlined in this letter, it becomes clear to me that they are hearing it for the first time.

Finally, it must be acknowledged that in addition to bypassing the treator’s presumption, the practice described above nullifies the second purpose of 4062.9 as outlined in *Minniear*, namely to reduce the number of med-legal reports in any given case and their associated cost. Labor Code 4061.5 states that the treating physician “*shall*” prepare a ratable closing report. As anyone familiar with the language of the Labor Code knows the word “*shall*” is a mandate. No exception of any kind is indicated, including the presence of an AME report.

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Presumption Should Not Apply To Psychotherapists

By Clifton Lamb, MD

Should the opinions of treating psychotherapists be presumed to be correct regarding med/legal issues?

Within the controversy as to whether treating doctors are to be presumed accurate, wise and just, the particular case of the patient/litigant who is being treated with psychotherapy by a mental health professional must be carefully studied. The relationship between patient and doctor in psychotherapy is far more intense, involved and encompassing of factors which may not be connected to the work injury than is the case in other specialties or disciplines.

The patient and doctor are and must be allies. A therapeutic relationship cannot begin without the therapist offering empathy, trust and validation. Even if the validation is provisional in the mind of the therapist, this cannot be shared with the patient whose feeling of victimization may be exaggerated. Much later in treatment, doubts can arise as insights are "discovered" together.

In extreme cases, the patient sees the therapist as a savior and the therapist responds with total advocacy of

the patient's claim. The therapist sometimes encounters an ethical dilemma when the industrial condition that they are authorized to treat subsidizes but their patient still needs treatment for long standing non-industrial problems. Should the patient be abandoned, or should treatment continue under the guise of it being industrial? The patient may decompensate, if overly dependent, when treatment is cut off. Thus, it is often better if the decision is not made by the treating doctor. When psychotherapy seems to be continuing far too long, the carrier should not presume that the treator is correct and should require a med/legal exam on the issue - which should be consultative rather than adversarial.

Because of the relatively small number of psychiatric claims that go onto treatment, not many therapists have much experience with the workers' compensation system. They are likely, when inexperienced, to feel as unfairly treated as their patients and to develop a bias against the insurance carrier that may be undeserved.

There are some advantages that the treating psychotherapist still has. Obviously, there remains a greater oppor-

tunity for in-depth understanding.

From the vantage of a number of sessions over time, the point when the condition becomes P & S can be better determined provided the concept is understood. Treators, however, are often at a disadvantage by not being provided information known by the defense that might provide information not disclosed by their patients.

Although I believe that, in general, the bias of the treating mental health provider is quite 'liberal', there are cases where the insurance industry has undue influence over the practice of physicians in large HMO's. This, not uncommonly, causes treatment to be extremely brief with appointments infrequent and return to work recommended very early. Med/legal exams should be demanded by the injured worker when treatment seems inadequate and return to work ordered too soon.

I have treated hundreds of psychiatrically injured workers over a period of fifteen years. Unfortunately, the reimbursement became too low for me to continue. My experience strongly suggests that the opinions of treating psychotherapists should not be presumed to be correct regarding M/L issues.

Waddell's Tests Apply in Multiple Settings

By Bryan Barber, MD

I appreciated some of the comments by Michael Sackett, D.C. in his article: Patient Believability Factors. However, I think some remarks are in order and are offered here to hopefully clear up a couple of misconceptions.

In his article, Dr. Sackett remarks that Waddell's tests should not be used in patients with serious spinal pathology; patients over 60 years of age; and ethnic minorities because of their "wide cultural and pain behaviors." I disagree strongly with this statement. If someone has serious spinal pathology, Waddell's tests can be modified accordingly (i.e., push down ever so slightly on top of the head during the axial loading tests). Age has nothing to do with Waddell's tests, nor does ethnicity. Waddell's tests are universal although I would caution that patients who do not speak the English language be given clear instructions in their own language before and while these tests are performed.

Speaking of Waddell's tests, which consists of six categories (tenderness to light touch, axial rotation, axial loading, distraction straight leg raising, regional disturbances, and overreaction), I have found it helpful to grade each of these maneuvers/estimations from 0-5, rather than pos or neg. In this way, one can determine if Waddell's tests indi-

cate slight, moderate or severe inorganic pain behavior. After estimating the degree of inorganic pain behavior, then it becomes necessary to determine if this inorganic pain behavior is all or in part due to a bona fide chronic pain syndrome, illness enhancement, malingering (fraud), factitious (fraud), or due to the Munchausen syndrome, etc. Malingering, for example, is uniquely identifiable if three criteria are present: 1. Willful acts, (verbal remarks or physical actions with intent to deceive), 2. Reasonable goals, and 3. Cost effectiveness (feigned condition has to be not so severe as to interfere with the malingerer's ability to engage in other activities important or meaningful to him or her).

For those who wish to learn more about malingering, illness enhancement, imposters, Munchausen Syndrome, factitious disorders, etc., I can recommend *Patients Who Deceive* by Dr. Leon Pankratz (psychiatrist), published in 1999. This book is easy reading, avoids technical medical terms, and most of all, entertaining, if not humorously macabre. A must book if one wishes to sweep away the cobwebs these kinds of patients weave in our offices. As Dr. Pankratz so eloquently puts it, the last thing we want to do as health care deliverers is overtreat these individuals, because overtreatment may cause harm and one of medicine's most important credos is, 'Do no harm!'

The AB 435 Controversy

Some Confusion Remains Over Access To Records

By James D. Fisher, Esq.

The Legislature in the 1999 session passed AB 435 amending section 3762 of the Labor Code, commonly known as the Employer's Bill of Rights. The purpose of AB 435 is to restrict the flow of medical information from insurance companies and third party administrators (TPAs) to the employer. The passage of this bill has produced confusion for physicians in the workers' compensation community. The purpose of this article is to clarify the obligations of treating doctors and QME's in the wake of this law.

Labor Code section 3762(c) of the Labor Code prohibits insurance companies, TPA and in-house claims administrators from disclosing or causing to be disclosed to the employer, any "medical information" as that term is defined in section 56.05(b) of the Confidentiality of Medical Information Act (CMIA). Section 56.05(b) of the CIMA gives a broad meaning to the term "medical information."¹ Employers are unhappy with the restrictions on the medical information being sent from the insurance companies or their TPA.

AB 435 has little, if any, direct impact on the work of treating physicians and QME's because the law only restricts the information an insurer, a third party administrator or, arguably, an in house administrator may share with the rest of the organization.² With rare exceptions, the injured worker is claiming benefits against the employer, if the employer is self-insured, or the employer and its insurance company, if the employee is injured. Needless to say, virtually every dispute in workers' compensation cases involve either some part of the injured worker's body, a portion of their medical history or the validity of their medical treatment they have received.

Two exemptions from the CMIA apply in workers' compensation cases that unravel the shield of confidentiality for medical information that would ordinarily apply to the disclosure of this information.

The first exemption to the coverage of the CMIA is Civil Code section 56.10(c)(A). This law requires disclosure if the information sought is "relevant in a lawsuit...or other claim or challenge where the employee and employer are parties, and where the patient has placed in issue their medical history, mental or physical condition or treatment."

The second exemption, is where a party issues a subpoena demanding the information. Section 56.10(b) of the Civil Code requires a provider health care to disclose medical information if the disclosure is compelled by a subpoena served pursuant to section 1987 of the Code of Civil Procedure.

Nothing in AB 435 prevents an employer from acquiring information directly from the treating doctor or the QME about the injured workers' medical condition because the information appears to be exempt from the CMIA. Consequently, the information that the employers insurance company or its TPA cannot provide to the employer is generally not confidential under the CMIA.

An employer, assuming it is a party to the compensation case, may issue a subpoena to a health care provider to acquire information held by the provider. As a practical matter, if you, as a medical practitioner receive a valid subpoena for medical records or medical reports, you should comply unless you receive an order from a Workers' Compensation Judge saying do not comply.

Practitioners who treat workers and receive a subpoena that they believe asks for information which may not be relevant to industrial injury may wish to discuss these issues with their patients. A valid subpoena requires that an injured worker be copied with the subpoena to allow the injured worker or their attorney to file an objection with the Workers' Compensation Appeals Board if they believe that the information requested is too broad and therefore violates the injured workers right to privacy.

The filing of a claim does not waive the injured workers' right to medical privacy on all issues, just the issues that are relevant to the workers' compensation claim. Allison v. WCAB (1999) 72 Cal.App.4th 654. For example, many medical practitioners have provided treatment of medical conditions that are unrelated to the condition that is the subject of the workers' compensation case. In Allison, the Court of Appeals held that whether medical information is exempt from confidentiality in workers' compensation claims depends on the injuries claimed by the worker. Of course, other non-industrial medical problems may or may not be relevant to the workers compensation case and their relevancy must be determined on a case by case basis. However, what is relevant to the claim is not your decision. The Allison court also held that the workers compensation judge, alone, and not the attorneys who represent the parties or doctors who treat the worker, have the power to limit the disclosure of medical information requested by a subpoena.

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AB 435 has little, if any, direct impact on the work of treating physicians and QME's because the law only restricts the information an insurer, a third party administrator or, arguably, an in house administrator may share with the employer.

"As a practical matter, if you as a medical practitioner receive a valid subpoena for medical records or medical reports, you should comply unless you receive an order from a Workers' Compensation Judge saying do not comply."

to the workers compensation case and their relevancy must be determined on a case by case basis. However, what is relevant to the claim is not your decision. The Allison court also held that the workers compensation judge, alone, and not the attorneys who represent the parties or doctors who treat the worker, have the power to limit the disclosure of medical information requested by a subpoena.

¹ Section 56.05(b) says "[A]ny individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care or health care service plan regarding a patient's medical his-



David Kizer, Esq.

This marks the return of one of our most popular columns. Recent decisions by the Administrative Director and Deputy AD reported in the *California Workers' Compensation Reporter* have helped answer some of the more common questions received by the IMC. The Reporter has long been held as the citable authority for decisions issued by the WCAB and the Administrative Director of the Division of Workers Compensation. Q & A is not intended as legal advice but as a general discussion of the law as it relates to certain issues. Every case is different and should be treated as such.

Q: I am a QME and I have been selected by an injured worker to evaluate his work related injury; however, at the time the worker was injured I was his employer. Am I required to evaluate the applicant who is both my employee and a claimant in a workers' compensation case against me?

A: The QME ethical rules, Title 8 California Code of Regulations section 41(c)(4), require the expert opinions or conclusions of a QME to be based on "the facts, and on the QMEs training and specialty knowledge, and shall be without bias either for the injured worker or the employer." Thus, in your case, you would be asked to render an opinion that is not biased in a claim against you. In the situation presented above, a QME is placed in an untenable situation, as a defendant to the workers' compensation claim of the injured employee while at the same time being asked to evaluate the injured employee entitlement to workers' compensation benefits. No matter how the QME writes the report, a claim of bias could, in all probability come from the employee the QMEs insurance carrier (who, by the way, you have contracted with to help defend the claim as an employer) or, on its own motion from the WCAB.

The IMC believes that the QME should not do these evaluations and that a replacement panel should be issued to the injured worker. Similar "bias" problems arise where the QME employs a family member of the injured worker. In this situation another replacement panel would be issued by the IMC.

Q: As a treater, do I have to serve both the employer/adjuster and the employer's attorneys with copies of all treatment reports?

A: Although most physicians do this as a courtesy upon request, there is no requirement that the treater serve the defense counsel with separate copies of the treatment reports. *Marino v. Petaluma Poultry* 26 CWCR 113 (ADD 1998).

Q: If a QME submits a report past the 30 days in violation of the IMC time frames (IMC Rule 38) will that support a petition for ratings reconsideration?

A: Failure to comply with the 30 day time frame will result in a complaint and potential discipline against the QME, but the Deputy AD has held that, provided the QME has notified the parties, that the report will be late, it does not constitute grounds for reconsideration *Duncan v. CIGNA Ins.* 24 CWCR 239 (ADD 1996). If the QME fails to notify all parties, including the IMC, that the report will be late, then the 15 day period in which the injured worker may request a new panel does not run. The worker must request a new panel however, and cannot simply wait to review the medical report and then file for reconsideration.

Q: What if my treatment differs from the IMC treatment guidelines? Can the employer object?

A: The answer is yes with a caveat. The treatment guidelines are educational in nature and, although regulatory, are simply guidelines. They are not intended to serve as substitutes for the clinician's judgment. Variance language is built into them. The Deputy AD has held that absent egregious deviation from the guidelines, the fact that the guidelines were not followed is not justification for a petition for change of physician pursuant to DWC Rule 9786. *Russian-Garner v. Glendale Federal Bank* 27 CWCR 143 (ADD 1999). Any petition would have to establish that the treatment is inappropriate and must be based on medical evidence. Egregious deviation from the IMC treatment guidelines would simply be one more factor to be considered.

Q: May an employer or family member serve as a primary treating physician?

A: This issue has been complicated somewhat by an earlier AD decision in which former AD Mr. Casey Young found, that as long as there was no showing of an actual conflict of interest, there was nothing invalid with the physician/employer serving as the primary treating physician. The new AD has taken a different view in *Mertz v. TIG Ins.* 28 CWCR 143 (ADD 2000) and held in that case, that a petition for a change of physician under AD Rule 9786 was appropriate when the employer was the treater because of the inherent conflict. This was held so despite the fact that these relationships are not specifically listed in section 9786.

Q: May a chiropractor be reimbursed for utilizing physical therapy modalities?

A: According to the Attorney General as cited in *Hughes Grocery v. WCAB* 58 C.C.C. 160 (WD 1993) a chiropractor is entitled to reimbursement for physical therapy modalities (muscle stimulation and ultrasound treatment) to cure or relieve the effects of the injury because the modalities are within a DC's scope of practice. A DC, of course may not hold him or herself out to be a physical therapist in their advertising.

Q: How many physician assistants may a supervising physician legally supervise?

A: Current law allows only two at any given time Bus & Prof Code section 3516 (a). The supervising physician must be available through at least electronic means during the supervision period.

Q: Can the Doctor's First Report be in narrative form?

A: Not any longer. AD Rule 9785 (e) requires all Doctor's First Reports of Injury to be on Form 5021. The former AD Rule 9785 (b) had allowed this practice. The

■ Cont'd on pg. 10

AN OVERVIEW OF THE NEW QME REGULATIONS

The following is offered to assist in explaining the most important changes to the new QME regulations. Editors note: with the passage of AB 776, the QME regulations will have to be modified again during the Fall to reflect the new law.

The QME forms

All of the QME forms have been simplified and moved to one section. Previously, the forms were scattered throughout the regulations behind the section that the form was based on (e.g. section 34 is the section on the QME notification requirements. Section 34.1 was the form). All forms now begin in Section 100 (beginning with the application form) and continue from there. The forms are free and are now available in one packet directly from the IMC and can be downloaded from the IMC web-site. The regulations, of course, can still be requested separately from the IMC and will continue to appear in various commercial publications or through continuing education providers. *It is important to note that IMC staff can return a form that is now outdated and does not contain current information.*

The Sanction Guidelines

The Sanction Guidelines are new and outline the range of penalties for QMEs who engage in prohibited conduct. The Sanction Guidelines provide a framework for the council to use when considering discipline against a QME; however, the Council is not limited to the provisions in the guidelines and may consider other sanctions as well. The Guidelines are intended to serve as notice to QMEs that certain conduct will bring with it a specific response.

One provision that should attract immediate notice is IMC Rule 41 (e) which prohibits a QME from contacting a QME selected from a panel in order to intimidate or influence the final outcome of their opinion. IMC Rule 35 (e) allows QMEs to consult with all of the worker's treating physicians in order to produce an accurate report. Consults are exchanges of opinion. Rule 41 relates directly to threatening or coercive behavior.

QME Eligibility

AB 776 has made significant changes to the QME criteria for eligibility. Other changes already in effect now include:

- ☞ An application that contains false information or does not include supporting documentation (e.g. proof of completion of a residency program) will be rejected.
- ☞ A physician must notify the IMC whether their licensing agency has placed the QME on probation prior to appointment.
- ☞ A physician retired from full time practice because of a disability must only have 10 years experience in workers compensation issues, previously the regulation required 25 years.

The QME Process

☞ If a QME fails to serve the QME Notification Form and/or fails to comply with IMC Rule 34, any party may request a replacement QME.

☞ If permanent disability is in issue under Labor Code section 4061, an adjuster should so notify the IMC prior to the injured worker attending an evaluation with an acupuncturist. If the adjuster fails to notify the IMC and the injured worker does attend a PD evaluation with an acupuncturist, the acupuncturist is now required to refer the injured worker to a physician (as defined under Labor Code 3209.3) for the PD assessment.

☞ If the workers' compensation judge believes that the medical evidence is insufficient and cannot qualify as substantial evidence, the judge may request a QME be assigned in an appropriate medical specialty provided the employer agrees to pay the cost.

☞ The Medical Director may review any objection to a panel QME that is made on a medical basis only (e.g. podiatrist for a psyche exam or orthopaedist for a cardiovascular problem).

☞ All QME evaluations must be performed in compliance with the appropriate IMC evaluation guidelines.

☞ All supplemental reports for panel cases must be completed and served within 60 days of the original request which was accompanied by the appropriate records to be reviewed.

☞ Face to face time for purposes of QME examinations specifically excludes time spent in a waiting room. Because of prior abuse, this provision will be strictly enforced if false information on face to face time is listed on a QME report.

☞ The QME Summary Form is not required to be served with a supplemental report.

☞ If a QME performs an evaluation and then leaves the QME system and a supplemental report is required, the QME may still review the records and submit the supplemental report provided a physical examination is not required. If the QME is unavailable then the IMC will issue a new panel in the same specialty to perform the supplemental/follow-up as required for a complete up to date evaluation.

Reappointment

☞ QMEs may be denied reappointment if they are found, after hearing, to have failed to comply with a WCAB ruling or order or have performed a QME evaluation while their QME status lapsed.

☞ All QMEs must continue to complete continuing education requirements. Many providers are now offering "distance learning" at home courses for the convenience of QMEs.

The changes to the IMC rules took effect May 15, 2000.

■ Cont'd from p. 8

treatment plan must be included in line 24 on the form. See: *Regalado v. Republic Ind.* 28 CWCR 23 (ADD 2000).

Q: If my patient's claim is denied by the carrier, can I bill my usual and customary charges or am I limited to the medical fee schedule?

A: This issue has been festering for a long time. In *California Workers Compensation Law & Practice, 5th ed.* P. 623 Judge St. Clair writes "the schedule does not necessarily apply to reimbursable, self-procured medical expenses ... such self-procured medical expense ordinarily will be awarded as billed by the treating physician so long as the bill is within the physicians usual and customary fees." It has been held that defendants are not entitled to the benefit of the fee schedule where they have somehow neglected or refused to provide medical treatment, *Federal Mogul Corp. v. WCAB (Whitworth)* 38 C.C.C. 584 (WD 1973).

In *Midas Recovery Services v. WCAB (Garcia)* 1997 62 C.C.C. 537 (WD) however, a board panel held that, in the absence of evidence to the contrary, the fee schedule would apply to denied claims.

Finally, in *Valdez v. WCAB* 62 C.C.C. 1145 (WD 1997), the board panel reaffirmed *Whitworth* in holding that if a claim is denied by a defendant, then the provider may bill up to his or her usual and customary, but no more. The basis for the decision was that in a denied claim situation, the provider is taking a risk that the services may not be reimbursed at all if the claim is without merit and therefore it would be a disincentive to all providers not to treat any injured worker unless the claim is accepted. This would be against public policy, the panel stated.

Thus, it appears that once the lien claimant establishes the usual and customary charges are reasonable, the defendant has the burden to show they are not.

Q: Does a psyche component arising from an orthopaedic injury have to have predominant causation as well?

A: No. This was settled (for the time being) in the case of *Rebello v. Washington Hospital* (1999) 27 CWCR 159. The psychiatric injury is a "compensable consequence" of the physical injury. The employment need only be contributing cause of psychiatric injury.

■ Cont'd from p. 7 - AB 435....

tory, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity."

² Labor Code section 3762(c) has two exceptions to the general prohibition against the disclosure of medical information to the employer. Under the first exception, an employer may be given information concerning the diagnosis of the injury if it would effect the employer's premium. The second exception is when the transmission of medical information regarding an injury is necessary for the employer to modify the employee's work duties.

QME M/L Report Survey Provides Valuable Feedback

Although it may come as a surprise to some, the quality of QME and AME reports has improved steadily over the past two years. As part of its legislative mandate, the IMC has been reviewing reports for the last four years and reporting the results of the survey to the Administrative Director of DWC. Many of you are aware of this project as the staff sends a letter to the evaluator after reviewing a report

For the last several years, the IMC has annually reviewed one thousand reports, most which were selected randomly. Each report is inspected for all of the elements required in a medical/legal report, such as a diagnosis and the declarations. Many reports are also examined in depth to see that the more difficult concepts, such as the factors of disability, are done properly.



Anne Searcy, MD

The majority of reports would receive an "A" if they were being graded. That doesn't mean that there isn't room for improvement however, only 27% of the reports were pristine in 1999, up from 10% in 1997.

Here is a list of the top ten errors.

- Failure to address face to face time
- Omitted county or date of declaration
- Work restriction incorrect or missing (e.g. not for the open labor market)
- Subjective factor incomplete/incorrect
- Physical examination not complete (e.g. grip)
- Declaration missing or altered
- Inconsistencies noted in the report
- Omitted statement about L.C. §139.3 (self-referral)
- Not served in a timely manner
- Reasons for tests not stated

In an effort to see if this program is having a positive effect on QME reports, the IMC staff checked the same reports against reports by QMEs who had not been contacted by the IMC about an error in the report. The error rate by the those who had been contacted by the IMC about earlier errors was about half that of QMEs who had never been contacted.

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This newsletter is intended as a public informational and educational source for QMEs and interested persons and may be reproduced.

Correspondence should be directed to the Industrial Medical Council P.O. Box 8888, San Francisco, CA 94128

Industrial Medical Council

The following providers have been approved by the Industrial Medical Council for Continuing Education Courses

Please contact individual providers for upcoming scheduled classes and specific information about the course. The IMC retains copies of all courses which are available for inspection at the IMC offices.

**** Denotes at home class option**

100**	California Orthopaedic Association (COA) (916) 454-9884	410	Michael M. Bronshvag, M.D., Inc. Neuro-Musculo-Skeletal System (415) 464-0373 ext. 812	720	California Acupuncture Medical Association (818) 710-1566
110**	California Chiropractic Association (CCA) (916) 648-2727 ext.125	420	University Of California-Berkeley Center For Occupational & Environmental-Health (510) 231-5645	730	Professional Psych Seminars (805) 371-9443
120**	David W. O'Brien Attorney at Law (949) 363-0684	450	California Society Of PM & R (510) 537-7873	740	University of California - Davis (530) 757-8824
140**	California Society of Industrial Medicine & Surgery (CSIMS) (916) 446-4199	470**	Livingstone-Lopez Consulting (760) 944-6769	750**	Orusa, Inc. (800) 936-7872
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180**	California Compensation Seminars (818) 349-7853	490	Glenn A. Ocker, DPM (909) 985-1831	780	Kaiser Permanente Southern California Regional Coordinator Occupational Health Services (626) 851-5369
210	Los Angeles College Of Chiropractic Post Graduate Division (562) 902-3379	520	Insurance Educational Association (IEA) (800) 655-4432	790	Edington Orthopaedic Group (916) 920-1222
220	Lerner Education (800) 838-8584	540	Industrial Claims Association (ICA) (415) 986-2011	800**	California Workers' Compensation Enquirer (CWCE) (800) 446-0070
230	Division Of Workers' Compensation (415) 703-4600	560	Saint Francis Memorial Hospital (415) 353-6000	810	Michael S. Kesselman, PhD (559) 222-7507
260	Sharon Collins & Margaret Easton (626) 798-8883	570	Dean Falltrick, D.C. (530) 269-1128	820	Roderick Richardson, PhD (760) 242-1088
270	International Chiropractors Association of California (ICAC) (916) 362-8816	580**	Industrial Medicine Seminar (650) 619-1998	830	James T. Platto, M.P.H., D.C. (209) 966-5652
310	CompRite (949) 581-7063	600	Academy for Chiropractic Education (209) 952-0126	840	Resolutions Associates (949) 262-1239
330	American Academy Of Disability Evaluating Physicians (800) 456-6095	610	American Academy Of PM&R (312) 464-9700	850	Current Compensation Seminars (415) 399-9769
340	Western Occupational Health Conference (WOHC) (415) 764-4803	640	Palmer College Of Chiropractic (408) 944-6041	860	Joel H. Sherman (661) 664-1383
360	Northbay Workers' Compensation Association (415) 721-0896	670**	State Compensation Insurance Fund (415) 565-1147	870	Innercalm Associates Post Graduate Department (800) 551-0755
380	AF ICC (661) 861-1000	690	American College of Chiropractic Orthopedists	880	American Institute of Acupuncture Ortho & Traumatology (415) 731-6683

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■Cont'd from p. 5 - Letters.....

Furthermore, Labor Code 4062.9 explicitly states that this report is presumed correct even in the presence of another comprehensive medical examination obtained under 4061, **including** an AME report. But for reasons I cannot explain, most adjusters, applicant's attorneys and even some Work Compensation Judges routinely misinterpret this aspect of the Labor Code.

In my opinion, no specific action is required to counteract this misconception, other than that all players in the work compensation arena need to be made fully aware of the significance of the treating physician's presumption and the appropriate labor codes securing it. Undoubtedly, when the parties are discussing the option of an AME, the adjuster is well aware of the treaters' opinion with regard to the patient's current permanent and stationary and/or disability status. As such, any proposed action should take this opinion into account and not simply ignore it as the AME option typically does. But just as important, treaters need to be prepared to accept the responsibility that goes along with this presumption by educating themselves on the rigors and subtleties of preparing a solid, ratable closing report. If they are unwilling or unable to prepare such a report, they should be ready to exercise their prerogative under L.C. 4061.5 to refer the patient to a competent doctor of their choice who can evaluate the patient and prepare this report for them.

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