

DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION  
MEDICAL UNIT

Qualified Medical Evaluator

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Competency Examination Study Guide

**DWC Medical Unit**

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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 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. Sections II and III describe the principles and laws governing permanent disability and apportionment determinations. Section IV discusses the types of disputes that are raised by injured workers and claims administrators that are resolved by QMEs. Section V discusses how QMEs are chosen in cases, depending on whether the injured worker is represented or unrepresented by an attorney. Section VI 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, the California Labor Code and regulations, a Physician's Guide, and forms used during the QME processes. Those resources may be accessed by using the links in Section VII at the end of this guide.

## **I. QME Accreditation and Reaccreditation: 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 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).)<sup>1</sup> These general appointment requirements are made more specific in other sections of Labor Code section 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).

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<sup>1</sup> The exception to the one-third treatment requirement and its AME alternative (when serving as AME on eight or more occasions) is if the physician is appointed under section 15 of the QME regulations, which regulates the certification of retired, teaching or disabled physicians as QMEs. (Cal. Code Regs., tit. 8, §§ 11, 15.)

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 Regs., tit. 8, §§ 11, 11.5.)

The Administrative Director 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 Regs., tit. 8, § 13.) For a QME to be placed in a specialty, the “physician’s licensing board must recognize the designated specialty board and the applicant for QME status must have provided to the Administrative Director documentation from the relevant board of certification or qualification.” (Cal. Code 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: compliance with all applicable regulations and evaluation guidelines adopted by the Administrative Director, completion of at least 12 hours of continuing education in impairment evaluation or workers’ compensation-related medical dispute evaluation approved by the Administrative Director in the previous 24 months before reappointment, no more than five evaluations rejected by a workers’ compensation judge (WCJ) while serving as a QME and, finally, no termination, suspension, or probation by any licensing board. (Lab. Code, § 139.2(d).) The failure of an applicant to meet any of the above referenced requirements allows the Administrative Director in his or her discretion to deny reappointment to an applicant. The Administrative Director is prohibited from reappointing a QME whose license to practice has been revoked or terminated by their licensing board.

The Administrative Director 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 Regs., tit. 8, §§ 17,18.) The Administrative Director may discipline a QME on grounds set forth in Labor Code section 139.2(k) after hearing; discipline includes suspension or termination.<sup>2</sup>

## **II. Permanent Disability Determination.**

California’s workers’ compensation laws must be “liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment.” (Cal. Lab. Code, § 3202.) This rule is applicable to all aspects of workers’ compensation law, including permanent disability and apportionment determinations. (*Milpitas Unified School Dist. v. Workers’ Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808, 820–21, as modified (Sept. 1, 2010).) The permanent disability evaluation occurs when an injured worker is permanent and stationary – that is, when the worker’s condition has reached maximal medical improvement (MMI) and is unlikely to change substantially within the next year, with or without medical treatment. To ensure that injured workers obtain the benefits to which they are entitled, the examining physician must fully and completely report their findings.

Disability determinations are based on the Permanent Disability Rating Schedule (PDRS),<sup>3</sup> a methodology for determining the nature and extent of an occupational injury. For injuries

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

<sup>3</sup> Not all injured workers who are evaluated after January 1, 2005 (after California adopted the AMA Guides) will have impairment reports based on the AMA Guides. If an injured worker had a permanent and stationary report describing permanent disability completed prior to January 1, 2005, for example, any subsequent report would use a previous PDRS, not the PDRS based on the AMA Guides. There are three versions of the PDRS currently in use: January 2005 (based on the AMA Guides and 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.)

occurring on or after January 1, 2005, the PDRS uses the American Medical Association Guides to the Evaluation of Permanent Impairment (5th Edition) (AMA Guides).<sup>4</sup> The AMA Guides, as the starting point of the permanent disability determination, examines a specific medical impairment's impact on an individual's activities of daily living, such as dressing/bathing, eating, ambulating, toileting, and attending to personal hygiene.<sup>5</sup> The AMA Guides are, of course, only a tool, and its proper use and application by a QME with medical expertise and ability to exercise clinical judgment to evaluate an individual injured worker's level of permanent impairment cannot be overstated. QMEs are expected to know the basic principles of workers' compensation laws related to QME responsibilities and the AMA Guides, discussed below.<sup>6</sup>

### **A. Substantial Evidence.**

Substantial evidence is "relevant evidence a reasonable mind might accept as adequate to support a conclusion." (*City of Jackson v. Workers' Comp. Appeals Bd.* (Cal. Ct. App., Apr. 26, 2017, No. C078706) 2017 WL 1488733, at \*5.) To constitute substantial evidence, a physician must conduct an adequate and comprehensive examination of the injured worker before making impairment determinations. (*See, e.g., Escobedo v. Marshalls* (2005) 70 Cal. Comp. Cases 604,

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<sup>4</sup> By incorporating the AMA Guides into California's workers' compensation system in 2004, the Legislature's goal was to make the measurement of impairment and permanent disability ratings more objective, uniform, and fair throughout the state, and to base decisions on the best available medical evidence. The AMA Guides are widely used in state workers' compensation systems, as well as the federal compensation system. (Note: 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).))

<sup>5</sup> A rater will change the AMA Guides-based impairment ratings into permanent disability ratings by applying scheduled PDRS adjustments such as age and occupation.

<sup>6</sup> *Blackledge v. Bank of America* (2010) 75 Cal. Comp. Cases 613, 615 (en banc) provides that 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.

619 (WCAB) (en banc) [“. . . [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.”]; *see also Milpitas Unified Sch. Dist. v. Workers’ Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808, 825 [“In order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability. . . . Also, 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. . . . Further, a medical report is not substantial evidence unless it sets forth the reasoning behind the physician’s opinion, not merely his or her conclusions. . . .”] citing *E.L. Yeager Const. v. Workers’ Comp. Appeals Bd.* (2006) 145 Cal.App.4th 922, 928.) The AMA Guides also require physicians to perform a thorough and comprehensive medical examination.

A QME must address the worker’s history and symptoms, the results of her medical examination, the results of various tests and diagnostic procedures, the diagnosis, the anticipated clinical course, the need for further treatment, and the residual functional capacity and ability to perform activities of daily living. In making impairment determinations, a QME must use her entire range of clinical skill and judgment to assess whether or not the measurements or test results are plausible and consistent with the impairment being evaluated. Further, an appropriate rating under the AMA Guides for any illness or injury should take into account all impairments, not only the primary body part or organ system impacted, but the full impact of the illness and injury and its treatment.<sup>7</sup> Different sections of the AMA Guides may apply, depending on the impact of any

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<sup>7</sup> Section 2.5b of the Guides, in Chapter 2 on “Practical Applications of the Guides,” explains that to determine whole person impairment:

[T]he physician should begin with an estimate of the individual’s most significant (primary) impairment and evaluate other impairments in relation to it. It may be necessary for the physician to refer to the criteria and estimates in several chapters if the impairing condition involves several organ systems. Related but separate conditions are rated separately and impairment ratings are combined unless criteria for the second impairment are included in the primary impairment. For example, an individual with an injury causing neurologic and muscular impairment to his upper extremity would be evaluated under the upper extremity criteria in Chapter 16. Any skin impairment due to significant scarring would be rated separately in the skin chapter and combined with the impairment from the

illness or injury and its treatment.<sup>8</sup> Only after consideration of all of these factors may a QME compare the medical findings for each condition with the AMA Guides' impairment criteria and calculate the appropriate whole person impairment (WPI) rating or ratings for each condition.<sup>9</sup>

### **B. Rating by Analogy and Using the Four Corners of the AMA Guides.**

While the WPI component of any rating must be based on the AMA Guides, physicians are not locked into any specific method for evaluating WPI under the AMA Guides. Instead, a physician must use her “judgment, experience, training, and skill” when evaluating an injured worker’s WPI “using the chapter, table, or method of assessing impairment of the AMA Guides that most accurately reflects the injured employee’s impairment.” (*City of Sacramento v. Workers’ Comp. Appeals Bd. (Cannon)* (2013) 222 Cal.App.4th 1360, 1369; *Milpitas Unified School Dist., supra*, 187 Cal.App.4th at 827-29 [physician has latitude to rely on entirety of the AMA Guides]; *see also* Cal. Lab. Code, § 4660(b)(1) and (c).) Where a particular impairment is not listed in the AMA Guides, physicians are instructed to “use clinical judgment, comparing measurable impairment resulting from the unlisted condition to measurable impairment resulting from similar conditions with similar impairment...” (AMA Guides, at Chap. 1, section 1.5, p. 11.)

QMEs should be also be aware that the PDRS provides rebuttable prima facie evidence of the percentage of disability attributable to injuries covered by the schedule. “To make an impairment determination in rebuttal of the Schedule, the physician is permitted... to use the ‘four

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upper extremity chapter. Loss of nerve function would be rated within either the musculoskeletal chapters or neurology chapter. (AMA Guides, Chap. 2, section 2.5b, p. 19.)

<sup>8</sup> The QME report should explain why a departure from the strict application of the AMA Guides may be appropriate for specific circumstances.

<sup>9</sup> Chapter 18 of the AMA Guides provides that a WPI rating may be increased by up to 3% WPI if the worker sustains a pain-related impairment in excess of the pain component already incorporated in the standard WPI rating for the applicable body part or organ. The 1-3% pain “add on” may only be added to the body part that already has a ratable impairment.

corners of the Guides.”” (*Milpitas Unified School Dist. v. Workers’ Comp. Appeals Bd.* (2010) 187 Cal.App.4th 808, 827 *as modified* (Sept. 1, 2010).)

### **C. Industrial Cancer.**

The AMA Guides do not provide direct ratings for cancer, as such. Instead, the AMA Guides provide ratings for specific impairments that a worker may experience as a result of any injury or illness, including cancer, and from the effects of treatments of such cancer. Different sections of the Guides may apply depending on the impact of the disease and its treatment.

Doctors must evaluate and report all ratable impairments resulting from an illness or injury, including cancer, and/or from the effects of treatment for such cancer, found through a full and thorough medical evaluation. It is important for a QME to perform a comprehensive medical evaluation that takes into account not only the primary body part or organ system impacted by industrial cancer, but the full impact of the cancer and its treatment. For breast cancer,<sup>10</sup> for example, the medical report should reflect that the QME has conducted a comprehensive medical examination of the injured worker and considered not only the impact from any mastectomy, lumpectomy, or lymph node surgery, but also any impairment resulting from other forms of treatment such as chemotherapy, radiation, and/or long-term medications taken to prevent recurrence. The impairment assessment should reflect consideration of the following factors, without limitation: (1) the presence or absence of the breast(s); (2) the loss of any function of the upper extremity (or extremities) due to surgery, including range of motion, loss of strength, neurological abnormalities and pain, lymphedema, etc.; (3) skin disfigurement and scarring; (4)

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<sup>10</sup> Accusations have been made that the permanent disability benefits provided to some women workers who have been diagnosed with and treated for breast cancer were too low due to incomplete or under-evaluation of the permanent impairment that may have resulted from the disease and its treatment, and that this could reflect possible discrimination against women. Discrimination within the workers’ compensation system on the basis of any protected category, including gender, is unlawful and impermissible. Medical providers should be alert and sensitive to this issue and should be vigilant in reviewing medical evaluations for workers who have suffered breast or other cancers to ensure that such evaluations accurately apply the AMA Guides and reflect the *full range of impairment* that such workers may have suffered from the cancer and its treatment.

any chronic pain; (5) any permanent impairment resulting from chemotherapy treatment, including any onset of premature menopause, loss of ovarian function, permanent neuropathy, or any other permanent side effects; (6) any permanent impairment resulting from radiation treatment; (7) any permanent impairment resulting from the side effects of aromatase inhibitors or other hormone therapy prescribed to prevent recurrence, including joint pain, fatigue, premature menopause or loss of bone density; and, (8) any other permanent impairment resulting from the breast cancer or its treatment. The completed evaluation must delineate all the factors present in the particular case, together with the WPI assigned to each, and a reference to the supporting sections and tables of the AMA Guides.

### **III. Apportionment Determinations.**

California's workers' compensation system requires employers to compensate employees for any disability directly caused by a work injury, but employers are not liable for disability that was caused by other factors occurring either before or after the industrial injury. (Lab. Code, §§ 4663, 4664.) This concept of "apportionment" protects employers from being forced to pay for disability that is not the direct result of an industrial injury. Labor Code section 4664, subdivision (a), provides that the employer "shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment." Medical-legal reports, including all QME reports, must include an "apportionment determination" in order to be considered complete on the issue of permanent disability.<sup>11</sup> Labor Code section 4663 requires a physician to make an apportionment determination "by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries." (Lab. Code, § 4663, subd. (c).)

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<sup>11</sup> 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 insufficient to meet the requirements of the statute. (*State Comp. Ins. Fund v. Workers' Comp. Appeals Bd. (Dorsett)* (2011) 201 Cal.App.4th 443.)

## A. Causation.

Although the law requires apportionment of the causation of the worker's permanent disability (i.e., what portion of the final *disability*, if any, was *caused by* factors other than the work injury), physicians may *not* apportion the causation *of the injury*. A QME report that apportions causation of the injury, rather than of the disability, is not substantial evidence. To be substantial medical evidence, the QME report 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, supra*, 70 Cal. Comp. Cases at 621.)

Physicians may occasionally make the mistake of apportioning causation of injury rather than causation of permanent disability.<sup>12</sup> This is more likely to occur when the injury is either a cumulative trauma or an event such as a heart attack or stroke, i.e., an injury that is not the result of a typical workplace accident, or in cases where the distinction between the injury and the disability may be unclear. (See, e.g., *City of Jackson v. Workers' Compensation Appeals Board* (April 26, 2017) 2017 WL 1488733, at \*5.) A good example of this issue is found in *Anderson v. Jaguar/Landrover of Ventura* (July 24, 2012) (panel decision) 2012 WL 4788501; 2012 Cal.Wrk.Comp. P.D. LEXIS 327. The worker suffered a shoulder injury at work, underwent surgery for the injury and suffered a stroke as a result of the surgical complications. The stroke (i.e., the injury) was clearly industrial because it occurred in course of treatment for the shoulder injury. In his report, the QME apportioned to pre-existing factors of diabetes and hypertension, which he asserted increased the risk of stroke. This was error, because doctor was apportioning to pre-existing health conditions that may have contributed *to the injury* (i.e., the stroke), but there was no evidence that these pre-existing conditions caused any of the worker's *disability*. Rather, the permanent disability was entirely the result of the stroke, which was indisputably industrial.

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<sup>12</sup> See, for example, *Ricken v. County of Riverside* (Nov. 20, 2015) (panel decision) 2015 WL 9212650; 2015 Cal. Work Comp. P.D. LEXIS 696; *Anderson v. Jaguar/Landrover of Ventura* (July 24, 2012) (panel decision) 2012 WL 4788501; 2012 Cal. Wrk. Comp. P.D. LEXIS 327; *United Airlines v. Workers' Comp. Appeals Bd. (Milivojevich)* (2007) 72 Cal. Comp. Cases 1415; 2007 Cal. Wrk. Comp. P.D. LEXIS 15; *Zajdel v. Calipatra State Prison (SCIF)* (2008) (panel decision) 2008 Cal. Wrk. Comp. P.D. LEXIS 923.

The *City of Jackson* case, cited above, also discusses this issue of the distinction between apportionment to causation of injury and apportionment to causation of disability.

### **B. Risk Factors and Unlawful Discrimination.**

As explained above, QMEs may not apportion causation *of the injury* (i.e., determining that *the injury* was more likely to happen due to specified factors). QMEs may also not apportion to *risk factors*, including to gender or age-based risk factors.<sup>13</sup> A factor that may increase the risk of a particular kind of injury or condition is not evidence that the factor actually caused a portion of an individual worker’s permanent disability. Risk of injury is not the same as cause of disability. Apportionment must be based on *actual evidence* as to the individual worker, not based on categorical risk factors and assumptions based on those factors.

There have been accusations in some cases of discrimination on the basis of age or other factors based on statements in medical reports about age or gender (or lifestyle, obesity, genetics, etc.) as a “risk factor” for a particular injury or condition. In other cases, medical evaluators may have referred to gender-based or gender-related risk factors such as menopause or pregnancy, leading to concern that workers may have suffered a reduction in benefits based on gender. Discrimination within the workers’ compensation system on the basis of any protected category, including gender, as well as age, race, religion, and national origin, is unlawful and impermissible. QMEs should be alert and sensitive to this issue at all times. A worker’s permanent disability compensation should never be reduced as a result of discrimination. QMEs are required to provide medical opinions that are fair, impartial, and based on their best medical judgment. Specifically, QMEs are required to treat all injured workers in the same way—that is, not to discriminate against

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<sup>13</sup> *Vaira v. Workers’ Comp. Appeals Bd.* (California Travel and Tourism Com’n) (Cal. Ct. App., Dec. 3, 2007) 1 Cal. WCC 1119, 2007 WL 4227253, 72 Cal. Comp. Cases 1586, Cal.App. Unpub. LEXIS 9750 (“we conclude the WCAB may not use risk factors *of injury* in apportioning disability”); *Ricken v. County of Riverside* (Nov. 20, 2015) (panel decision) 2015 WL 9212650; 2015 Cal. Work Comp. P.D. LEXIS 696 (“A risk factor is not pathology and does not cause permanent impairment”); *United Airlines v. Workers’ Comp. Appeals Bd. (Milivojevich)* (2007) 72 Cal. Comp. Cases 1415; 2007 Cal. Wrk. Comp. P.D. LEXIS 15 (a risk factor is not “the . . . injury itself.”).

or be biased against anyone because of race, sex, national origin, religion, or sexual preference or because of whether the worker is represented by an attorney. (See, e.g., Cal. Code Regs., tit. 8, § 41(c)(1).)

It is important, however, to recognize the distinction between apportionment to a gender or age-based risk factor, which is *not* permissible, and apportionment to an *actual medical condition* that a worker may have, as established by the medical evidence in a particular case, and that may be an *actual cause* of a portion of that worker’s permanent disability. For example, apportionment to age as a risk factor is not permissible, but apportionment to pre-existing arthritis, as evidenced in the medical records of the worker, *is* permissible, even though arthritis is an age-related condition. Apportionment to gender or menopause as a risk factor for industrial carpal tunnel syndrome is not permissible, but apportionment to actual pre-existing and/or non-industrial carpal tunnel syndrome, as established in the worker’s own medical history, is permissible, even though carpal tunnel syndrome may be more common among post-menopausal women. In these cases, apportionment to these pre-existing conditions, even if age or gender-related, is not discrimination; it is a medical determination as to the actual cause of the disability.<sup>14</sup>

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<sup>14</sup> See, e.g., *Allen v. Workers’ Comp. Appeals Bd.* (2008) (unpublished) 2 Cal. WCC 1457, 73 Cal. Comp. Cases 1631 (apportionment proper because it was based on specific medical conditions established by the worker’s records, “not simply to her being sixty years old”); *Kos v. Kimes-Morris Construction* (October 2, 2007) 2007 WL 5434475 (panel decision) (apportioning to age-related degenerative conditions is not age discrimination because the evidence establishes these conditions as a cause of a portion of the permanent disability); *Vaira v. W.C.A.B.* (California Travel and Tourism Com’n) (Cal. Ct. App., Dec. 3, 2007) 1 Cal. WCC 1119, 2007 WL 4227253, 72 Cal. Comp. Cases 1586, Cal.App. Unpub. LEXIS 9750 (panel decision) (“Reducing permanent disability benefits based on a pre-existing condition that is a contributing factor of disability is not discrimination. When the WCAB determines a pre-existing condition contributes to a given disability, and apportions accordingly, this is merely a recognition that a portion of the disability exists independent of the industrial injury. The injured worker is being compensated only for the disability caused by the industrial injury.”)

Similarly, in the recent *City of Jackson* case, a California court of appeal upheld an apportionment determination of a QME who assigned 49% of an employee’s disability (neck, shoulder, arm, and hand pain) to the employee’s personal history which included cervical degenerative disc disease, caused in large part by heredity or genetics. (*City of Jackson v. Workers’ Comp. Appeals Bd.* (Cal. Ct. App., Apr. 26, 2017, No. C078706) 2017 WL 1488733, at \*5.)

In summary, the question to be answered in any apportionment determination is that set forth in Labor Code section 4663 (“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 . . .”), and the answer to this question must be based on the actual medical evidence as to each individual worker. Determinations on the wrong issue, or based on an inadequate medical examination, or based on statements about risk factors, or based on assumptions or stereotypes about classes of workers, are not substantial medical evidence.

#### **IV. 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 are discussed on pages 9 and 10 of the DWC’s *Physician’s Guide to Medical Practice in the California Workers’ Compensation System*, Fourth Edition, 2016 (Physician’s Guide). The Physician’s Guide is available on the DWC website and a link to its location is found in Section V of this study guide. The discussion in Chapter 3 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 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 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 Sections 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 or has reached maximum medical improvement (MMI) that requires the claims administrator to send certain notices to the injured worker.<sup>15</sup> Like the compensability examination, the procedure for obtaining a panel of QMEs

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<sup>15</sup> 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

depends on whether the injured worker is represented by an attorney. (Lab. Code, §§ 4062.1, 4062.2.)

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.)

### **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.

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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 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.

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 permanent and stationary 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 permanent and stationary.

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 permanent and stationary status. (Lab. 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 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.

## **V. 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 online 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 105<sup>16</sup> (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)(4).)

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<sup>16</sup> Request for QME Panel under Labor Code section 4062.1 - Unrepresented (QME form 105).

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 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 submit the QME form 106<sup>17</sup> 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

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<sup>17</sup> Request for QME Panel under Labor Code section 4062.1 - Represented (QME form 106).

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.

## **VI. 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 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 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 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 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 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 Regs., tit. 8, § 34(a).) The employer is responsible for arranging for, and paying, the interpreter.

Once scheduled, an appointment may not be cancelled by the QME evaluator, or by any party, less than six (6) business days prior to the appointment date, except for good cause. Whenever an evaluator cancels a scheduled appointment, the evaluator must advise the parties in writing of the reason for the cancellation, and must reschedule the appointment to a date within thirty (30) calendar days of the date of cancellation. The re-scheduled appointment date may not be more than sixty (60) calendar days from the date of the initial request for an appointment, unless the parties agree in writing to accept the date beyond the sixty (60) day limit.

Whenever a party or a party's attorney cancels an appointment, the cancellation must be made in writing, and must state the reason for the cancellation and be served on the opposing party. An oral cancellation must be followed with a written confirming letter that is faxed or mailed by first class U.S. mail within twenty four hours of the verbal cancellation. An injured worker will not be liable for any missed appointment fee whenever an appointment is cancelled for good cause.

The Appeals Board has jurisdiction to resolve disputes among the parties regarding whether an appointment cancellation less than six days prior to the appointment date was for good cause, and the Administrative Director has jurisdiction to take appropriate disciplinary action against any Agreed Panel QME or QME for violations of the regulations on this issue. (Cal. Code Regs., tit. 8, § 34, subds. (d), (e), (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 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 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 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 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.<sup>18</sup> *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

(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 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.<sup>19</sup> The evaluator shall note in the report that the records

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<sup>18</sup> 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 Regs., tit. 8, § 35(b)(2).)

<sup>19</sup> The time frame for a comprehensive medical-legal report is 30 days. (Cal. Code Regs., tit. 8, § 38 (a).) The time frame for supplemental medical report is 60 days. (Cal. Code Reg., tit. 8, § 38 (h).)

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 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. (Lab. Code, § 4062.3(i).) The rules are also relaxed in represented cases involving an AME. “Oral or written communications with physician staff or, as applicable, with the agreed medical evaluator, relative to non-substantial 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 Labor Code section 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 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 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 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 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 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 in writing. (Cal. Code 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 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 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 Regs., tit. 8, § 41.6(d).)

#### **E. Examination Disclosures (Cal. Code 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 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 Regs., tit. 8, § 41(g).)

#### **F. Ethical Obligations of the QME (Cal. Code 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 Regulations 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 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 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 Regs., tit. 8, § 41(h);41(i).)

#### **G. Evaluation Protocols (Cal. Code 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 Regs., tit. 8, §§ 43, 9726.)
- Pulmonary disability evaluations (Cal. Code Regs., tit. 8, § 44.)
- Cardiac disability evaluations (Cal. Code Regs., tit. 8, § 45.)
- Neuromusculoskeletal evaluations (Cal. Code Regs., tit. 8, § 46.)
- Foot and Ankle evaluations (Cal. Code Regs., tit. 8, § 46.1.)

- Immunological evaluations (Cal. Code 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 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 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 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 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 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 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 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 Regs., tit. 8, § 49.9.)

## **I. Report Content, Report Disclosures, Fraud Reporting, and Substantial Medical 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 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 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 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 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.<sup>20</sup> 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.<sup>21</sup> QMEs are encouraged to review and understand this section of the law.

### **4) Substantial Evidence.**

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 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, 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

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<sup>20</sup> QMEs may report suspected fraud to the Administrative Director. "Any insurer, self-insured employer, third-part 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, § 823 (b).) The communication is privileged under Labor Code section 3823 (c).

<sup>21</sup> 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.

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 (see also discussion at pp. 8-10):

- 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 Regs., tit. 8, § 9793 (c).)
- Follow-up medical-legal evaluation (Cal. Code Regs., tit. 8, § 9793 (f).)
- Supplemental medical-legal evaluation (Cal. Code 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 Regs., tit. 8, § 37.)

#### **K. QME Unavailability (Cal. Code 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 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.

#### **L. 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 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 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 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 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 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 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 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 (60) 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 (30) 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 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 Regs., tit. 8, § 36.5.) The alternative service of the medical report is optional at the discretion of the injured worker. (Cal. Code 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 Regs., tit. 8, § 36.5. (b).)

**O. Retention of Reports and Return of Records (Cal. Code 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.

## **VII. 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](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](http://www.dir.ca.gov/wcab/wcab_enbanc.htm)

**California Department of Industrial Relations, Division of Workers' Compensation. *Physician's Guide to Medical Practice in the California Workers' Compensation System. Fourth Edition, 2016.***

<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](http://www.dir.ca.gov/DWC/Laws_Regulations.htm)