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The California Applicants' Attorneys Association ("CAAA") offers the following comments regarding the proposed revisions to the Medical Legal Fee Schedule which are currently posted on the DWC Forum.

Initially, medical-legal fees must be sufficient to attract qualified physicians to provide quality evaluations as QMEs and AMEs. In the last five years the availability of physicians to conduct medical-legal evaluations in the State of California has decreased dramatically by 20% (See CWCI report on changes in QME population and Medical Legal Trends, February 2018). In some medical specialties there are not even five physicians certified in the requested specialty to issue a Panel QME list. In other medical specialties, the injured worker is provided a list of physicians ranging geographically from San Francisco to Santa Ana to Sacramento while the injured worker resides in San Diego. In more rural areas, injured workers have to drive more than four hours to attend an evaluation. In addition, as noted in other recent studies there has been a 'graying' of currently available QMEs who upon retirement are not being replaced. This will contribute to a further decrease in available QMEs in the next five years.

California has a workers' compensation system based on a complex evidence based medicine standard to assist all parties, in getting accurate evaluations of work impairment, apportionment, and causation which serves to reduce frictional costs. This requires the medical experts who provide these evaluations to prepare reports with a thorough analysis of medical history, and application of AMA rating guidelines, so that the reports constitute substantial medical evidence. Doctors must be adequately paid for this level of expertise and time involved to properly prepare reports on complex claims.

The most likely outcome if the proposed revisions to the medical legal fee schedule are adopted as written is that frictional costs and therefore allocated loss adjustment expenses will increase dramatically in the system thereby raising employers' costs. Because physicians will not be adequately compensated to

provide a report with a thoughtful and complete analysis, by necessity there will be an increase in doctors' depositions, supplemental reports and defense attorney fees to assure that an analysis on important issues is properly completed. Failure to adequately compensate evaluators will lead to inadequate apportionment analyses (harming employers), inadequate Almaraz/Guzman and causation analyses (harming workers), creating further needless expense to payors, delay of resolution of the applicant's case, and ultimately an increase in employer expenses and premiums.

Further, a medical legal fee schedule that is inadequate to compensate physicians for necessary work actually performed on cases can only lead to disputes and increased frictional costs from litigation which could have been avoided with an adequate fee schedule. Proponents of fair compensation for work performed will have substantial legal precedent to argue in these cases.

Based on the CWCI study cited above, the DWC should be focusing on improving QME access. They should also be focusing on improving quality QME reporting which has been identified as a significant problem. Cutting payments to evaluating physicians with the revisions to this fee schedule is an extremely misplaced priority, especially in light of the unprecedented cost savings to carriers in the last 5 years from the passage of SB 863.

Lastly, and essential to this public dialogue, RAND presented at the May 25, 2017 meeting of the California Health and Safety Workers' Compensation Commission("CHSWC") on their preliminary findings on the Medical Legal Fee Schedule and reports required in the workers' compensation system. This study was done at the request of the DIR with a Request for Proposal ("RFP") approved by CHSWC in 2014 as part of broader research on the evaluation of SB 863 Medical Reforms. Over a three-year period leading up to this 2017 presentation, RAND conducted stakeholder interviews and consulted with a technical advisory group. RAND also regularly reported at CHSWC meetings on the progress of this study. The study was to be released in Spring 2016 but after additional delay RAND reported at the May 2017 CHSWC meeting that the draft study was in the final stages of "peer review" and would be posted soon for public comment. At this meeting, the CHSWC Commissioners approved the "Posting of DRAFT report titled "Evaluation of SB 863 Medical Care Reforms," by Andrew Mulcahy and

Barbara Wynn at RAND, for feedback and comment after it is available, with final posting after 30 days". (See Minutes of Hearing from May 25, 2017 CHSWC Meeting.) One year later the RAND study including recommendations on the medical legal fee schedule has never been posted for public comment. At a minimum, the posting of these proposed medical legal fee schedule regulations on the DWC Forum is premature until the RAND study is released for public comment. More importantly, this action should be considered an attempt by the DWC to circumvent the role of CHSWC and the public meeting laws to which it is bound with regard to a study contracted through the DIR and CHSWC with recommendations on changes to the medical legal fee schedule that the public has never seen. Based on the foregoing, the current rulemaking process on proposed changes to the medical legal fee schedule should go no further until valuable feedback from the RAND study, the public, and the CHSWC commissioners is completed.

The following are our specific comments by regulation section.

§ 9795(c)

ML101, ML 104 and ML 106 No more than 3 hours may be billed for report preparation

This comment applies wherever there is a proposal to cap report preparation at 3 hours in these regulations. There needs to be clarification on what is included in the 3 hours of report preparation time. It should not include the medical records summary, face to face time, etc. Is it contemplated that a doctor should dictate and proof a report on even the most complex claims in three hours or less? Many follow up medical legal evaluations involve a significant amount of medical records to review. What about the firefighter with a cumulative trauma claim to 10 body parts encompassing a 25 year career and with 15 specific injuries where the records come in after the initial evaluation? What about the Psychiatric injury claim where the doctor is requested to review twenty years of records? A 3 hour cap simply does not work for complex cases particularly those with multiple organ systems involved. Does the doctor stop after three hours? Work for free after three hours? Forget about providing a report that is substantial medical evidence? If the doctor stops after 3 hours, do the parties then request a supplemental report to

continue the medical legal analysis?? Simply put, there should be no hourly cap on report preparation.

ML 103 (3) - The requirement that medical research used in the preceding 12 months can't be billed for seems unfair. It will likely be used as the new QME licensing 'gotcha' to deny re-certification. How is a physician to remember if they used research from 11 months ago when they have performed 100 QME evaluations since then? Additionally, the facts of each case are different.

How are carriers going to enforce this without increasing their time and costs in investigating whether the research was previously used in the last year by the physician. This will increase frictional costs in the system.

Also, if physicians are required to attach their research this will increase report preparation time and costs.

ML 103 (6) - The requirement of agreement of the parties for the physician to address causation will cause gamesmanship and prevent valid medical-legal evaluations on disputed issues. If one party refuses to agree, then additional litigation is inevitable since that will be the only recourse to resolve the standoff.

Also, this appears to be contrary to Regulation 10909 mandating the carrier to do a good faith investigation of all issues on the case. The issue of causation is often outside the expertise of the parties and must be addressed by the medical experts. It is in many cases the essence of a medical legal analysis.

ML 103(7)(A) and ML 104- As written this section does not consider the complexity of psychiatric claims. An individual's entire life experience, prior psyche history, non- industrial personal issues, effects of non -industrial medical problems, whether apportionment of an orthopedic impairment passes through to a psychiatric apportionment, Benson, *Kite,* and now LC4660. l, in post 1/ 1/ 13 cases must be considered. According to the current proposed apportionment complexity factor definition, such an analysis is not considered a complexity factor!

ML 103 (7)(B) - This will cause delays and add to frictional costs. Often the parties need an apportionment analysis before an MMI determination is reached, whether to assist the parties in an early settlement evaluation or to assist in the assessment of liability between employers and other carriers.

ML 104 (1) & (2) - Again, a definition of what is included in report preparation would be helpful but we continue to assert that there should be no hourly cap on report preparation time.

ML 104 (3) - What does "start of the evaluation" mean? Is it when the physician first reads the cover letters from the parties before the exam of the injured worker? Does it start with the review of the medical records? This needs to be clarified.

ML 106

See comment under ML 103(3) above.

Also for complex cases, two hours of research time may simply not be enough to provide substantial medical evidence when issuing a supplemental report particularly when the parties have raised new medical issues or additional medical records have been provided.

In conclusion, when the totality of the proposed revisions to the fee schedule are considered, CAAA believes this is a misguided attempt which will result in the degradation of the quality of medical evidence. Further, it will drive more doctors out of the QME practice, thereby harming the very injured workers the system is supposed to protect.