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Western Occupational & Environmental Medical Association

A Component Society of the American College of Occupational and Environmental Medicine

December 14, 2018

Administrative Director George Parisotto
Division of Workers' Compensation
1515 Clay St., 17th Floor
Oakland, CA 94612

RE: QME Fee Schedule

Dear Administrative Director Parisotto,

The Western Occupational and Environmental Medicine Association (WOEMA) appreciates the opportunity to provide input regarding a new fee schedule for Qualified Medical Evaluators (QMEs). Within California's Workers' Compensation system, WOEMA members serve as QMEs and AMEs, as well as Primary Treating Physicians, UR physicians and company medical directors. As members of WOEMA and the American College of Occupational and Environmental Medicine (ACOEM), we believe that high-quality, evidence-based care best serves the injured worker, the employer, and the system as a whole.

WOEMA believes that:

1) The ideal QME system is one in which QME reports are completed in timely fashion and demonstrate medical expertise based on evidence-based treatment guidelines
2) A rational fee schedule is just one element of such system, which would also include better education for QMEs and allow Primary Treating Physicians to be compensated for QME reports at the medical-legal scale.

Regarding the various aspects of a schedule outlined in DWC's request, WOEMA members have a range of opinions. The following thoughts should not be construed as WOEMA positions, and nor do they represent a consensus among any subgroup of our members or leaders. Rather, they are simply ideas we have shared internally, and we offer them in the interest of your having a full body of ideas to consider.

Format

In a QME report (much as for a PR-4), there are a number of required elements, each of which might be more or less complex. Essentials elements include:

1. *Complete narrative summary of how the illness or injury happened with initial and present treatment (includes record review).*
2. *A review of the patient's current symptoms, present limitations, and concerns.*
3. *Physical Examination that includes; basic medical exam and a focused exam on the injured body part.*
4. *Summary of diagnostic studies (includes record review).*
5. *A discussion of causation. Basic causation meaning; Did the mechanism contribute to or cause the injury.*
6. **Impairment rating. (If applicant is permanent and stationary, P&S) Appropriate Impairment rating performed per 5th edition AMA Guidelines, by standard rating and Almaraz to provide the most accurate determination.*
7. **A discussion of basic apportionment addressing LC 4663 and 4664, if any.*
8. **A statement about needed future medical treatment.*
9. **A detailed listing of work restrictions and ability return to usual work*

**Only included in those applicants that are P&S*

A flat fee should be paid for a basic evaluation in a case with a single date of injury and requiring minimal record review, basic apportionment and causation analysis, and 30-60 minutes face-to-face time. Modifiers or points reflecting higher levels of complexity can be used to compensate above the basic rate. Modifiers might include:

- *Multiple injured body parts > 2.*
- *Multiple dates of injury.*
- *Causation determination requested (AOE/COE)*
- *Apportionment to previous injuries, claims, or multifactorial causation.*
- *Apportionment to liability*
- *Record review in excess of 3 inches*
- *Literature Research. By specific Request.*
- *Face to face time > 1.5 hours for non-psychological evaluations. (Specific Documentation required)*
- *Any other item(s) upon specific request (carrier, attorney(s), judge).*

Reasonable Rate

The majority of evaluations likely would be basic evaluations, so it makes sense to keep the ML 102 and ML 103. We would define the ML 102 as straightforward and requiring minimal record review. For an ML 103, the amount of record view might be set at 2-3 inches of medical record and involve one of the additional modifiers listed above. Cases that are more complex would warrant an ML 104, and might involve 2 or more of the above the modifiers. Exact boundaries between the levels should be determined by an expert panel convened by DWC, with WOEMA having a representative.

- *ML 102 would be paid at x.*
- *ML 103 would be paid 2x.*
- *ML 104 initial value would be 2x and from there reflect increasing complexity, which could be pegged to 15-minute increments or inches of records involved.*

Alternatively, fees could be set according to a relative-value scale, with various elements assigned various "units" of work. For example, a complicated causation discussion might merit many "units" of work, while a simple statement about a single traumatic event might merit just one "unit." Specific value would be assigned to each of the modifiers listed above. In this way, compensation could more accurately reflect the aggregated complexity of a case, rather than some other measurable but less important factors.

In general, the issue of report of report complexity is challenging. It might make sense to insist on the use of AMEs in complex cases, with the AMEs being:

- *Chosen directly by the concerned parties*
- *Assigned by a WCAB judge, or*
- *Chosen from a list of three names provided by DWC based on recommendations from carriers, attorneys and judges, and with each side being able to strike out a name.*

Record Review

Basic Medical Records: Have all medical records for a specific injured worker electronically sorted by a single entity with duplicates pulled. That entity would host and share the records the various parties including with the QME or AME. The records could be listed by date and made downloadable. Thus, the concerned parties, and particularly the QME or AME, could go through the records chronologically. Even if a summary were provided, the QME or AME could quickly review the actual medical record (in order and with no sorting needed) as is appropriate and either summarize the record directly or add information/correct to an existing summary. Theoretically, a computer program could keep track of the QME or AME time reviewing the records; such programs already exist. This would solve the issues of late records, no records at exam time, and multiple packets of records that are not complete. It would also significantly decrease evaluating physician time spent sorting and identifying the critical reports.

Reimbursement could be based both upon a flat rate and volume.

- *Up to 3 inches of records is included in payment as an ML 103, described above.*
- *A flat fee for records between 3 and 12 inches.*
- *Beyond 12 inches, a single rate per every additional 3 inches, uncapped.*

Missed Appointment Fee:

An allocation for missed appointment is essential, as often significant time is spent reviewing case documents before an appointment. This should also apply to scheduled depositions or testimony. The fee could be based upon the value of a basic QME or Determined Testimony fee and recognize when the cancellation was made. One possible format:

- *No cancellation/no-show. 100% QME Value*
- *< 2 working day = 75% QME Value.*
- *2-5 working days = 50% QME Value.*
- *5 working days. No charge.*

Testimony Fee

Depositions should be charged at a flat rate for the first hour (which includes prep time, record/chart review) with payment for additional time. Currently depositions are approved for one hour of physician time for record review ($500). Subsequent time could be reimbursed in 15-minute increments.

Supplemental Report

Such reports should be billed by time, in 15-minute increments. Compensation could also take into account complexity factors.

Report Incentives

The fee schedule should discourage poor quality. One way to achieve this might be to add a "quality" modifier for three items – 6, 7, 8 — in the initial list of necessary elements for a QME. DEU could determine eligibility for a payment bump on elements 6 and 7 and carriers could determine eligibility for item 8. To illustrate: The QME report would be sent to the DEU, who would determine whether the QME report correctly applied the use of the various tables in the AMA Guides, and whether the physician's approach to apportionment and causation was correct (i.e., apportioning to pathology instead of impairment). If the QME flunked either or both of those two sections, payments for those sections could be downgraded. Similarly, for Future Medical, the carrier is in a good position to determine whether the QME's recommendations for Future Medical match MTUS. If they don't, the physician would get downgraded on element 8.

The DWC might consider having a panel of recognized AMEs review reports at the request of the payers where there is questionable billing for time spent and/or low-quality reporting.

Again, we would like to emphasize that these comments represent some of the ideas that members have raised rather than formal WOEMA positions. We fully recognize the challenge involved in developing a schedule that meets the needs of payers, QME physicians, and above all, injured workers, while at the same time balancing some of those interests. We look forward to continued conversations with the Division and other stakeholders.

Kind regards,

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WOEMA President

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