California Society of Industrial Medicine and Surgery
CSIMS

August 19, 2019

Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142-0603 Attn: DWC Forums

RE: DWC Forum - Reimbursement of Medical-Legal Expenses Regulations

Via USPS and email (DWCForums@dir.ca.gov)

The California Society of Industrial Medicine and Surgery (CSIMS) submits the following comments on the DWC Forum concerning Reimbursement of Medical-Legal Expenses Regulations:

Introduction

The DWC *Newsline* No.: 2019-65 dated August 6, 2019, indicates that the proposed revisions to the Medical-Legal Fee Schedule (MLFS) attempt to establish the following goals:

The implementation of a predominantly fixed fee for all procedure billing codes is anticipated to reduce frictional costs by establishing reimbursement that is based on objective and quantifiable criteria. The increase in the multiplier for setting fees will increase the reimbursement for the vast majority of evaluations performed by physicians.

A careful review and analysis of the proposed revisions leads CSIMS to the conclusion that the stated goals will not be satisfied. Rather than "reducing frictional costs," the proposed revisions are likely to lead to more confusion, friction, litigation, delayed resolution of complex medical-legal issues, and will reduce the quality and usefulness of medical legal reports. It is also questionable as to whether the proposed revisions will result in an "increase [in] reimbursement for the vast majority of evaluations." Further, these revisions, if adopted as written may reduce the supply of physicians willing to provide this vital service.

DWC last adjusted the medical-legal fee schedule in 2006. Since that time, the workers' compensation system in California has become much more complex. This additional complexity, which has come by way of new case law and a substantial increase in the number of medical records reviewed per case, has directly impacted QMEs and AMEs. The average case requires significantly more time and expert analysis than 10 years ago. As such, we believe that a substantial increase in compensation to medical-legal providers is warranted in order to a) adjust reimbursement for the past 13 years of inflation and b) reflect today's more complex medical-legal environment as compared to 2006.

We recognize that the proposed regulations are a "take two" for DWC. Last year's proposal was released by DWC in May of 2018 in response to the defeat of the Division's underground regulations through the *Howard v. Baker* case. That proposal, which sought to dramatically slash QME reimbursement resulted in a collective uproar from QMEs. DWC wisely shelved that proposal.

We also recognize that the current proposal is a response by the Division to the introduction of AB1832 which seeks to require DWC to increase QME fees which it has not done since 2006. Unfortunately, the current proposal by DWC would result in substantially lower compensation for complex reports than the increase in compensation contemplated by AB1832. The importance of producing high-quality medical-legal reports that constitute substantial medical evidence, especially in complex cases cannot be understated. Any revisions to the MLFS should aim to enhance, not reduce, the quality of these reports.

Comments on Specific Changes to the MLFS

1. Addition of §9794(a)(3). The proposed subdivision (3), in effect, provides that other than permitted by subdivision (1), "no other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report." Although DWC staff indicates that they intend to limit billing under the OMFS to medical-legal diagnostic tests, the overly-restrictive proposed language could prevent appropriate billing for medical-legal consultations. Current regulations (§§31.7 and 32(b)) concerning medical-legal consultations are ambiguous and incomplete. If a medical-legal consultation, because of its content, is not eligible for reimbursement under the MLFS, it should be reimbursable under the OMFS. The proposed language of subdivision (3) is defective because a medical-legal consultation is an expense incurred "in connection with a medical-legal evaluation or report" and it is also in conflict with the second paragraph of §9795(a).
2. ML100/Missed Appointment Fee. The current fee schedule does not provide for any

reimbursement for missed appointments which are to be billed under the code ML100. to the current fee schedule,

"This code is designed for communication purposes only. It does not imply that compensation is necessarily owed."

This is a significant concern for QMEs as carriers routinely point to this language as justification for denying reimbursement completely or in part for missed appointments. Additionally, this is currently a substantial area of friction as QMEs must resort to litigation in order to pursue reimbursement for missed appointments in many cases.

Further, there appears to be a double standard in play. On the one hand, QMEs are limited in the number of evaluations that they may schedule in a day or within a certain period of time as they are required to see an injured worker within one hour of their appointment time under 8 CCR 41(f). Indeed, the Division makes it clear on its website that QMEs are subject to discipline if an injured worker waits beyond one hour prior to the evaluation. In order to comply with this regulation, many QMEs book appointment slots exclusively for QME evaluations and do not double or triple book patients as is common in clinical practice.

It is our position that it is unreasonable for DWC to require QMEs to set aside time exclusively for QME evaluations but on the other hand, not to require that carriers reimburse providers for a missed appointment.

We believe that DWC has an opportunity to reduce this friction by updating this language in a meaningful way in order to require reimbursement to providers for these missed appointments.

Unfortunately, the proposed revision does not accomplish any of these goals. Rather, the proposed language keeps the existing language and adds the sentence:

"However, in no event shall the missed appointment fee exceed the sum of $550."

Such a revision would cap the fees that a provider may charge for a missed appointment but continues not to require that carriers reimburse providers for missed appointments.

Given that 10% of all scheduled evaluations result in missed appointments this is inappropriate.

We suggest that DWC require reimbursement of an appropriate fee for missed appointments varying by specialty. In our experience mental health providers typically set aside the most time for QME evaluations, followed by internal medicine/neurology, followed by musculoskeletal providers.

We also suggest renaming "missed appointments" to the term "failed appointment/late cancellation" which would cover both appointments rescheduled or cancelled late by a party and a broader set of circumstances contributing to the failure of an evaluation.

Under 8 CCR 34(d), QMEs are precluded from cancelling appointments within six business days except for good cause. Currently, there is no such requirement for the parties to a case. We suggest that evaluations which are cancelled or re-scheduled within this six-business day period also be

eligible for reimbursement under ML100.

Further, the definition of "missed appointment" should be expanded beyond just an appointment for which an injured worker does not appear. There are many other circumstances, beyond the control of the medical-legal evaluator, which may contribute to the failure of an appointment to be completed. These include, but are not limited to, the injured worker leaving prior to the conclusion of the evaluation, an interpreter not showing up or leaving prematurely, or a hostile or intoxicated injured worker which results in the evaluator not moving forward with the evaluation under 8 CCR 41(i). We suggest allowing for reimbursement for these circumstances under ML 100 and renaming "missed appointment" to "failed appointment."

When there is a failed appointment there should be a per page charge for the record review performed for the evaluation. A quality evaluation requires reviewing the records before the evaluation actually takes place.

3. Threshold of 400 Pages of Medical Records Included in Flat Fee. DWC proposes a flat fee for Comprehensive and Follow-Up Medical-Legal Evaluations which would be inclusive of the first 400 pages of medical records.

First, the term "medical records" is narrow and does not adequately encompass the breadth of records submitted to a medical-legal evaluator for review. QMEs are frequently sent documents, other than medical-legal records, which they are asked to review in connection with a medical-legal evaluation. These records include cover letters, depositions, investigative reports, personnel files, accident reports, police reports, subpoenas, legal documents from the instant case and prior cases, if applicable, billing documents, etc. The proposal should be modified to be sufficiently broad to cover ALL documents sent to the medical-legal evaluator. We suggest replacing "medical records" with "Documents."

Second, the term "page" is not defined nor standardized. This will invite gamesmanship and disputes resulting in more litigation and friction. This term must be defined and standardized. To reiterate from our December fee schedule submission to DWC,

"Page count is based on:

o 12-point or larger Times New Roman, Calibri, or Arial font (cover letters)

o Original font with no shrinking/condensation of multiple pages onto one

o Actual number of deposition pages (i.e. in a condensed deposition that has 4-pages shrunk to fit on each page, each actual page of the deposition is counted – i.e. a 40-page deposition transcript equates to a 10-page condensed deposition transcript → 40 pages would be included in the record count)

o Single-sided"

Third, it is unclear why DWC's proposal seeks to include the first 400 pages to be included in the flat fee rate. Such a high threshold appears to be arbitrary and excessive. DWC has not provided any data or explanation supportive of such a high page count. Further, CSIMS is unaware of any empirical data supportive of such a high threshold. When searching other states' fee structures, we have learned that our neighbors to the east in the State of Nevada, have a fee schedule with a similar structure to the one that DWC has proposed. Nevada's fee schedule only includes 50 pages in its flat fee. We suggest that the Division modify the instant proposal to include only 50 pages in the flat fee as well.

4. $2 per page DWC proposes reimbursement of $2 per page in excess of the first 400 pages for Comprehensive and Follow-Up medical-legal evaluations.

First, it is unclear how or why DWC has arrived at the compensation rate of $2. Such a low dollar figure appears to be arbitrary and insufficient. DWC has not provided any data or explanation supportive of such a low level of reimbursement. Further, CSIMS is unaware of any empirical data supportive of such a number. It is our understanding that medical-legal evaluators typically review between 100 to 200 pages per hour, although we have not seen any data on this issue. Turning again to Nevada, the Silver State reimburses its IME providers $4.34 per page. Nevada has a much lower cost of living and no state income tax. California's reimbursement should be substantially higher than $4.34 per page to reflect the economic reality between the states.

Second, DWC's proposal does not specify who has the burden for determining the number of pages of "medical records" reviewed by the medical-legal evaluator. The proposal states,

"When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of medical records reviewed by the physician as part of the medical-legal evaluation and preparation of the report."

We are led to believe that the burden for page count verification is therefore placed on the medical-legal evaluator. This will certainly lead to friction and litigation due to disputes over page count. Further, placing the burden of such a ministerial task on the medical-legal evaluator is inappropriate. The Parties are tasked with obtaining, collating, preparing and sending the Documents to the medical-legal evaluator for review. As such they are in a much better position to ascertain the correct page count than the medical-legal evaluator who has the Documents dropped in his or her lap.

We propose that the burden of page count verification be placed on the party sending Documents to the medical-legal evaluator for review. Each party should be required, under penalty of perjury, to specify the page count for all Documents sent each time they submit Documents to the medical-legal evaluator for review with a penalty if they substantially misrepresent the number of pages sent for review. Essentially all the documents sent require a review.

Third, DWC's proposal states that the $2 per page fee for follow-up evaluations and supplemental evaluations will only be counted towards review of medical records that were not reviewed as part of a prior evaluation. As the proposal has no requirement on either Party to determine which records were previously provided to the evaluator, one can only assume that DWC, again, seeks to place this ministerial burden on the medical-legal evaluator.

The Workers' Compensation system is rife with examples in which the burden for a ministerial duty is placed on the employer. For instance, an employer has 90 days to accept or deny a claim. If the employer does not respond within the 90 days, then the claim is deemed accepted. Similar rules exist for utilization review; if the employer does not complete utilization review within a timely manner then the requested treatment is deemed authorized.

Accordingly, we propose that the administrative burden of reducing or minimizing previously reviewed documents sent to the medical-legal evaluator be placed on the parties. Such a ministerial duty should not be placed on the evaluator. Further, the DWC's proposal would render the QME into an uncompensated file clerk, mind-numbingly sorting thousands of medical records without any compensation whatsoever. We would point out that the defense clearly has more significant resources at their disposal then any physician. If the insurance company finds it too burdensome to sort the records how can the DWC reasonably require the physician to provide this service on a regular basis.

Fourth, if the burden of sorting and collating records is to fall on the QME, then the physician should be compensated for this activity. Turning again to Nevada, the IME fee schedule in the Silver State mandates that all medical records be provided to the IME "in chronological order based on date of service." If the insurer fails to do so then the IME is compensated an additional $0.95 per page. Such a structure wisely incentivizes the payor, with its vastly greater administrative resources, to furnish the evaluator with a properly organized set of medical records. We suggest that DWC adopt a similar requirement for payors and compensation for evaluators. This would promote greater efficiency and reduce waste in the QME system.

Fifth, we are concerned that the proposed fee scheduled bypasses the current method for determining QME compensation. Under the current fee schedule, the method involves the multiplication of relative value units by the conversion factor (the "RV Times CF Method"). The values of both of these metrics are established in the fee schedule. These metrics, in turn, determine the compensation for all medical-legal codes. Such a scheme appears to be mandatory upon a reading of LC5307.6

The DWC's current proposal establishes the per page fee at $2 and it is not assigned a relative value code unlike all other billable codes in the fee schedule. The per page fee is defined in the "Procedure Description" section. In the current fee schedule all billable codes are assigned a relative value. The fact that the current proposal seeks to circumvent the statutorily mandated RV Times CF Method is concerning. The Legislature recently introduced AB1832 which seeks to increase QME reimbursement by mandating an increase to the conversion factor. Such a circumvention of the conversion factor, as proposed in DWC's new fee schedule would nullify the effect of AB 1832 on the per page fee. We query the legality of such a proposal in light of DWC's statutory obligations vis-à-vis the mandated structure of the Medical Legal Fee Schedule.

5. Flat Fee of $1,650 for Initial Evaluations and $1,150 for Re-evaluations

The flat fees proposed by DWC are unreasonably low and do not adequately compensate medical-legal evaluators for their time. A lower complexity and lower cost-of-living state such as Nevada has a flat fee of $1,735 for all evaluations which only includes the first 50 pages of medical records. We are concerned that establishing such a low flat fee may encourage medical-legal evaluators to cut corners and sacrifice report complexity. This will mean that more reports will be challenged as lacking substantial medical

evidence, resulting in more litigation, friction and costs. Such increased friction would be to the detriment of both employers and injured workers.

Of particular concern is that the lower flat fees for re-evaluations appears to be apply to all re-evaluations regardless of how soon or far after the re-evaluation occurs relative to the initial evaluation. The current structure of the fee schedule wisely recognizes the difference of complexity between re-evaluations occurring prior to or later than 9 months of the prior evaluation. Under the current fee schedule structure, re-evaluations which occur within 9 months of the most recent evaluation are afforded the ML101 code.

We encourage DWC to simplify the proposal by ascribing identical reimbursement for re-evaluations and initial evaluations. Re-evaluations often times present substantial complexity and may be more complicated than initial evaluations. Such complexity may involve interval treatment (or denial of same), injuries which may ultimately constitute apportionable events, and permanent and stationary determinations necessitating apportionment analyses via *Escobedo* and *Benson, Almaraz-Guzman* analyses and *Kite* analyses. For this reason, we suggest elevating the level of reimbursement of re-evaluations to that of initial evaluations.

6. Modifiers For Increased Compensation Not Applicable to Record Review or Deposition Testimony

The Division's proposal indicates that all modifiers, whether for AMEs or the 50% increase in reimbursement for mental health specialists, does not apply to per page review fees or deposition testimony. We encourage the Division to modify this to allow for the application of psych (and other specialty modifiers, as described more fully below) and AME modifiers to record review and the AME modifier to deposition testimony.

We hope that the Division has closely reviewed the already submitted comments from many QMEs. Of particular concern is the outcry from psychiatrists and psychologists who would be woefully undercompensated under the instant proposal. DWC would help ameliorate this concern by allowing for the application of the psych modifier to the per page review fee.

While we agree with the Division's recognition of the additional complexity of mental health evaluations by way of the creation of modifier -96, we disagree with DWC's proposal to bar the use of this complexity factor for per page review fees. Simply stated, record reviews associated with mental health evaluations are more complex than record reviews associated with non-mental health evaluations. Depositions must be scoured in detail as must any and all mental health records for any past or concurrent stressors which may play a role in the applicant's alleged psychiatric injury. Such close scrutiny of the records is particularly important in light of the predominance of injury threshold required under LC3208.3. Because mental health evaluators review records in excruciating detail, interview the injured worker with these records in mind, and then exhaustively reconcile any discrepancies between the history and the medical records, we urge the Division to allow for the application of modifier -96 to per page record review fees.

The Division has stricken the phrase "and medical-legal testimony" from the text of modifier -94, the AME modifier. We disagree with this change. AME's have been, and should continue to receive, a premium for all of their services including for deposition testimony.

7. Psych Modifier of 50% and No Modifier for Other Specialties

DWC's proposal offers a 50% increase in the flat fee rate for psychiatric and psychological evaluations. No other specialties are eligible for modifier increases under DWC's proposal.

As was discussed at the provider stakeholder meeting with DWC on May 21, 2019, our position is that other specialties, in particular neurology and internal medicine (and internal medicine subspecialties) are significantly more complex than musculoskeletal examinations and therefore merit increases in reimbursement.

We suggest a 100% modifier for psychiatric and psychological evaluations and a 50% modifier for internal medicine and neurology. Again, we believe that specialty-specific modifiers should apply towards the per page record review fee as well the flat fee and not the flat fee alone as DWC has proposed.

8. Missing Reimbursement for Areas of Additional Complexity

A significant omission in DWC's proposal is allowance for reimbursement for variable complexity. As all medical-legal evaluators can attest, no two reports are created alike and there is more complexity to an evaluation than just record review pages.

Under LC 5307.6, the DWC is required to create a fee schedule which compensates medical-legal evaluators for face-to-face time as well as other factors which inform evaluation complexity. The fact that DWC's proposal does not provide for any compensation specifically related to face-to-face time appears to be noncompliant with LC 5307.6.

We suggest that DWC ascribe a reasonable hourly rate to face-to-face time, which is verifiable, in excess of the first two hours. The current fee schedule recognizes same as a complexity factor. We recommend an hourly rate of $400 per hour (pro-rated in quarter hour increments) for each hour in excess of the first hour of face-to-face time for musculoskeletal reports and in excess of two hours for other reports.

Another common area of complexity which is neglected by DWC's current proposal is the need for multiple impairment ratings. An evaluator performing one impairment rating should not be compensated the same as one who performs twenty. We express our concern that omitting compensation for such a variable task would disincentivize evaluators from performing impairment ratings. This raises a concern that the current DWC proposal is biased against injured workers with multiple claimed body parts. We suggest that DWC ascribe a reasonable value for each impairment rating provided beyond the first body part. We believe that $400 per additional body part is a reasonable value, Nevada currently reimbursed $325 for each body part above the state's threshold.

Further, body part should be defined more narrowly than the current definition of a "body system or region as defined by the Table of Contents of the AMA Guides 5th edition." Under this current definition, a rating of each of the 10 fingers, both hands, both wrists, both elbows, and both shoulders" would be considered "one body part" consisting of "the upper extremities." The definition of body part should be expanded to include each digit, joint, hand and foot. Bilateral impairment ratings of each body part should be counted as two body parts.

Yet another area requiring attention is complex apportionment analysis. We suggest grandfathering in current complexity factor #7 related to apportionment as a separately reimbursable complexity item. Specifically:

"A discussion of apportionment of disability when determination of this issue involves the physician evaluating (1) the injured worker's employment by three or more employers, (2) more than two injuries to the same body system or body region or (3) more than one injury involving two or more body systems or body regions."

9. The charge for a supplemental report of $275 implies that the average time spent on a supplemental report is less then 45 minutes. That is clearly not correct. Time spent varies widely but the average time is clearly an hour or more exclusive of record review. A reasonable minimum charge for a supplemental report would seem to be $400 plus a per page charge for record review. It is unreasonable to expect the physician to determine which records have been previously reviewed. When records are sent they must all be reviewed.

10. Finally, DWC has not designated any reimbursement for the performance of medical research. Such research is frequently necessary in various instances including cancer cases alleged to be the result of industrial exposure and other areas with complex causation theories. We suggest that the medical-legal evaluator be reimbursed $400 per hour for the performance of medical research that is requested by a party or authorized by the defense.

11. COLA Omitted

Of significant concern is the fact that DWC has inexplicably omitted any form of COLA increases to the fee schedule in future years. The substantial omission of such a COLA increase is particularly alarming in light of the fact that: 1) DWC is being audited by the California State Auditor in part for failing to provide such a COLA increase to medical-legal evaluators since 2006, 2) AB1832 specifically seeks to require DWC to include a COLA increase in the medical-legal fee schedule and 3) DWC very recently proposed a COLA allowance in the recent fee schedule proposal for copy service providers.

It is dumbfounding that DWC would omit a COLA adjustment for medical-legal evaluators, thereby guaranteeing that the recent controversy plaguing the QME community for the past several years would continue on indefinitely, due to DWC's inaction.

12. Premium for Expedited Reports

Currently QMEs have up to 30 days to provide their reports for initial evaluations and re-evaluations. These reports are critical in allowing the parties to resolve medical disputes and move cases closer to resolution. We suggest that DWC provide a financial incentive to medical-legal evaluators who provide their reports in an expedited fashion. Such a policy would recognize and reward medical-legal evaluators for the critically important and time-sensitive role they play in the outcome of workers' compensation claims.

We suggest a 10% increase in the overall compensation for reports which are served 10 or fewer days

from the date of the evaluation.

13. Premium for late cover letters/medical records

Previously we described how DWC's proposal fails to remedy the significant issue of the parties sending records to medical-legal evaluators in a disorganized and haphazard fashion. DWC's proposal also fails to address another significant issue regarding the medical records: the lateness of the provision of cover letters and medical records to the medical-legal evaluator.

Currently, there is nothing in the QME regulations obligating the parties to send medical records or a cover letter to the medical-legal evaluator with the exception of regulation 34(g) which allows for a mental health medical-legal evaluator to cancel an evaluation due to non-provision of the medical records prior to the evaluation. We strongly encourage DWC to update the QME regulations with language that would hold the parties accountable to providing a cover letter and medical records to the evaluator in a timely manner.

Specifically, we recommend that the parties be obligated to provide a cover letter and medical records no less than ten business days prior to the evaluation. In the event that these are not provided within the required time frame, the evaluator should be allowed to cancel the evaluation, be reimbursed a failed appointment fee, and be allowed to reschedule the evaluation once provided with the cover letter and medical records. Alternatively, the evaluator could elect to continue with the evaluation, notwithstanding the late cover letter/medical records, and be paid a reasonable exigency premium specified by DWC in the fee schedule. We suggest an exigency premium of $500.

14. Electronic Service

Currently, QME Appointment Notification Forms ("ANF") and Medical-Legal Reports are required to be served by mail. This is due to the fact that the proof of service forms (a Declaration of Service accompanying the ANF and QME Form 122 for medical-legal reports) do not allow for electronic service.

We strongly urge the DWC to update these proofs of service forms to allow for an option of electronic service. Each year millions of pieces of paper, toner cartridges, and unnecessary postage are purchased and utilized because of these outdated forms. We have pointed out this environmentally unfriendly and needlessly financially punitive matter to DWC several times over the years but the Division has failed to update these forms nonetheless. We can think of no good reason to continue the status quo and strongly encourage the Division to update service options for QMEs to the 21st century and allow for electronic service.

15. Notice of cancellation must be sent to QME by parties if they settle/cancel

Currently, QME regulations do not require that the parties inform the evaluator if they have settled the case or if they would like to cancel an evaluation. Frequently the first notice that an evaluator receives that an evaluation is not moving forward is when the injured worker fails to appear for the evaluation. Upon contacting the parties, evaluators are often informed that the case settled weeks ago and that the evaluator was not notified because no such requirement exists in the regulations.

It is time to update the regulations and require that QMEs be informed if their services are no longer needed because the appointment has been cancelled, the case has been settled or for any other reason. We recommend that the DWC update the QME regs with this requirement.

16. Notice of objection to QME report must be sent to QME by objecting party

Similar to the previous issue, there is no current requirement that the parties notify the QME that an objection has been lodged to his or her report. Under Labor Code 4622, insurers are required to pay uncontested fees to a QME within 60 days of receiving the report. However, QMEs frequently discover (after 60 days has lapsed) that the insurer will not be reimbursing them because they have objected to the evaluator's report. Frequently, the objection is only sent to opposing counsel but not to the QME.

We strongly encourage the DWC to update the QME regulations to require that a party objecting to a QME's report send a copy of such objection to the evaluator in question.

17. Underserved area Premium

DWC's current proposal seeks to offer a premium to medical-legal evaluators who perform an evaluation in an "underserved area." From the proposal,

"This modifier will be applicable when an evaluation is performed in a geographic area where there were fewer than three physicians in a chosen specialty with a QME-certified office location in that geographic area as of July 1, 2019."

While we applaud DWC for its creativity in trying to remunerate QMEs for performing evaluations in underserved area, the language is drafted in such an ambiguous manner as to render it useless.

First, the term "geographic area" is vague and ambiguous. The term needs to be defined. We suggest replacing "geographic area" with "zip code."

Second, it is unclear why DWC seeks to tether the definition of "underserved area" to the date of July 1, 2019. We suggest instead using the date that the QME panel was generated as the operative date for determining whether an area is underrepresented or not. Further, DWC is in the best position to know, at any given date, which areas are underserved for each specialty or not. As such, we recommend that all panels generated which would meet the "underserved area" designation be labelled clearly as an "underserved area panel." The regulations should be updated to require that the parties notify the QME, at the time of scheduling, that the case will qualify for the "underserved area premium" so that the QME and the parties are all aware of this ahead of time.

18. Underserved Specialty

While DWC's goal of encouraging QMEs to perform evaluations in underserved areas is laudable, we believe that a more pressing issue facing the QME system is that of underrepresented medical specialties. There are already several specialties for which an injured worker cannot receive a panel due to there being less than the minimum number of 5 QMEs in the entire state of that specialty.

These specialties, to so-called "lost specialties," include Oncology, Infectious Disease, Nephrology, Obstetrics and Gynecology, and Endocrinology.

Several more specialties have significantly fewer providers as a percentage of total provider headcount relative to the demand for their services relative to total system demand. These should be designated as "Underserved Specialties." These include Orthopedic Surgery, Pain Medicine, Physical Medicine and Rehabilitation, and Neurology.

We suggest that DWC provide a modifier and a methodology for identifying and compensating QMEs who are in an Underserved Specialty at a premium rate.

CSIMS appreciates this opportunity to comment on the proposed revisions to the MLFS. In sum, we believe that most of the recommended changes are biased, unreasonable and short-sighted and we urge the Division to consider seriously the comments made herein.