SUM-100

SUMMONS
(CITACION JUDICIAL)

FOR COURT USE ONLY
(SOLO PARA USO DE LA CORTE)

NOTICE TO DEFENDANT:
(AVISO AL DEMANDADO):

CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS;
"Additional Parties Attachment form is attached."

YOU ARE BEING SUED BY PLAINTIFF:
(LO ESTÁ DEMANDANDO EL DEMANDANTE):

DR. TIMOTHY C. HOWARD; DR. MEERA JANI; DR. BENJAMIN SIMON

NOTICE! You have been sued. The court may decide against you without your being heard unless you respond within 30 days. Read the information below.

You have 30 CALENDAR DAYS after this summons and legal papers are served on you to file a written response at this court and have a copy served on the plaintiff. A letter or phone call will not protect you. Your written response must be in proper legal form if you want the court to hear your case. There may be a court form that you can use for your response. You can find these court forms and more information at the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), your county law library, or the courthouse nearest you. If you cannot pay the filing fee, ask the court clerk for a fee waiver form. If you do not file your response on time, you may lose the case by default, and your wages, money, and property may be taken without further warning from the court.

There are other legal requirements. You may want to call an attorney right away. If you do not know an attorney, you may want to call an attorney referral service. If you cannot afford an attorney, you may be eligible for free legal services from a nonprofit legal services program. You can locate these nonprofit groups at the California Legal Services Web site (*www.lawhelpcalifornia.org*), the California Courts Online Self-Help Center (*www.courtinfo.ca.gov/selfhelp*), or by contacting your local court or county bar association. **NOTE:** The court has a statutory lien for waived fees and costs on any settlement or arbitration award of $10,000 or more in a civil case. The court's lien must be paid before the court will dismiss the case.
¡AVISO! *Lo han demandado. Si no responde dentro de 30 días, la corte puede decidir en su contra sin escuchar su versión. Lea la información a continuación.*

*Tiene 30 DÍAS DE CALENDARIO después de que le entreguen esta citación y papeles legales para presentar una respuesta por escrito en esta corte y hacer que se entregue una copia al demandante. Una carta o una llamada telefónica no lo protegen. Su respuesta por escrito tiene que estar en formato legal correcto si desea que procesen su caso en la corte. Es posible que haya un formulario que usted pueda usar para su respuesta. Puede encontrar estos formularios de la corte y más información en el Centro de Ayuda de las Cortes de California (*www.sucorte.ca.gov*), en la biblioteca de leyes de su condado o en la corte que le quede más cerca. Si no puede pagar la cuota de presentación, pida al secretario de la corte que le dé un formulario de exención de pago de cuotas. Si no presenta su respuesta a tiempo, puede perder el caso por incumplimiento y la corte le podrá quitar su sueldo, dinero y bienes sin más advertencia.*

*Hay otros requisitos legales. Es recomendable que llame a un abogado inmediatamente. Si no conoce a un abogado, puede llamar a un servicio de remisión a abogados. Si no puede pagar a un abogado, es posible que cumpla con los requisitos para obtener servicios legales gratuitos de un programa de servicios legales sin fines de lucro. Puede encontrar estos grupos sin fines de lucro en el sitio web de California Legal Services, (*www.lawhelpcalifornia.org*), en el Centro de Ayuda de las Cortes de California, (*www.sucorte.ca.gov*) o poniéndose en contacto con la corte o el colegio de abogados locales. AVISO: Por ley, la corte tiene derecho a reclamar las cuotas y los costos exentos por imponer un gravamen sobre cualquier recuperación de $10,000 ó más de valor recibida mediante un acuerdo o una concesión de arbitraje en un caso de derecho civil. Tiene que pagar el gravamen de la corte antes de que la corte pueda desechar el caso.*

The name and address of the court is:
(El nombre y dirección de la corte es):

LOS ANGELES SUPERIOR COURT
111 North Hill Street, Los Angeles, CA 90012

CASE NUMBER:
(Número del Caso):

The name, address, and telephone number of plaintiff's attorney, or plaintiff without an attorney, is:
(El nombre, la dirección y el número de teléfono del abogado del demandante, o del demandante que no tiene abogado, es):

Nicholas Roxborough/Roxborough,Pomerance,Nye&Adreani,LLP/5820CanogaAve.#250/WoodlandHills,CA 91367

DATE: *(Fecha)* Clerk, by *(Secretario)* _____ , Deputy *(Adjunto)*

(For proof of service of this summons, use Proof of Service of Summons *(form POS-010).)*
(Para prueba de entrega de esta citatión use el formulario Proof of Service of Summons, *(POS-010)).*

[SEAL]

NOTICE TO THE PERSON SERVED: You are served
1. ☐ as an individual defendant.
2. ☐ as the person sued under the fictitious name of *(specify):*
3. ☐ on behalf of *(specify):*

under: ☐ CCP 416.10 (corporation) ☐ CCP 416.60 (minor)
☐ CCP 416.20 (defunct corporation) ☐ CCP 416.70 (conservatee)
☐ CCP 416.40 (association or partnership) ☐ CCP 416.90 (authorized person)
☐ other *(specify):*

4. ☐ by personal delivery on *(date):*

Form Adopted for Mandatory Use
Judicial Council of California
SUM-100 [Rev. July 1, 2009]

SUMMONS

Code of Civil Procedure §§ 412.20, 465
www.courtinfo.ca.gov

SHORT TITLE:	CASE NUMBER:
Howard, et al. vs. California Department of Industrial Relations et al.	

INSTRUCTIONS FOR USE

- This form may be used as an attachment to any summons if space does not permit the listing of all parties on the summons.
- If this attachment is used, insert the following statement in the plaintiff or defendant box on the summons: "Additional Parties Attachment form is attached."

List additional parties *(Check only one box. Use a separate page for each type of party.)*:

☐ Plaintiff ☑ Defendant ☐ Cross-Complainant ☐ Cross-Defendant

CHRISTINE BAKER, in her official capacity as Director of the California Department of Industrial Relations;

CALIFORNIA DIVISION OF WORKERS' COMPENSATION;

GEORGE PARISOTTO, in his official capacity as Administrative Director, California Department Of Industrial Relations, Division of Workers' Compensation;

DR. RAYMOND MEISTER, in his official capacity as Executive Medical Director, California Department of Industrial Relations, Division Of Workers' Compensation

and DOES 1 through 100, inclusive

Form Adopted for Mandatory Use
Judicial Council of California
SUM-200(A) [Rev. January 1, 2007]

ADDITIONAL PARTIES ATTACHMENT
Attachment to Summons

CM-010

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):	FOR COURT USE ONLY
Nicholas P. Roxborough (SBN 113540); Burton E. Falk (SBN 100644) ROXBOROUGH, POMERANCE, NYE & ADREANI, LLP 5820 Canoga Avenue, Suite 250, Woodland Hills, CA 91367 TELEPHONE NO.: (818) 992-9999 FAX NO.: (818) 992-9991 ATTORNEY FOR (Name): Plaintiffs and Petitioners	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES STREET ADDRESS: 111 North Hill Street MAILING ADDRESS: CITY AND ZIP CODE: Los Angeles, CA 90012 BRANCH NAME:	
CASE NAME: Howard, et al. vs. California Department of Industrial Relations et al.	
CIVIL CASE COVER SHEET ☑ Unlimited (Amount demanded exceeds $25,000) ☐ Limited (Amount demanded is $25,000 or less) **Complex Case Designation** ☐ Counter ☐ Joinder Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)	CASE NUMBER: JUDGE: DEPT:

Items 1–6 below must be completed (see instructions on page 2).

1. Check **one** box below for the case type that best describes this case:

Auto Tort
- ☐ Auto (22)
- ☐ Uninsured motorist (46)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- ☐ Asbestos (04)
- ☐ Product liability (24)
- ☐ Medical malpractice (45)
- ☐ Other PI/PD/WD (23)

Non-PI/PD/WD (Other) Tort
- ☐ Business tort/unfair business practice (07)
- ☐ Civil rights (08)
- ☐ Defamation (13)
- ☐ Fraud (16)
- ☐ Intellectual property (19)
- ☐ Professional negligence (25)
- ☐ Other non-PI/PD/WD tort (35)

Employment
- ☐ Wrongful termination (36)
- ☐ Other employment (15)

Contract
- ☐ Breach of contract/warranty (06)
- ☐ Rule 3.740 collections (09)
- ☐ Other collections (09)
- ☐ Insurance coverage (18)
- ☐ Other contract (37)

Real Property
- ☐ Eminent domain/Inverse condemnation (14)
- ☐ Wrongful eviction (33)
- ☐ Other real property (26)

Unlawful Detainer
- ☐ Commercial (31)
- ☐ Residential (32)
- ☐ Drugs (38)

Judicial Review
- ☐ Asset forfeiture (05)
- ☐ Petition re: arbitration award (11)
- ☐ Writ of mandate (02)
- ☐ Other judicial review (39)

Provisionally Complex Civil Litigation (Cal. Rules of Court, rules 3.400–3.403)
- ☐ Antitrust/Trade regulation (03)
- ☐ Construction defect (10)
- ☐ Mass tort (40)
- ☐ Securities litigation (28)
- ☐ Environmental/Toxic tort (30)
- ☐ Insurance coverage claims arising from the above listed provisionally complex case types (41)

Enforcement of Judgment
- ☐ Enforcement of judgment (20)

Miscellaneous Civil Complaint
- ☐ RICO (27)
- ☐ Other complaint *(not specified above)* (42)

Miscellaneous Civil Petition
- ☐ Partnership and corporate governance (21)
- ☑ Other petition *(not specified above)* (43)

2. This case ☐ is ☑ is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
   a. ☐ Large number of separately represented parties
   b. ☐ Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve
   c. ☐ Substantial amount of documentary evidence
   d. ☐ Large number of witnesses
   e. ☐ Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
   f. ☐ Substantial postjudgment judicial supervision
3. Remedies sought *(check all that apply)*: a. ☐ monetary b. ☑ nonmonetary; declaratory or injunctive relief c. ☐ punitive
4. Number of causes of action *(specify)*: Five (5).
5. This case ☐ is ☑ is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. *(You may use form CM-015.)*

Date: September 26, 2017

BURTON E. FALK
(TYPE OR PRINT NAME)

Burton E. Falk
(SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

NOTICE
- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on **all** other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

Form Adopted for Mandatory Use
Judicial Council of California
CM-010 [Rev. July 1, 2007]

CIVIL CASE COVER SHEET

Cal. Rules of Court, rules 2.30, 3.220, 3.400–3.403, 3.740;
Cal. Standards of Judicial Administration, std. 3.10
www.courtinfo.ca.gov

INSTRUCTIONS ON HOW TO COMPLETE THE COVER SHEET

To Plaintiffs and Others Filing First Papers. If you are filing a first paper (for example, a complaint) in a civil case, you **must** complete and file, along with your first paper, the *Civil Case Cover Sheet* contained on page 1. This information will be used to compile statistics about the types and numbers of cases filed. You must complete items 1 through 6 on the sheet. In item 1, you must check **one** box for the case type that best describes the case. If the case fits both a general and a more specific type of case listed in item 1, check the more specific one. If the case has multiple causes of action, check the box that best indicates the **primary** cause of action. To assist you in completing the sheet, examples of the cases that belong under each case type in item 1 are provided below. A cover sheet must be filed only with your initial paper. Failure to file a cover sheet with the first paper filed in a civil case may subject a party, its counsel, or both to sanctions under rules 2.30 and 3.220 of the California Rules of Court.

To Parties in Rule 3.740 Collections Cases. A "collections case" under rule 3.740 is defined as an action for recovery of money owed in a sum stated to be certain that is not more than $25,000, exclusive of interest and attorney's fees, arising from a transaction in which property, services, or money was acquired on credit. A collections case does not include an action seeking the following: (1) tort damages, (2) punitive damages, (3) recovery of real property, (4) recovery of personal property, or (5) a prejudgment writ of attachment. The identification of a case as a rule 3.740 collections case on this form means that it will be exempt from the general time-for-service requirements and case management rules, unless a defendant files a responsive pleading. A rule 3.740 collections case will be subject to the requirements for service and obtaining a judgment in rule 3.740.

To Parties in Complex Cases. In complex cases only, parties must also use the *Civil Case Cover Sheet* to designate whether the case is complex. If a plaintiff believes the case is complex under rule 3.400 of the California Rules of Court, this must be indicated by completing the appropriate boxes in items 1 and 2. If a plaintiff designates a case as complex, the cover sheet must be served with the complaint on all parties to the action. A defendant may file and serve no later than the time of its first appearance a joinder in the plaintiff's designation, a counter-designation that the case is not complex, or, if the plaintiff has made no designation, a designation that the case is complex.

CASE TYPES AND EXAMPLES

Auto Tort
- Auto (22)–Personal Injury/Property Damage/Wrongful Death
- Uninsured Motorist (46) *(if the case involves an uninsured motorist claim subject to arbitration, check this item instead of Auto)*

Other PI/PD/WD (Personal Injury/ Property Damage/Wrongful Death) Tort
- Asbestos (04)
  - Asbestos Property Damage
  - Asbestos Personal Injury/ Wrongful Death
- Product Liability *(not asbestos or toxic/environmental)* (24)
- Medical Malpractice (45)
  - Medical Malpractice–Physicians & Surgeons
  - Other Professional Health Care Malpractice
- Other PI/PD/WD (23)
  - Premises Liability (e.g., slip and fall)
  - Intentional Bodily Injury/PD/WD (e.g., assault, vandalism)
  - Intentional Infliction of Emotional Distress
  - Negligent Infliction of Emotional Distress
  - Other PI/PD/WD

Non-PI/PD/WD (Other) Tort
- Business Tort/Unfair Business Practice (07)
- Civil Rights (e.g., discrimination, false arrest) *(not civil harassment)* (08)
- Defamation (e.g., slander, libel) (13)
- Fraud (16)
- Intellectual Property (19)
- Professional Negligence (25)
  - Legal Malpractice
  - Other Professional Malpractice *(not medical or legal)*
- Other Non-PI/PD/WD Tort (35)

Employment
- Wrongful Termination (36)
- Other Employment (15)

Contract
- Breach of Contract/Warranty (06)
  - Breach of Rental/Lease Contract *(not unlawful detainer or wrongful eviction)*
  - Contract/Warranty Breach–Seller Plaintiff *(not fraud or negligence)*
  - Negligent Breach of Contract/ Warranty
  - Other Breach of Contract/Warranty
- Collections (e.g., money owed, open book accounts) (09)
  - Collection Case–Seller Plaintiff
  - Other Promissory Note/Collections Case
- Insurance Coverage *(not provisionally complex)* (18)
  - Auto Subrogation
  - Other Coverage
- Other Contract (37)
  - Contractual Fraud
  - Other Contract Dispute

Real Property
- Eminent Domain/Inverse Condemnation (14)
- Wrongful Eviction (33)
- Other Real Property (e.g., quiet title) (26)
  - Writ of Possession of Real Property
  - Mortgage Foreclosure
  - Quiet Title
  - Other Real Property *(not eminent domain, landlord/tenant, or foreclosure)*

Unlawful Detainer
- Commercial (31)
- Residential (32)
- Drugs (38) *(if the case involves illegal drugs, check this item; otherwise, report as Commercial or Residential)*

Judicial Review
- Asset Forfeiture (05)
- Petition Re: Arbitration Award (11)
- Writ of Mandate (02)
  - Writ–Administrative Mandamus
  - Writ–Mandamus on Limited Court Case Matter
  - Writ–Other Limited Court Case Review
- Other Judicial Review (39)
  - Review of Health Officer Order
  - Notice of Appeal–Labor Commissioner Appeals

Provisionally Complex Civil Litigation (Cal. Rules of Court Rules 3.400–3.403)
- Antitrust/Trade Regulation (03)
- Construction Defect (10)
- Claims Involving Mass Tort (40)
- Securities Litigation (28)
- Environmental/Toxic Tort (30)
- Insurance Coverage Claims *(arising from provisionally complex case type listed above)* (41)

Enforcement of Judgment
- Enforcement of Judgment (20)
  - Abstract of Judgment (Out of County)
  - Confession of Judgment *(non-domestic relations)*
  - Sister State Judgment
  - Administrative Agency Award *(not unpaid taxes)*
  - Petition/Certification of Entry of Judgment on Unpaid Taxes
  - Other Enforcement of Judgment Case

Miscellaneous Civil Complaint
- RICO (27)
- Other Complaint *(not specified above)* (42)
  - Declaratory Relief Only
  - Injunctive Relief Only *(non-harassment)*
  - Mechanics Lien
  - Other Commercial Complaint Case *(non-tort/non-complex)*
  - Other Civil Complaint *(non-tort/non-complex)*

Miscellaneous Civil Petition
- Partnership and Corporate Governance (21)
- Other Petition *(not specified above)* (43)
  - Civil Harassment
  - Workplace Violence
  - Elder/Dependent Adult Abuse
  - Election Contest
  - Petition for Name Change
  - Petition for Relief From Late Claim
  - Other Civil Petition

SHORT TITLE: Howard, et al. vs. California Department of Industrial Relations et	CASE NUMBER

CIVIL CASE COVER SHEET ADDENDUM AND STATEMENT OF LOCATION (CERTIFICATE OF GROUNDS FOR ASSIGNMENT TO COURTHOUSE LOCATION)

This form is required pursuant to Local Rule 2.3 in all new civil case filings in the Los Angeles Superior Court.

Step 1: After completing the Civil Case Cover Sheet (Judicial Council form CM-010), find the exact case type in Column A that corresponds to the case type indicated in the Civil Case Cover Sheet.

Step 2: In Column B, check the box for the type of action that best describes the nature of the case.

Step 3: In Column C, circle the number which explains the reason for the court filing location you have chosen.

Applicable Reasons for Choosing Court Filing Location (Column C)

1. Class actions must be filed in the Stanley Mosk Courthouse, Central District.
2. Permissive filing in central district.
3. Location where cause of action arose.
4. Mandatory personal injury filing in North District.
5. Location where performance required or defendant resides.
6. Location of property or permanently garaged vehicle.
7. Location where petitioner resides.
8. Location wherein defendant/respondent functions wholly.
9. Location where one or more of the parties reside.
10. Location of Labor Commissioner Office.
11. Mandatory filing location (Hub Cases – unlawful detainer, limited non-collection, limited collection, or personal injury).

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Auto Tort	Auto (22)	☐ A7100 Motor Vehicle - Personal Injury/Property Damage/Wrongful Death	1, 4, 11
	Uninsured Motorist (46)	☐ A7110 Personal Injury/Property Damage/Wrongful Death – Uninsured Motorist	1, 4, 11
Other Personal Injury/ Property Damage/ Wrongful Death Tort	Asbestos (04)	☐ A6070 Asbestos Property Damage ☐ A7221 Asbestos - Personal Injury/Wrongful Death	1, 11 1, 11
	Product Liability (24)	☐ A7260 Product Liability (not asbestos or toxic/environmental)	1, 4, 11
	Medical Malpractice (45)	☐ A7210 Medical Malpractice - Physicians & Surgeons ☐ A7240 Other Professional Health Care Malpractice	1, 4, 11 1, 4, 11
	Other Personal Injury Property Damage Wrongful Death (23)	☐ A7250 Premises Liability (e.g., slip and fall) ☐ A7230 Intentional Bodily Injury/Property Damage/Wrongful Death (e.g., assault, vandalism, etc.) ☐ A7270 Intentional Infliction of Emotional Distress ☐ A7220 Other Personal Injury/Property Damage/Wrongful Death	1, 4, 11 1, 4, 11 1, 4, 11 1, 4, 11

SHORT TITLE: Howard, et al. vs. California Department of Industrial Relations et	CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Non-Personal Injury/ Property Damage/ Wrongful Death Tort	Business Tort (07)	☐ A6029 Other Commercial/Business Tort (not fraud/breach of contract)	1, 2, 3
	Civil Rights (08)	☐ A6005 Civil Rights/Discrimination	1, 2, 3
	Defamation (13)	☐ A6010 Defamation (slander/libel)	1, 2, 3
	Fraud (16)	☐ A6013 Fraud (no contract)	1, 2, 3
	Professional Negligence (25)	☐ A6017 Legal Malpractice ☐ A6050 Other Professional Malpractice (not medical or legal)	1, 2, 3 1, 2, 3
	Other (35)	☐ A6025 Other Non-Personal Injury/Property Damage tort	1, 2, 3
Employment	Wrongful Termination (36)	☐ A6037 Wrongful Termination	1, 2, 3
	Other Employment (15)	☐ A6024 Other Employment Complaint Case ☐ A6109 Labor Commissioner Appeals	1, 2, 3 10
Contract	Breach of Contract/ Warranty (06) (not insurance)	☐ A6004 Breach of Rental/Lease Contract (not unlawful detainer or wrongful eviction) ☐ A6008 Contract/Warranty Breach -Seller Plaintiff (no fraud/negligence) ☐ A6019 Negligent Breach of Contract/Warranty (no fraud) ☐ A6028 Other Breach of Contract/Warranty (not fraud or negligence)	2, 5 2, 5 1, 2, 5 1, 2, 5
	Collections (09)	☐ A6002 Collections Case-Seller Plaintiff ☐ A6012 Other Promissory Note/Collections Case ☐ A6034 Collections Case-Purchased Debt (Charged Off Consumer Debt Purchased on or after January 1, 2014)	5, 6, 11 5, 11 5, 6, 11
	Insurance Coverage (18)	☐ A6015 Insurance Coverage (not complex)	1, 2, 5, 8
	Other Contract (37)	☐ A6009 Contractual Fraud ☐ A6031 Tortious Interference ☐ A6027 Other Contract Dispute(not breach/insurance/fraud/negligence)	1, 2, 3, 5 1, 2, 3, 5 1, 2, 3, 8, 9
Real Property	Eminent Domain/Inverse Condemnation (14)	☐ A7300 Eminent Domain/Condemnation Number of parcels_____	2, 6
	Wrongful Eviction (33)	☐ A6023 Wrongful Eviction Case	2, 6
	Other Real Property (26)	☐ A6018 Mortgage Foreclosure ☐ A6032 Quiet Title ☐ A6060 Other Real Property (not eminent domain, landlord/tenant, foreclosure)	2, 6 2, 6 2, 6
Unlawful Detainer	Unlawful Detainer-Commercial (31)	☐ A6021 Unlawful Detainer-Commercial (not drugs or wrongful eviction)	6, 11
	Unlawful Detainer-Residential (32)	☐ A6020 Unlawful Detainer-Residential (not drugs or wrongful eviction)	6, 11
	Unlawful Detainer-Post-Foreclosure (34)	☐ A6020F Unlawful Detainer-Post-Foreclosure	2, 6, 11
	Unlawful Detainer-Drugs (38)	☐ A6022 Unlawful Detainer-Drugs	2, 6, 11

SHORT TITLE: Howard, et al. vs. California Department of Industrial Relations et	CASE NUMBER

	A Civil Case Cover Sheet Category No.	B Type of Action (Check only one)	C Applicable Reasons - See Step 3 Above
Judicial Review	Asset Forfeiture (05)	☐ A6108 Asset Forfeiture Case	2, 3, 6
	Petition re Arbitration (11)	☐ A6115 Petition to Compel/Confirm/Vacate Arbitration	2, 5
	Writ of Mandate (02)	☐ A6151 Writ - Administrative Mandamus	2, 8
		☐ A6152 Writ - Mandamus on Limited Court Case Matter	2
		☐ A6153 Writ - Other Limited Court Case Review	2
	Other Judicial Review (39)	☐ A6150 Other Writ /Judicial Review	2, 8
Provisionally Complex Litigation	Antitrust/Trade Regulation (03)	☐ A6003 Antitrust/Trade Regulation	1, 2, 8
	Construction Defect (10)	☐ A6007 Construction Defect	1, 2, 3
	Claims Involving Mass Tort (40)	☐ A6006 Claims Involving Mass Tort	1, 2, 8
	Securities Litigation (28)	☐ A6035 Securities Litigation Case	1, 2, 8
	Toxic Tort Environmental (30)	☐ A6036 Toxic Tort/Environmental	1, 2, 3, 8
	Insurance Coverage Claims from Complex Case (41)	☐ A6014 Insurance Coverage/Subrogation (complex case only)	1, 2, 5, 8
Enforcement of Judgment	Enforcement of Judgment (20)	☐ A6141 Sister State Judgment	2, 5, 11
		☐ A6160 Abstract of Judgment	2, 6
		☐ A6107 Confession of Judgment (non-domestic relations)	2, 9
		☐ A6140 Administrative Agency Award (not unpaid taxes)	2, 8
		☐ A6114 Petition/Certificate for Entry of Judgment on Unpaid Tax	2, 8
		☐ A6112 Other Enforcement of Judgment Case	2, 8, 9
Miscellaneous Civil Complaints	RICO (27)	☐ A6033 Racketeering (RICO) Case	1, 2, 8
	Other Complaints (Not Specified Above) (42)	☐ A6030 Declaratory Relief Only	1, 2, 8
		☐ A6040 Injunctive Relief Only (not domestic/harassment)	2, 8
		☐ A6011 Other Commercial Complaint Case (non-tort/non-complex)	1, 2, 8
		☐ A6000 Other Civil Complaint (non-tort/non-complex)	1, 2, 8
Miscellaneous Civil Petitions	Partnership Corporation Governance (21)	☐ A6113 Partnership and Corporate Governance Case	2, 8
	Other Petitions (Not Specified Above) (43)	☐ A6121 Civil Harassment	2, 3, 9
		☐ A6123 Workplace Harassment	2, 3, 9
		☐ A6124 Elder/Dependent Adult Abuse Case	2, 3, 9
		☐ A6190 Election Contest	2
		☐ A6110 Petition for Change of Name/Change of Gender	2, 7
		☐ A6170 Petition for Relief from Late Claim Law	2, 3, 8
		☑ A6100 Other Civil Petition Writ of Mandamus CCP §1085	2, 9

SHORT TITLE: Howard, et al. vs. California Department of Industrial Relations et	CASE NUMBER

Step 4: Statement of Reason and Address: Check the appropriate boxes for the numbers shown under Column C for the type of action that you have selected. Enter the address which is the basis for the filing location, including zip code. (No address required for class action cases).

REASON: ☐ 1. ☑ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐ 7. ☐ 8. ☐ 9. ☐ 10. ☐ 11.			ADDRESS: 18370 Burbank Blvd., Suite 707
CITY: Tarzana	STATE: CA	ZIP CODE: 91356	

Step 5: Certification of Assignment: I certify that this case is properly filed in the Central District of the Superior Court of California, County of Los Angeles [Code Civ. Proc., §392 et seq., and Local Rule 2.3(a)(1)(E)].

Dated: September 26, 2017

Burton E. Falk

(SIGNATURE OF ATTORNEY/FILING PARTY)

PLEASE HAVE THE FOLLOWING ITEMS COMPLETED AND READY TO BE FILED IN ORDER TO PROPERLY COMMENCE YOUR NEW COURT CASE:

1. Original Complaint or Petition.
2. If filing a Complaint, a completed Summons form for issuance by the Clerk.
3. Civil Case Cover Sheet, Judicial Council form CM-010.
4. Civil Case Cover Sheet Addendum and Statement of Location form, LACIV 109, LASC Approved 03-04 (Rev. 02/16).
5. Payment in full of the filing fee, unless there is court order for waiver, partial or scheduled payments.
6. A signed order appointing the Guardian ad Litem, Judicial Council form CIV-010, if the plaintiff or petitioner is a minor under 18 years of age will be required by Court in order to issue a summons.
7. Additional copies of documents to be conformed by the Clerk. Copies of the cover sheet and this addendum must be served along with the summons and complaint, or other initiating pleading in the case.

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

DR. TIMOTHY C. HOWARD; DR. MEERA JANI; DR. BENJAMIN SIMON,

Plaintiffs and Petitioners,

vs.

CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS; CHRISTINE BAKER, in her official capacity as Director of the California Department of Industrial Relations; CALIFORNIA DIVISION OF WORKERS' COMPENSATION; GEORGE PARISOTTO, in his official capacity as Administrative Director, California Department Of Industrial Relations, Division of Workers' Compensation; DR. RAYMOND MEISTER, in his official capacity as Executive Medical Director, California Department of Industrial Relations, Division Of Workers' Compensation; and DOES 1 through 100, inclusive,

Defendants and Respondents.

Case No.

VERIFIED PETITION FOR WRIT OF MANDATE AND COMPLAINT FOR:

1. **Violation Of Administrative Procedures Act, Government Code § 11340, Et Seq. – Writ of Mandate, Code of Civil Procedure § 1085**
2. **Violation Of Administrative Procedures Act, Government Code § 11340, Et Seq. – Declaratory Relief, Code Of Civil Procedure § 1060; Government Code § 11350**
3. **Violation of Administrative Procedures Act, Government Code § 11340, Et Seq. – Injunctive Relief, Code Of Civil Procedure §§ 525 And 526**
4. **Violation of United States Constitution, Amendment XIV, Due Process – Declaratory And Injunctive Relief**
5. **Violation Of The California Constitution, Article I, Section 7(A) Against All Respondents – Declaratory And Injunctive Relief**

[Code of Civil Procedure §§ 525, 526, 1060, and 1085; Government Code § 11340, et seq.]

COMES NOW Plaintiffs and Petitioners, Dr. Timothy C. Howard ("Petitioner Howard"), Dr. Meera Jani ("Petitioner Jani") and Dr. Benjamin Simon ("Petitioner Simon") (collectively "Petitioners") who hereby allege as follows:

INTRODUCTION

1. Respondents have engaged in a scorched earth policy to deny reappointment licenses to qualified medical evaluators ("QMEs") without due process of law – including without a hearing to challenge Respondents' mere accusations – through Respondents' imposition of new and different criteria governing such reappointments and the medical-legal fee schedule applicable to QMEs in California.

2. This Petition and Complaint challenges the validity of certain void and illegal policies, internal guidelines and actions consisting of statutes and regulations that have been supplemented with new, different and/or additional criteria that have not been properly adopted through the Administrative Procedures Act, Government Code § 11340, et seq. (the "APA") (herein "underground regulations"). These underground regulations are being enforced by the California Department of Industrial Relations (the "DIR"), the DIR Director Christine Baker ("Director Baker"), the DIR's Division of Workers' Compensation ("the DWC"), the DWC's Administrative Director George Parisotto ("DWC Admin. Dir. Parisotto"), and the DWC's Executive Medical Director Dr. Raymond Meister ("DWC Med. Dir. Meister") (collectively "Respondents"). Director Baker, DWC Admin. Dir. Parisotto, and DWC Med. Dir. Meister are sued herein in their official capacities.

3. Respondents have, without notice, intentionally adopted underground regulations regarding the medical-legal fee schedule used as prima facie evidence of the reasonable fees paid for QME medical-legal evaluations of injured workers under California's workers' compensation system. These underground regulations are being utilized by Respondents to impose new and different criteria that effectively eliminate hourly billing code 104, a goal sought by the workers' compensation insurers and other payors of the workers' compensation benefits, which is contrary to the interests of the injured workers that workers' compensation laws, for over 100 years, are designed to protect.

4. By effectively challenging and attempting to eliminate hourly billing code 104 for QMEs, Respondents have falsely accused QMEs of having violated the medical-legal fee schedule, thereby purporting to justify Respondents' denials of reappointment licenses to hundreds of QMEs. Respondents are essentially accusing QMEs of fraud, where none exists or has been proven, and are using these allegations as a pretext to demanding payments, the failure of which is to then lead Respondents to deny QME's their license to serve as QMEs.

5. It is beyond frustrating that Respondents are required by California law to provide QMEs with a hearing that protects QME rights to due process of law and procedural safeguards, before suspending, terminating or otherwise disciplining a QME for crimes, fraud, and all other violations of law, save for a few specifically enumerated circumstances that are irrelevant herein. However, through its use of underground regulations, Respondents have improperly extended the "no due process hearing" exception to apply specifically to the reappointment process for QMEs, thereby illegally denying reappointment based solely on mere accusations, and thus achieving an end-run around the QMEs' rights to a due process hearing. In essence, Respondents are acting both as the prosecuting attorney and the judge regarding enforcement of Respondents' own illegal regulations, thus imposing the sentence of denial of QME reappointment licenses **before** any evidence is presented before an impartial body. In this way, Respondents have started to systematically and illegally purge the workers' compensation system of its most qualified, experienced, productive and ethical QMEs without due process of law, thereby also potentially decimating the California workers' compensation system.

6. Petitioners are informed and allege that, so far, approximately 400 QMEs have been denied reappointment in this manner, out of a total DWC panel of only 3,000 QMEs, or approximately 13.3% of all QMEs in California. The denial of Petitioners' reappointments as QMEs will prevent Petitioners – and literally hundreds more doctors – from serving as QMEs in the State of California, unless and until they are reappointed as QMEs by the Respondents.

7. Respondents have a ministerial duty to provide a hearing before disciplining any QME. By denying reappointment of QMEs based on mere accusations without any hearing, Respondents have deprived QMEs of due process of law.

8. Respondents also have a ministerial duty to apply the medical-legal fee schedule as expressly written and as originally intended. By denying reappointment of QMEs based on new and different criteria for use of the medical-legal fee schedule, particularly billing code 104, Respondents have again deprived QMEs of due process of law.

9. Accordingly, unless the relief requested in this Petition and Complaint is granted, California's workers' compensation QME system will be placed in jeopardy, thousands of injured workers' claims will be delayed until different QMEs can evaluate or re-evaluate them, thousands of injured workers will face substantial delay in receiving medical care and indemnity payments that are determined by QME disability and impairment ratings due to a sudden and substantial shortage of QMEs, and hundreds of the most qualified, ethical, and experienced physicians will no longer be able to perform qualified medical examinations and will have their medical practices substantially destroyed or eliminated altogether.

PARTIES

10. For over 45 years, Petitioner Howard has been licensed as an orthopedist (since 1971), and has performed 400 to 500 total knee and hip surgeries, and 200 to 300 spinal surgeries. Petitioner Howard was first appointed as a QME in 2005, has prepared approximately, or more than, 1,500 QME reports, and prior to the DWC's actions described below, Petitioner Howard has never before received any billing or other complaints from the DWC. In short, Petitioner Howard satisfies all the requirements to be reappointed as a QME. Petitioner Howard is over 70 years of age and is thus entitled to trial preference and priority pursuant to C.C.P. § §36(a). Petitioner Howard is and at all times herein mentioned was an individual residing in the County of Contra Costa, City of Danville, State of California.

11. Petitioner Jani has been licensed as a chiropractor since 2000. Petitioner Jani was first appointed as a QME by Respondents in 2001, and prior to the DWC's actions described below, Petitioner Jani she has never before received any billing other complaints from the DWC. Petitioner Jani satisfies all requirements to be reappointed as a QME. Petitioner Jani is and at all times herein mentioned was an individual residing in the County of San Bernardino, City of Rancho Cucamonga, State of California.

12. Petitioner Simon has practiced medicine as a cardiologist for 30 years during which time he has performed thousands of interventional procedures. He has been a QME since 2015 and has prepared approximately 150 QME reports. Prior to the DWC's actions described below, Petitioner Simon has never before received any billing or other complaints from the DWC. In short, Petitioner Simon satisfies all the requirements to be reappointed as a QME. Petitioner Simon is and at all times herein mentioned was an individual residing in the County of Los Angeles, City of Agoura, State of California.

13. On information and belief, Petitioners allege that a disproportionate number of QMES who have been denied reappointment without a due process hearing based on Respondents' mere accusations of violations of the medical-legal fee schedule, reside in Los Angeles County.

14. The DIR is a statutorily created part of the California Labor and Workforce Development Agency. (Labor Code §§18.5, 19.) The DIR administers and enforces laws governing aspects of the workers' compensation system, including, without limitation: (1) the reappointment of QMEs (Labor Code § 139.2), (2) the suspension of physicians from participation in the workers' compensation system for certain felony or misdemeanor convictions (Labor Code § 139.21), and (3) the disciplining of QMEs through suspension or termination (California Code of Regulations ("CCR"), Title 8, Section 60 ("8 CCR § 60"), *et seq.*) Consistent with these legal duties, and at all times relevant hereto, the DIR was responsible for properly and legally administering, overseeing, and enforcing the laws relating to reappointment of QMEs. The DIR has an office in the City of Los Angeles.

15. Director Baker is the Director of the DIR and she is sued herein in her official capacity. (Labor Code § 20.) Pursuant to Labor Code § 51, the DIR is under the control of its Director. As required by statute, and at all times relevant herein, Director Baker was and is responsible to perform all duties, exercise all powers and jurisdiction, assume and discharge all responsibilities, and carry out and affect all purposes vested, by law, in the DIR. (Labor Code §54.)

16. At all times relevant, the DWC was a division of the DIR, and, as such, under the complete control of the DIR.

17. DWC Admin. Dir. Parisotto is the Administrative Director of the DWC, and is sued

herein in his official capacity. (Labor Code § 110(b).) The Administrative Director is under the control of Director Baker. As required by statute, and at all times relevant herein, DWC Admin. Dir. Parisotto was and is responsible to perform all duties, exercise all powers and jurisdiction, assume and discharge all responsibilities, and carry out and affect all purposes vested by law in the DWC. (Labor Code §110 *et seq.*)

18. DWC Med. Dir. Meister is the Executive Medical Director of the DWC and is sued herein in his official capacity. (Labor Code §§ 110(b), 122.) The Medical Director is under the control of Director Baker and DWC Admin. Dir. Parisotto. As required by statute, and at all times relevant herein, DWC Med. Dir. Meister was and is responsible to perform all duties, exercise all powers and jurisdiction, assume and discharge all responsibilities, and carry out and affect all purposes vested by law in the DWC. (Labor Code §110 *et seq.*) In particular, all the powers and discretion of the DWC's Administrative Director are delegated to the DWC's Medical Director with respect to, *inter alia*, all investigations, and all other functions, related to QME discipline. (8 CCR § 60(d)(1)-(8).)

19. Petitioners are unaware of the true names and capacities of Respondents DOES 1 through 100, inclusive, and they are therefore sued by such fictitious names pursuant to Code of Civil Procedure § 474. Petitioners allege on information and belief that each such fictitiously named Respondent is responsible or liable in some manner for the events and happenings referred to herein, and Petitioners will seek leave to amend this Petition and Complaint to allege the true names and capacities of DOES 1 through 100, inclusive, after the same have been ascertained.

JURISDICTION AND VENUE

20. Pursuant to Code of Civil Procedure § 410.10, this Court has jurisdiction over Respondents because each is a person or business entity that resides and/or that was established, incorporated and/or has sufficient minimum contacts with the State of California to render exercise of jurisdiction over him, her, or it consistent with traditional notions of fair play and substantial justice.

21. Venue is proper in the County of Los Angeles pursuant to Code of Civil Procedure § 393(b) and *Lipari v. Department of Motor Vehicles*, 16 Cal. App. 4th 667, 670, fn. 2 (1993).

GENERAL ALLEGATIONS

22. The Medical Unit is a unit within the DWC that manages medical issues in workers' compensation ("the DWC Medical Unit"). The DWC Medical Unit appoints QMEs. These QMEs help resolve important and often complex medical disputes in the workers' compensation system by issuing medical opinions that can be used as evidence before the Workers' Compensation Appeals Board ("WCAB"). The DWC Administrative Director appoints QMEs in specialties as required for the evaluation of medical issues, for two-year terms. (Labor Code § 139.2(a).) A QME is certified and licensed by the DWC to provide an expert, objective opinion on a work injury case. QMEs can come from many medical fields, including psychology, orthopedics, chiropractic, etc. (Labor Code § 139.2.) The primary job of the QME is to provide his/her objective review of the claim. This might include providing a pain impairment rating of the patient which would ultimately determine what benefits the injured worker should receive, often times involving hundreds of thousands of dollars. (*See* www.dir.ca.gov.) A QME is selected, by a specified process, from a QME panel issued to the injured worker and the claims administrator. (Labor Code §§ 4060-4062.2.)

23. In this context, the word "panel" means a list. A panel QME is a randomly generated list of three QME physicians issued when there is a question about whether an injury is work related, or when there is a medical dispute that has not been resolved by the treating physician's report. A QME also evaluates an injured worker when there are questions about what benefits the injured worker should receive. (*See* www.dir.ca.gov.)

24. Pursuant to Labor Code § 139.2, the DIR is obligated to reappoint QMEs who meet all the educational and other standards set forth therein, and have not been found to have violated applicable regulations after a due process hearing, with specifically enumerated exceptions, none of which are applicable to Petitioners.

25. Respondents have instead recently decided to specifically rely upon 8 CCR § 63 when notifying Petitioners and other QMEs of the denial of their QME reappointments without a hearing. However, 8 CCR § 63 does not permit Respondents to actually deny reappointment of a QME until after a due process hearing.

26. Respondents have denied Petitioners' reappointment as QMEs based on mere accusations of violations of 8 CCR § 9795 (commonly called the "medical-legal fee schedule") based on new and different criteria they have applied to 8 CCR § 9795, which have not been approved pursuant to the APA. Respondents primarily allege that Petitioners billed for some QME reports under the hourly medical-legal ("ML") 104 billing code, instead of the lower fixed fee ML 102 or 103 billing codes, in violation of Respondents' new and different criteria for enforcing 8 CCR § 9795. By doing so, Respondents have effectively eliminated billing code ML 104, as set forth in 8 CCR § 9795. Respondents' conduct therefore violates the APA. Respondents' new and different criteria for enforcing 8 CCR § 9795 constitute void and illegal underground regulations.

27. Petitioners allege that the guidelines, criteria, instructions, standards of general application, and other statements contained in Respondents' denial of Petitioner Howard's and Petitioner Jani's reappointments as QMEs constitute regulations pursuant to Government Code § 11342.600. Accordingly, Respondents were required to comply with the procedures mandated by the APA prior to enforcing or applying those regulations. However, the Respondents did not comply with the APA. Therefore, the denials of reappointment are void and illegal. (*See Tidewater Marine Western v. Bradshaw* (1996) 14 Cal. 4th 557, 576.)

28. Further, Respondents have no statutory or regulatory authority to actually deny reappointment of Petitioners as QMEs based on alleged mistakes by Petitioners in using billing codes, without a due process hearing. Respondents are therefore intentionally violating Petitioners' due process rights by denying them reappointment as QMEs based solely on mere accusations of mistakes in determining the applicable medical-legal fee schedule code, thereby applying void and illegal underground regulations, which deprive doctors of their income and livelihood as QMEs, and damage their reputations. By depriving Petitioners of their QME income, Petitioners are substantially unable to defend themselves against Respondents' accusations. To further delay and frustrate QMEs, Respondents not only deny renewal of their reappointment, but then delay the scheduling of hearings in which Petitioners could vindicate their rights and defend their billing practices. By denying Petitioners reappointment based on mere accusations, Respondents are illegally imposing *de facto* permanent denials of

reappointment licenses, in violation of Petitioners' rights to due process of law.

a. Respondents Cannot Suspend, Terminate or Otherwise Discipline QMEs Without A Due Process Hearing. Nevertheless, Respondents Have Imposed An Underground Regulation Exception To The Due Process Hearing Requirement For Denials of Reappointments of QMEs, In Violation of The APA.

29. By law, Respondents must reappoint a QME if they meet certain standards. Labor Code § 139.2 provides, in relevant part:

> (b) The administrative director shall appoint or reappoint as a qualified medical evaluator a physician, as defined in Section 3209.3, who is licensed to practice in this state and who demonstrates that he or she meets the requirements in paragraphs (1), (2), (6), and (7), and, if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5). [Emphasis added.]

30. None of subsections (1)-(7) of Labor Code § 139.2(b) states that an alleged misapplication of billing codes by QMEs is a ground for denial of reappointment as a QME.

31. Petitioners are entitled to be reappointed as QMEs as long as they meet certain medical standards and each "Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director." (Labor Code § 139.2(d)(1).) However, Labor Code § 139.2(d)(1) does not permit Respondents to determine for themselves whether QMEs are, in fact, in compliance with applicable regulations in the absence of a due process hearing. The requirement that no disciplinary actions against QMEs may be imposed without a due process hearing is set forth elsewhere in Labor Code §139.2, and also in 8 CCR § 63, the precise regulation that Respondents rely upon when denying reappointments of QMEs (discussed more fully below).

32. That Respondents must provide a hearing before suspending, terminating, placing a QME on probation, or otherwise disciplining a QME, is Black Letter Law. (Labor Code § 139.2.) And, Labor Code §139.2(k) provides that a hearing is required in all but two circumstances (not applicable herein) before a QME can be suspended, terminated or otherwise disciplined, as

follows:

> (k) Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (l), determines, based on substantial evidence, that a qualified medical evaluator:
>
> (1) Has violated any material statutory or administrative duty.
>
> (2) Has failed to follow the medical procedures or qualifications established pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).
>
> (3) Has failed to comply with the timeframe standards established pursuant to subdivision (j).
>
> (4) Has failed to meet the requirements of subdivision (b) or (c).
>
> (5) Has prepared medical-legal evaluations that fail to meet the minimum standards for those reports established by the administrative director or the appeals board.
>
> (6) Has made material misrepresentations or false statements in an application for appointment or reappointment as a qualified medical evaluator.

33. None of subsections (1)-(6) set forth in Labor Code § 139.2(k) states that an alleged misapplication of billing codes by QMEs is a ground for denial of reappointment as a QME. However, all of the grounds for discipline set forth in Labor Code § 139.2(k)(1)-(6) require a due process hearing before imposing any discipline, contrary to what Respondents have done herein in denying reappointment of Petitioners and other QMEs without such a hearing.

34. The only exceptions to the due process hearing requirement set forth in Labor Code § 139.2 – which are not applicable herein – are set forth in Labor Code § 139.2(k), as follows:

> A hearing shall not be required prior to the suspension or termination of a physician's privilege to serve as a qualified medical evaluator when the physician has done either of the following:
>
> (A) Failed to timely pay the fee required pursuant to subdivision (n).

(B) Had his or her license to practice in California suspended by the relevant licensing authority so as to preclude practice, or had the license revoked or terminated by the licensing authority.

None of these exceptions apply to Petitioners.

35. The only other exceptions to the due process hearing requirement are set forth in 8 CCR § 60(a), which provides that the DWC Administrative Director's has the right to suspend or terminate a physician without a hearing for very serious violations of statutes and regulations, as follows:

(a) The Administrative Director may, in his or her discretion, suspend or terminate any physician from the QME list without hearing:

(1) whose license has been revoked;

(2) whose license has been suspended or terminated by the relevant licensing board so as to preclude practice;

(3) who has been convicted of a misdemeanor or felony related to the conduct of his or her practice or who has been suspended or placed on probation by his or her licensing board;

(4) based on a stipulation or a decision by the physician's licensing board that the physician has been placed on probation;

(5) who has failed to pay timely the appropriate fee as required under section 17 of Title 8 of the California Code of Regulations.

36. Again, none of the grounds for suspending or terminating QMEs without a hearing, as set forth in 8 CCR § 60(a)(1)-(5) above, has been alleged or proven by Respondents against Petitioners. Further, those five grounds do not include an alleged or even proven mistake, by a QME, in applying the medical-legal billing codes, such as have been alleged by Respondents.

37. The Labor Code does not distinguish between "termination" of a QME during his/her two-year term, and denial of reappointment of a QME at the end of his/her two-year term, in requiring that Respondents must provide the QMEs with a statement of reasons for the recommended disciplinary action. Labor Code § 139.2(f) provides in relevant part: "The

administrative director shall furnish a physician, upon request, with a written statement of its reasons for termination of, or for denying appointment or reappointment as, a qualified medical evaluator."

38. Labor Code § 139.2 is immediately followed by Labor Code § 139.21, which allows for suspension of a physician from participation in the workers' compensation system only for certain egregious and serious statutory or regulatory violations, such as felony or misdemeanor convictions (§ 139.21(A)), fraud or abuse of the federal Medicare or Medicaid programs (§139.21(B)), or the surrender or revocation of a physician's license to provide health care (§ 139.21(C)). None of these serious grounds for discipline is alleged against Petitioners. Critically, such suspensions may occur only after an administrative hearing where due process procedural safeguards are provided (§ 139.21(b)(1)-(2)).

39. A due process hearing is also required by 8 CCR § 60(b), which provides in relevant part:

> The Administrative Director may, based on a complaint by the Medical Director, and following a hearing pursuant to section 61 of Title 8 of the California Code of Regulations, suspend, terminate or place on probation a QME found in violation of a statutory or administrative duty as described in the Administrative Director Sanction Guidelines for QMEs under section 65 of Title 8 of the California Code of Regulations. [Emphasis added.]

40. None of the ten violations of a statutory or administrative duty set forth in 8 CCR § 60(b)(1)-(10) include anything related to an alleged or proven mistake by a QME in applying the medical-legal billing codes, such as have been alleged by Respondents against Petitioners. Further, none of the ten violations of a statutory or administrative duty set forth in 8 CCR §§ 60(b)(1)-(10) authorizes Respondents to deny the reappointment of a QME without a due process hearing.

41. 8 CCR § 60(d) provides that the powers and discretion of the Administrative Director are delegated to the Medical Director, "except for issuing statements of issues, issuing accusations and disciplinary orders after hearing." (8 CCR § 60(d)(8); emphasis added.) However,

Respondent DWC Med. Dir. Meister issued all Denial Letters to Petitioners, and did so before any hearing, in direct contravention of 8 CCR § 60(d).

42. Indeed, 8 CCR § 61 specifically provides that when the DWC Medical Director determines that there is *prima facie* evidence of any violation of 8 CCR § 60, evidence of the violation must be submitted to the DWC Administrative Director. Further, if the DWC Administrative Director then sustains the DWC Medical Director's determination, the QME must be provided with written notice of a right to a hearing to be conducted according to the due process protections of the APA. (8 CCR § 61(a)-(b).) Nowhere in 8 CCR § 61 are Respondents entitled to actually deny reappointment of a QME before the conclusion of a due process hearing for violation of the medical-legal fee schedule (8 CCR § 9795.). Yet shockingly, that is precisely what Respondents have done to Petitioners and other QMEs. Additionally, as a strong arm tactic, Respondents have also threatened to continue to deny reappointment unless the QME agrees with Respondents' accusations and pays the amount Respondents demand.

43. Critically, Respondents have specifically relied upon 8 CCR § 63 when notifying Petitioners, and other QMEs, of Respondents' denials of their applications for reappointment as QMEs. However, 8 CCR § 63, which derives its authority from Labor Code § 139.2(f), does not permit Respondents to actually deny reappointment of a QME until after a hearing. Instead, 8 CCR § 63 only permits Respondents to notify a QME of their initial determination of their intent to seek to deny reappointment, and then, of their final determination to seek to deny reappointment. However, the denial itself cannot be implemented until after a due process hearing. 8 CCR § 63, a copy of which is attached to Respondents' Denial Letters sent to Petitioners (discussed below) and to other QMEs, states, in relevant part:

> (a) Whenever the Administrative Director determines that an application for appointment or reappointment as a Qualified Medical Evaluator will be denied, the Administrative Director shall:
>
> (1) Notify the applicant in writing of the decision to deny the application and the reasons for the denial; and
>
> (2) Provide notice that if the applicant submits a specific, written response to the notice of denial within thirty (30) days, the Administrative Director will

review the decision to deny the application, and within sixty (60) days of receipt of the response notify the applicant of the Administrative Director's final decision.

(b) If the applicant fails to submit a specific, written response to the notice of denial within thirty (30) days, the decision to deny shall become final without any further notice.

(c) If the applicant submits a specific, written response, and the Administrative Director's final decision is that the application **should be denied**, notice of the final decision shall be provided to the applicant by means of a statement of issues and **notice of right to hearing** under Chapter 5 (commencing with section 11500) of Title 2 of the Government Code. [Emphasis added.]

44. Therefore, Respondents cannot reasonably evade the requirements of due process of law by denying reappointment of a QME without a hearing. However, Respondents have, in fact, imposed, adopted and enforced denials of QME reappointments before providing the due process hearing required by 8 CCR §§ 60-63, and Labor Code §§ 139.2 and 139.21, as to Petitioners Howard, Jani and Simon through mere accusations set forth in preliminary Denial Letters and in orders reconsidering their preliminary Denial Letters.

SPECIFIC EVIDENCE OF RESPONDENTS UNDERGROUND REGULATIONS AND DENIAL OF REAPPOINTMENTS WITHOUT ANY HEARING

45. Petitioner Howard submitted an application for reappointment as a QME on February 19, 2017, to be effective as of April 15, 2017. After waiting over 100 days, on June 1, 2017, DWC Med. Dir. Meister sent a denial of reappointment letter to Petitioner Howard ("June 1, 2017 Denial Letter") stating in relevant part:

The apparent violations of 8 CCR §§9795 and Labor Code 4628 prevent your reappointment as a Qualified Medical Evaluator pursuant to Labor Code §§139.2(j) (6) & 139.2(k) (1).

Accordingly, your application for reappointment will be denied and your check number 1748, in the amount of $550.00 will be returned to you herewith.

Please be advised that notice of your rights with respect to this denial pursuant to 8 CCR §63 is attached hereto.

Please be further advised that you cannot participate in any panel qualified medical evaluations that require a face-to-face evaluation of the injured

> worker after receipt of this letter. [Emphasis added.] (Attached hereto as Exhibit "A" is a true and complete copy of the June 1, 2017 Denial Letter.)

46. Petitioner Howard was, therefore, actually denied reappointment as a QME based upon Respondents' preliminary accusation and before any due process hearing was granted, despite the language 8 CCR § 63 and other provisions requiring such a hearing.

47. Accordingly, on June 29, 2017, counsel for Petitioner Howard timely responded to the DWC's June 1, 2017 Denial Letter and requested an administrative hearing pursuant to 8 CCR § 63 ("Petitioner Howard's June 29, 2017 Denial Response"). (Attached hereto as Exhibit "B" is a true and complete copy of Petitioner Howard's June 29, 2017 response.) Despite this request made over three months ago, Respondents have refused to set any date for a hearing.

48. Instead, on September 12, 2017, DWC Admin. Dir. Parisotto issued to Petitioner Howard an "Order on Reconsideration and Statement of Issues Regarding Denial of Appointment" ("Denial Order"), stating in part: "IT IS ORDERED that the application of Timothy C. Howard… for appointment as a Qualified Medical Evaluator ("QME") is hereby denied." (Attached hereto as Exhibit "C" is a true and complete copy of the Denial Order.)

49. In response to Respondents' Denial Order, Petitioner Howard served a second "Request For Hearing" on September 25, 2017. No hearing has been provided.

50. Petitioner Jani also submitted an application for reappointment as a QME on May 31, 2017, to be effective as of July 15, 2017. On August 11, 2017, 72 days later, DWC Med. Dir. Meister sent a denial of reappointment letter to Petitioner Jani ("August 11, 2017 Denial Letter") stating once again, in relevant part:

> The apparent violations of 8 CCR §§9795 prevent your reappointment as a Qualified Medical Evaluator pursuant to Labor Code §§139.2(j) (6) & 139.2(k) (1).
>
> Accordingly, your application for reappointment will be denied and your check number 4095, in the amount of $1,010.00 will be returned to you herewith.
>
> Please be advised that notice of your rights with respect to this denial pursuant to 8 CCR §63 is attached hereto.
>
> Please be further advised that you cannot participate in any panel qualified medical evaluations that require a face-to-face evaluation of the injured

worker after receipt of this letter. [Emphasis added.] (Attached hereto as Exhibit "D" is a true and complete copy of the August 11, 2017 Denial Letter.)

51. On September 6, 2017, counsel for Petitioner Jani timely responded to the DWC's August 11, 2017 Denial Letter and requested an administrative hearing pursuant to 8 CCR § 63 ("Petitioner Jani's September 6, 2017 Denial Response"). (Attached hereto as Exhibit "E" is a true and complete copy of Petitioner Jani's September 6, 2017 Denial Response.) No hearing has been provided.

52. Petitioner Jani was, therefore, actually denied reappointment as a QME based upon Respondents' preliminary accusation and before any due process hearing was granted, despite the language 8 CCR § 63 and other provisions requiring such a hearing.

53. Petitioner Simon also submitted an application for reappointment as a QME on May 23, 2017, to be effective as of July 15, 2017. On August 7, 2017, 76 days later, DWC Med. Dir. Meister sent a denial of reappointment letter to Petitioner Simon ("August 7, 2017 Denial Letter") stating once again, in relevant part:

> The apparent violations of 8 CCR §9795 prevent your reappointment as a Qualified Medical Evaluator pursuant to Labor Code §§139.2U) (6) & 139.2(k) (1).
>
> Accordingly, your application for reappointment will be denied and your check number 1009 in the amount of $950.00 will be returned to you herewith.
>
> Please be advised that notice of your rights with respect to this denial pursuant to 8 CCR §63 is attached hereto.
>
> Please be further advised that you cannot participate in any panel qualified medical evaluations that require a face-to-face evaluation of the injured worker after receipt of this letter. [Emphasis added.] (Attached hereto as Exhibit "F" is a true and complete copy of the August 7, 2017 Denial Letter.)[1]

54. On September 6, 2017, counsel for Petitioner Simon timely responded to the DWC's August 7, 2017 Denial Letter and requested an administrative hearing pursuant to 8 CCR § 63

[1] The June 1,2017 Denial Letter to Petitioner Howard (Exhibit "A"), the August 11, 2017 Denial Letter to Petitioner Jani (Exhibit "D"), and the August 7, 2017 Denial Letter to Petitioner Simon (Exhibit "F"), are sometimes collectively referred to herein as the "Denial Letters."

("Petitioner Simon's September 6, 2017 Denial Response"). (Attached hereto as Exhibit "G" is a true and complete copy of Petitioner Simon's September 6, 2017 Denial Response.) No hearing has been provided.

55. As shown above, Respondents have also waited from three to six weeks after Petitioners' reappointment deadlines had passed, thereby imposing *de facto* denials of their reappointment without even an explanation, thereby further damaging Petitioners' reputations and their ability to continue to provide new or supplemental QME evaluations, which further impaired the workers' compensation system.

56. On information and belief, Petitioners allege that many other QME's have received Denial Letters and/or Denial Orders with identical or nearly identical language actually terminating their QME licenses without a due process hearing.

57. Therefore, Respondents have established a new track record adopting a regulation that creates a previously unrecognized exception to the due process hearing requirements set forth in Labor Code § 139.2, Labor Code § 139.21, and 8 CCR §§ 60-63, for the denial of reappointment of QMEs even though such exception does not appear in the aforementioned statutes and regulations. In short, Respondents have created guidelines, rules and regulations that differ from the express language of Labor Code § 139.2, Labor Code § 139.21, and 8 CCR §§ 60-63, thereby imposing new and different criteria, in violation of the APA as underground regulations.

b. The Medical-Legal Fee Schedule Is Set Forth In 8 CCR § 9795

58. The DWC Administrative Director is authorized to adopt, amend or repeal any rules and regulations that are reasonably necessary to enforce DWC programs. However, this authority is critically limited as follows: "No rule or regulation of the administrative director pursuant to this section shall be adopted, amended, or rescinded without public hearings." (Emphasis added.)

59. The DWC Administrative Director is authorized to adopt a fee schedule for medical-legal expenses (as defined by Labor Code § 4620) consisting of a "series of procedure codes, relative values, and a conversion factor producing fees which provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of

various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report." (Labor Code § 5307.6(a); emphasis added.) The medical legal fee schedule is set forth exclusively in 8 CCR § 9795 (discussed more fully below).

60. Pursuant to Labor Code § 5307.6(a), the DWC Administrative Director has adopted 8 CCR § 9795 as the medical-legal fee schedule, as follows: "The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony." (Emphasis added.)

61. The fee schedule, 8 CCR § 9795, sets forth medical-legal ("ML") billing codes 101 through 106. Of relevance herein, ML 102 is billed at a flat rate of $625, and ML 103 is billed at a flat rate of $937.50. ML 101, which is for follow-up medical-legal evaluations, is billed hourly. Also, of particular relevance herein is ML 104, which sets forth an hourly rate based on the existence of certain "complexity factors" and other billing factors. Respondents have, through their Denial Letters and Denial Orders, effectively eliminated the use by QMEs of the ML 104 billing code from 8 CCR § 9795, by imposing additional criteria, guidelines and requirements not set forth in 8 CCR § 9795, and have done so without complying with the procedural requirements of the APA.

62. Since ML code 104 sets forth its own billing factor requirements, and also incorporates the complexity factors set forth in ML code 103, both ML codes 103 and 104 are quoted, in relevant part, below:

> (c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:
>
> . . .
>
> **Code ML 103**
> *Complex Comprehensive Medical-Legal Evaluation.* Includes evaluations which require three of the complexity factors set forth below.
>
> . . .
>
> (1) Two or more hours of face-to-face time by the physician with the injured worker;
>
> (2) Two or more hours of record review by the physician;

(3) Two or more hours of medical research by the physician;

(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;

(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;

(7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region …, or two or more or more injuries involving two or more body systems or body regions. …

(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

…

Code ML 104

Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:

(1) An evaluation which requires four or more of the complexity factors listed under ML 103; …

(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;

(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. [¶ [2]] When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the

[2] As discussed hereinbelow, the final sentence of ML 104 subsection (3) was originally drafted by the DWC itself and intended to be a new paragraph. A typographical error, perhaps made by the publisher of the California Code of Regulations, inadvertently connected this last sentence to the prior sentence numbered (3). Respondents are aware of this obvious printing error.

> total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

63. Respondents have covertly adopted an agenda to remove hundreds of QMEs from the DWC panel, including Petitioners, by searching for any sort of insubstantial, frivolous alleged "complaint" about the QMEs – often an alleged complaint more than two years old that should have been investigated during the QMEs' prior two-year recertification period – in order to justify commencing disciplinary investigations of QMEs. As part of its imposition of its underground regulations, the disciplinary investigations are then used to demand an audit of the QMEs' ten most recent QME reports for specified periods commencing from several months to nearly two years ago, to the present. Once the QMEs comply with the audit request, Respondents inevitably reject the hourly ML 104 billing code, and often the ML 103 billing code as well, used in good faith by QMEs.

c. "Medical Causation" Is A Valid Complexity Billing Factor Under ML 104 When A Party Simply Requests That It Be Evaluated. However, Respondents Have Imposed Three Additional Requirements That There Also Be A "Contested Claim Putting Causation At Issue," A "Denied Claim," And A Letter From A Party Specifically Stating That "Medical Causation Is An Issue," As Underground Regulations In Violation of The APA

64. The "medical causation" complexity billing factor is set forth in 8 CCR § 9795, code ML 103(6), which is, in turn, incorporated by code ML 104(1). The "medical causation" complexity factor merely requires that a QME must be "Addressing the issue of medical causation, upon written request of the party or parties requesting the report."

65. However, Respondents have imposed, adopted and enforced new and different criteria, guidelines and requirements for satisfaction of the "medical causation" complexity factor, as follows: First, that there be a "contested claim putting causation at issue," thereby precluding the use of this factor where an industrial injury appears to be accepted. Second, that there be a "denied claim," thereby also precluding the use of this factor where an industrial injury appears to be accepted. Third, on information and belief, Petitioners allege that Respondents require specific words stating that "medical causation is an issue" must be included in the "written request of the party or parties requesting the report." None of these three requirements actually

exist anywhere under 8 CCR § 9795. On its face, Respondents have materially modified what 8 CCR § 9795 subsection (6) means by implementing, adopting and enforcing void and prohibited underground regulations regarding the "medical causation" complexity billing factor.

66. Respondent's underground regulation regarding the "medical causation" complexity billing factor is evident in Respondents' September 12, 2017 Denial Order to Petitioner Howard (Exhibit "C"), which states, in relevant part:

> As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance. [Emphasis added.]

67. Respondent's underground regulation regarding the "medical causation" complexity billing factor is also evident in Respondents' August 11, 2017 Denial Letter to Petitioner Jani (Exhibit "D"), which states, in relevant part: "There was no indication that this was a denied claim, therefore medical causation was not at issue and could not be claimed as a complexity factor." (Emphasis added.)

d. Winslow West's Rogue Threats Based On New And Different Criteria

68. Winslow West, Esq., who is employed by the DWC as an in-house attorney, has been making presentations in the State of California in 2017 in which he sets forth his understanding of the "medical causation" and "report preparation" complexity billing factors. One such presentation was made to CSIMS[3] in 2017 ("West's CSIMS Presentation"). Petitioners are informed and believe, and on that basis allege, that Mr. West is the attorney who actually authored, drafted and/or supervised the drafting of, the September 12, 2017 Denial Order sent to Petitioner Howard, the June 1, 2017 Denial Letter sent to Petitioner Howard, the August 11, 2017 Denial Letter sent to Petitioner Jani, the August 7, 2017 Denial Letter sent to Petitioner Simon, and similar Denial Orders and Denial Letters sent to other QMEs.

[3] Petitioners are informed and allege that CSIMS is an unincorporated association whose members are private physicians practicing occupational medicine in the workers' compensation system in California. CSIMS is dedicated to assisting its members, including QMEs, to excel in the practice of occupational medicine so as to provide accurate evaluations and treatment of California's injured workers. CSIMS has hundreds of members who are or were, until recently, QMEs (herein "QME members"), and who are and have been directly affected by Respondents' actions alleged herein.

69. Regarding the "medical causation" factor in his speeches, Mr. West proclaims: "IS MEDICAL CAUSATION REALLY AN ISSUE? … Do the Charge letters ask: 'please address the issue of medical causation' … So it really doesn't matter what the parties ask to be addressed…"[.] (Attached hereto as Exhibit "H" is a true and complete copy of slide no. 10 from West's CSIMS Presentation with its talking point notes revealed.)

70. Mr. West further proclaims:

> The analysis is further complicated by the fact that once a case is accepted by the employer, the issue of medical causation is no longer in dispute. Despite what might be contained in the charge letters provided to the QME from the parties, once the employer starts providing benefits for an accepted injury the issue of medical causation is no longer in dispute[.]" [Emphasis added.] (Attached hereto as Exhibit "I" is a true and complete copy of slide no. 9 from West's CSIMS Presentation with its talking point notes revealed.)

71. Mr. West has thus publicly admitted changing the meaning of 8 CCR § 9795, subsection ML 103(6) (incorporated into ML 104), by adding the new and different criterion that the parties' written request to address medical causation must also include the specific words "please address the issue of medical causation." However, these words are not contained in the language of ML 103(6). Mr. West has also changed the meaning of ML 103(6) by adding the new and different criterion that the injured worker's claim cannot be an "accepted" claim and that medical causation must be "in dispute," which are not contained in the language of ML 103(6). Furthermore, if indeed these different criteria and modifications are to be imposed, such can only be undertaken pursuant to the APA after first having a public hearing. At no point have public hearings been requested by Respondents on any of these criteria whatsoever.

72. Mr. West's new and different criteria for the application of the "medical causation" complexity billing are also contrary to reality. For example, it is well established that an employer may accept an injury as industrially caused (i.e., medical causation) because the employee complains of back and leg pain after lifting something heavy. But when the QME interviews the injured worker and takes a full medical history, the QME may determine that the injured worker actually injured himself a week earlier sliding into home plate during a recreational softball game unrelated to work. The QME may then decide that the back and leg

injuries are more consistent with the non- industrial sliding injury than with the industrial lifting injury. Medical causation on an industrial basis may then be refuted. Mr. West's changes to the written text of 8 CCR § 9795, ML 103(6), thus fails a reality check against real world facts and circumstances.

73. Mr. West's new and different criteria regarding the "medical causation" complexity factor are consistent with the actual language used in Respondents' official Denial Order to Petitioner Howard, which states: "There is no is indication that this was a contested claim putting causation at issue... Therefore, causation could not be claimed as a complexity factor in this circumstance." (Emphasis added.) (See Exhibit "C".) Further, Mr. West's new and different criteria regarding the "medical causation" complexity factor are also consistent with the actual language used in Respondents' August 11, 2017 Denial Letter to Petitioner Jani, which states: "There was no indication that this was a denied claim, therefore medical causation was not at issue and could not be claimed as a complexity factor." (Emphasis added.) (See Exhibit "D.") As noted above, there is absolutely no language in 8 CCR § 9795 requiring that "medical causation" be a "contested claim" or "denied claim," or that the specific words "medical causation is an issue" must be included in the "written request of the party or parties requesting the report," in order for "medical causation" to be used as a complexity billing factor. Therefore, Respondents have created, adopted and are enforcing illegal underground regulations concerning the "medical causation" complexity billing factor.

e. Respondents Have Imposed An Additional Requirement to The ML 104 "Report Preparation" Complexity Billing Factor By Arguing That It Can Only Apply To ML 104 Subsection (3) Insofar As "The Physician And The Parties Agree, Prior To The Evaluation, That The Evaluation Involves Extraordinary Circumstances." Such Is In Violation of The APA

74. The "report preparation" complexity billing factor set forth in ML 104 of CCR § 9795 states:

> (3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. [¶] When billing under **this code** for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by

> the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, **preparing the report** and, if applicable, any other activities. [Emphasis added.]

75. However, the final sentence of CCR § 9795, ML 104(3), was originally drafted and intended to be a standalone paragraph, applicable to ML 104 (1) through (3) of CCR § 9795, as set forth below:

> (d) An agreed medical evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances.
>
> When billing under this code for extraordinary circumstances, ~~T~~the physician shall include ~~with~~ in his or her ~~billing~~ report (1) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (2) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the patient, preparing the report and, if applicable, any other activities.

76. (Attached hereto as Exhibit "J" is a true and complete copy of part of the 1993 Legislative History of 8 CCR § 9795,entitled "In re: WORKERS' COMPENSATION REGULATORY ACTION:[,] Title 08[,] California Code of Regulations) [,] Amend 9793, 9794, and 9795[,] NOTICE OF APPROVAL FOR PRINTING. 12/31/93"; [emphasis added].)

77. As described above, there is obviously a typographical error in the publication of 8 CCR § 9795 because a line space was left out, a fact that should be well-known to Respondents who drafted 8 CCR § 9795 themselves. Respondents imposition, adoption and enforcement of a new and different criterion for application of the "report preparation" billable time factor that it is only applicable when there is a "prior agreement between the parties before the evaluation that the evaluation involves extraordinary circumstances" (emphasis added), clearly does not reflect the intent of the regulation. Such is apparent from the original rule-making file in the DWC's possession, which shows quite clearly that the language "When billing under this code for extraordinary circumstances," as used in ML Code 104(3), was clearly meant to refer to subsections (l) through (3) of ML 104 equally, not just subsection (3).

78. Furthermore, time spent reviewing medical records, face-to-face time with the injured worker, and preparing the report itself, are each separate billing factors under ML 104. It is

standard practice that writing a report is part of the evaluation and ML 104 pays for the QME's direct time in doing the evaluation. All of the other time-based codes that require the verification include the preparation of the report.

79. Respondent's adoption of an underground regulation regarding the "report preparation" complexity billing factor is evident in Respondents' Denial Order regarding Petitioner Howard (Exhibit "C"), which states, in relevant part:

> As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been a prior agreement between parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed this circumstance, and it cannot count as a complexity factor. [Emphasis added.]

80. Respondent's underground regulation regarding the "report preparation" complexity billing factor is evident in Respondents' June 1, 2017 Denial Letter to Petitioner Howard (Exhibit "A") and in Respondents' August 11, 2017 Denial Letter to Petitioner Jani (Exhibit "D"), which both state, in relevant part:

> In addition, you billed time for report preparation which is only allowed under ML104 billing when the parties have agreed prior to the evaluation that the evaluation will involve extraordinary circumstances. [Emphasis added.]

81. Respondent's underground regulation regarding the "report preparation" complexity billing factor is evident in Respondents' August 7, 2017 Denial Letter to Petitioner Simon (Exhibit "F"), which states, in relevant part:

> In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed before the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795. [Emphasis added.]

82. Regarding the "report preparation" factor in ML 104, subsection (3), Mr. West proclaims:

> This is the method that basically represents the regulatory embodiment of Labor Code §5307.6 which allows for billing in excess of the medical legal fee schedule when there are extraordinary circumstances. That labor code allows for billing in excess of the medical legal fee schedule when there are

> extraordinary circumstances relating to the medical condition being evaluated. This regulatory embodiment of those principles simply requires prior agreement of the parties that the evaluation involves extraordinary circumstances. Also be aware that this is the ML 104 billing method that explicitly allows for report preparation. (Attached hereto as Exhibit "K" is a true and complete copy of slide no. 16 from West's CSIMS Presentation with its talking point notes revealed.)

83. As shown above, Mr. West's interpretation, adoption and enforcement of the requirement that the "parties have agreed prior to the evaluation that the evaluation will involve extraordinary circumstances," as limited to ML 104 (3), is new and different because it disregards the actual, intended language of the DWC regarding billing for report preparation time. However, Mr. West's statements are consistent with Respondents' official application of the "record preparation" complexity billing factor, and therefore constitute an underground regulation.

f. Respondents Have Imposed An Additional Requirement That The "Medical Causation" and The ""Psychiatric Evaluation" Complexity Billing Factors Cannot Both Be Used Under ML 104 For The Same QME Evaluation. Such Is Also In Violation of The APA

84. The medical-legal fee schedule (8 CCR § 9795), sets forth nine separate and distinct complexity factors under the ML 103 billing code, including "medical causation" and "a "psychiatric or psychological evaluation," which can be used together in any combination as the circumstances warrant. That is made clear because ML 103 states in relevant part:

> **Code ML 103**
> Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth below.
>
> In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation…:
>
> …
>
> (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;
> …
> (8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. [Emphasis added.]

85. Based on information and belief, Petitioners allege that Respondents have imposed,

adopted and enforced new and additional criteria, guidelines and requirements that prohibit QMEs from using both the "medical causation" complexity billing factor set forth as ML 103(6) and the "psychiatric evaluation" complexity billing factor set forth in ML 103(8) in the same QME evaluation.

86. There is no support in 8 CCR § 9795 for the DWC's contention that billing code ML 103 prohibits the use of both the "medical causation" and the "psychiatric evaluation" complexity billing factors in the same QME evaluation. Instead, Respondents have changed what the complexity billing factors set forth in the ML 103 billing code mean by implementing and enforcing a void and prohibited underground regulation.

g. Respondents Have Admitted, Through Mr. West, That They Have Imposed and Enforced Void and Illegal Underground Regulations Regarding The Medical-Legal Fee Schedule Set Forth In 8 CCR§ 9795

87. Mr. West's proclamations contain this startling admission regarding Respondents' imposition, adoption and enforcement of new and different criteria, guidelines and requirements for the medical-fee schedule set forth in 8 CCR § 9795:

> **The current interpretation** of the regulations by the DWC **may or may not be a standard interpretation** upheld by all the administrative law judges. ¶ However you can be assured that if you follow **the current interpretation** of the regulations with respect to billing, you will not receive a letter from the discipline unit, and you will in all likelihood be reappointed upon submission of your application. [Emphasis added.] (See Exhibit "K.")

88. Thus, Respondents have admitted that they are implementing underground regulations regarding the medical-legal fee schedule without a hearing. Further, Respondents have threatened Petitioners, and the QME community, that if they do not adhere to Respondents' underground regulations regarding the medical-legal fee schedule, they will be disciplined and denied reappointment as QMEs. Respondents have gone even further and threatened to report their mere accusations regarding alleged billing code mistakes, to the California Medical Board, in order to take away QME medical licenses entirely. Petitioners believe that these threats have succeeded in intimidating some QMEs to acquiesce in whatever void and illegal demands Respondents have made, in order for the QMEs to maintain their QME license.

///

FIRST CAUSE OF ACTION

(Violation Of Administrative Procedures Act, Government Code § 11340, *Et Seq.*, By All Petitioners Against All Respondents)
(Writ of Mandate, Code of Civil Procedure § 1085)

89. Petitioners re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 88 as though fully setforth herein.

90. Respondents have a clear, present, and ministerial duty to comply with the APA (Government Code § 11340, *et seq.*), which provides, *inter alia*, that "[n]o state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in § 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to this chapter." (Government Code § 11340.5(a).) Government Code §11340.600, in turn, broadly defines a "regulation" as "a rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure." (*Id.* at § 11340.600; *see also, Tidewater Marine Western, Inc. v. Bradshaw*, 14 Cal. 4th 557, 571 (1996) ("*Tidewater Marine*") (describing "regulation" definition as "very broad[]").)

91. Courts apply the following two-part test set forth by the California Supreme Court in *Tidewater Marine* to determine whether an agency rule that was not adopted pursuant to the APA is an "underground regulation." "First, the agency must intend its rule to apply generally, rather than in a specific case. ... Second, the rule must implement, interpret, or make specific the law enforced or administered by the agency, or govern the agency's procedure (Gov. Code, § 11342, subd. (g))." (*Id.* at 571.) If the agency action constitutes a "regulation," and there is no express statutory exception excusing the agency from complying with the APA's strict procedural requirements, then the underground regulation is void, invalid, and cannot be enforced. (*Id.* at 576.)

92. As set forth above, Respondent's Denial Letters to Petitioners (Exhibits' "A," "D" and

"F") all imposed as a rule, regulation and/or standard of general application, actual denials of Petitioners Howard's, Jani's and Simon's applications for reappointment as a QME before a due process hearing, despite the contrary language and intent of 8 CCR § 63, as further evidenced by Labor Code § 139.2, Labor Code § 139.21, and 8 CCR §§ 60- 62.

93. As set forth above, Respondents' Denial Order issued to Petitioner Howard (Exhibit "C") imposed, as a rule, regulation and/or standard of general application, that 8 CCR § 9795 does not allow QMEs to count "medical causation" as a complexity factor under code ML104 unless there is a "contested claim putting causation at issue," a "denied claim," or a letter from a party specifically stating that "medical causation is an issue." Further, Respondents' August 11, 2017 Denial Letter to Petitioner Jani (Exhibit "D") further imposed as a rule, regulation and/or standard of general application, that 8 CCR § 9795 does not allow QMEs to count "medical causation" as a complexity factor under code ML104 unless there is a "contested claim putting causation at issue," a "denied claim," or a letter from a party specifically stating that "medical causation is an issue." As set forth herein, Winslow West has confirmed this rule, regulation and/or standard of general application in public presentations, including to CSIMS.

94. As set forth above, Respondents' Denial Order issued to Petitioner Howard, Respondents' August 11, 2017 Denial Letter sent to Petitioner Jani, and Respondents' August 7, 2017 Denial Letter sent to Petitioner Simon, imposed, as a rule, regulation and/or standard of general application, that 8 CCR § 9795 does not allow QMEs to bill for "report preparation" as a complexity billing factor under all subsections of code ML104 unless there has been a "prior agreement between parties that the evaluation involves extraordinary circumstances."

95. As set forth above, on information and belief, Respondents imposed, as a rule, regulation and/or standard of general application, that 8 CCR § 9795 does not allow QMEs to bill for "medical causation" and a "psychiatric evaluation" simultaneously in the same evaluation.

96. Respondents' Denial Order and Denial Letters, and Respondent's other rules, regulations and standard s of general application, as alleged hereinabove, were not issued pursuant to the strict public notice and other requirements of the APA. And, there is no express statutory exemption excusing Respondents from complying with the APA's strict procedural requirements

with respect to the Denial Order and Denial Letters. In fact, the Director's power to promulgate regulations is specifically required to be "in accordance with [the Administrative Procedures Act, Government Code § 11340, et seq.]." (Labor Code § 3702.10.)

97. Respondents' Denial Order and Denial Letters (Exhibits "A," "C," "D" and "F") are not "emergency" regulations, as defined in Government Code § 11342.545, and they were not adopted pursuant to the procedures described in Government Code § 11346.1.

98. Petitioners allege, on information and belief, that Respondents' Denial Order and Denial Letters are examples of boilerplate Denial Orders and boilerplate Denial Letters, which have been issued to Petitioners, including other similarly situated QMEs, almost verbatim with regard to (1) "medical causation," (2) "report preparation," (3) the use of "medcial causation" and "psychiatric evaluation in the same report, and (4) Respondents' actual denials of QME reappointments before a due process heairng, all of which was carried out as part of Respondent's uniform practices.

99. Mr. West's public proclamations regarding these regulations are fully consistent with, and reinforce the rules, regulations, guidelines and standards of general application set forth in Respondent's Denial Order and Denial Letters, thus making them Respondent's official interpretations of the regulations and statutes at issue. Therefore, the rules, regulations, guidelines and standards of general application stated in the Denial Order and Denial Letters, and other regulations, apply to all physicians licensed by the State of California as QMEs under Labor Code § 139.2, and were intended to apply generally, rather than to a specific case.

100. Respondents have utilized, enforced, and attempted to enforce their Denial Order and their Denial Letters, and other regulations to implement, interpret, or make specific the law as enforced or administered by the DIR.

101. The Denial Order and the Denial Letters constitute, as a matter of law, void and illegal underground regulations because they apply generally to all QMEs, and because they implement, interpret, or make specific the law enforced or administered by Respondents.

102. A writ of mandate may be issued by any court under Code of Civil Procedure § 1085 to any person "to compel the performance of an act which the law specifically enjoins, as

a duty arising from an office, trust, or station...." And, a writ of mandate is proper to compel a government official to perform a statutory duty. *Santa Clara County Counsel Attys. Assn. v. Woodside*, 7 Cal.4th 525, 540 (1994).

103. If not otherwise directed by this Court's issuance of the requested writ of mandate, Respondents will continue to violate their clear, present, and ministerial duty to comply with the APA by continuing to utilize, enforce, or attempt to enforce the Denial Order and the Denial Letters, and other regulations, all of which constitute void and illegal underground regulations. Issuance of the requested writ of mandate is therefore necessary to prevent Respondents from continuing to violate California law, and to ensure that the Denial Order and the Denial Letters, and other regulations, are not used by Respondents to deny Petitioners' reappointment as QMEs until after a due process hearing in which Respondents must apply 8 CCR § 9795 as expressly written, and as originally drafted and intended to apply, so that the ML 104 billing code may still be used by QMEs.

104. Petitioners, including other similarly situated QME members, have a direct and beneficial interest in the issuance of a writ of mandate, apart from the public at large, because they each have been denied reappointment as QMEs by Respondents based on mere accusations of violations of the medical-legal fee schedule set forth in 8 CCR § 9795 before the provision of any due process hearing. If this writ of mandate does not issue, Petitioners will have to spend an extraordinary amount of time and money to attempt to obtain administrative relief without any income as QMEs. Further, Petitioners will never get a fair hearing as long as Respondents continue to enforce underground regulations that make the Petitioners' good faith use of billing code ML 104 impossible. Additionally, Respondents are using scare tactics and threatening to report Respondents' mere accusations of alleged billing code mistakes by Petitioners, to the California Medical Board, thereby frightening Petitioners and other QMEs into believing that they will lose their licenses to practice medicine altogether, thereby further intimidating Petitioners and other QMEs into not pursuing their legal remedies. On information and belief, Petitioners allege that some QMEs have succumbed to these scare tactics, and have even resigned their appointments as QMEs, in order to avoid Respondents' threats to their

professional licenses to practice medicine at all.

105. On information and belief, Petitioners allege that, when QMEs do pursue their legal remedies by requesting a hearing, Respondents unnecessarily delay and fail to set any hearing date knowing that QMEs have already been denied their QME reappointments without sufficient notice or a hearing. Respondents thereby suffocate the medical practices and referral sources of former QMEs, such as Petitioners, thereby forcing those QMEs to forfeit their due process rights in order to regain their QME reappointments, or, alternatively, to change the nature of their medical practices to find new and different sources of income. Since QME reports comprise a very substantial amount of a QME's income, Petitioners may no longer be able to fully continue to practice medicine, unless the writ of mandate issues.

106. Petitioners have no plain, speedy, and adequate remedy in the ordinary course of law because no damages or other legal remedy could compensate them for the harm to their medical practices from the loss of referrals for QME reports, and for the damage to their reputations from the denial of their QME licenses, if Respondents continue to evade their clear, present, and ministerial duty to comply with the APA and continue to enforce the Denial Order and Denial Letters, and other regulations, without first providing a due process hearing in which 8 CCR § 9795 is applied as expressly written and originally intended, all of which constitute void and illegal underground regulations. Further, Respondents are immune from money damages under Government Code § 818.4 for denial of a license, so no money damages are available to Petitioners.

107. Exhaustion of administrative remedies is not required to bring a Superior Court action to challenge an underground regulation under the APA. The California Supreme Court has been clear that it is "well settled that where a statute provides an administrative remedy and also provides an alternative judicial remedy the rule requiring exhaustion of the administrative remedy has no application if the person aggrieved and having both remedies afforded to him by the same statute elects the judicial one." *City of Susanville v. Lee C. Hess Co.* (1955) 45 Cal.2d 684, 689. Here, the statute itself gives an affected person the right to "a judicial determination as to the validity of any regulation ... by bringing an action for declaratory relief in the Superior

Court...." (Government Code § 11350(a).)

108. Petitioners are excepted from exhausting administrative remedies because Petitioners will suffer irreparable injury if the administrative remedy were first required to be exhausted before seeking judicial relief.

109. Petitioners are excepted from exhausting administrative remedies because such would be futile.

110. Petitioners are excepted from exhausting administrative remedies because the administrative remedy is inadequate.

111. Finally, Petitioners are excepted from exhausting administrative remedies because Petitioners' challenge is to the validity of the Denial Order, the Denial Letters and other underground regulations, regarding the general applicability of the "medical causation," "report preparation" and "psychiatric evaluation" complexity billing factors, and regarding Respondents' actual denial of QME reappointments before any due process hearing is granted, rather than to specific facts or circumstances relating to each individual Petitioner.

SECOND CAUSE OF ACTION

(Violation Of Administrative Procedures Act, Government Code § 11340, *Et Seq.*, By All Petitioners Against All Respondents)
(Declaratory Relief, Code Of Civil Procedure § 1060; Government Code § 11350)

112. Petitioners re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 111 as though fully setforth herein.

113. An actual controversy has arisen and now exists between Petitioners and Respondents concerning the obligations and duties of Respondents under the APA. As set forth more fully above, Petitioners contend that the Denial Order and Denial Letters, and other such rules, regulations, guidelines and standards of general application regarding the "medical causation," "report preparation," and the "psychiatric evaluation" complexity billing factors set forth in 8 CCR § 9795, and Respondents' actual denial of Petitioners' applications for reappointment as QMEs before any due process hearing is held, all constitute illegal and void underground regulations. Respondents have issued, interpreted, utilized, enforced, and are attempting to enforce these underground regulations, all in complete violation of the APA.

Petitioners are informed and believe, and on that basis allege, that Respondents contend, in all respects, to the contrary. A judicial determination and declaration as to the legal obligations of Respondents is therefore necessary and appropriate in order to determine the duties of Respondents and the rights of Petitioners to be immediately reappointed as QMEs pending any due process hearing, all of which should occur only after Respondents' underground regulations regarding the "medical causation," "report preparation" and "psychiatric evaluation" complexity billing factors are declared void and illegal.

THIRD CAUSE OF ACTION

(Violation of Administrative Procedures Act, Government Code § 11340, *et seq.* By All Petitioners Against All Respondents)
(Injunctive Relief, Code Of Civil Procedure §§ 525 And 526)

114. Petitioners re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 113 as though fully setforth herein.

115. By their actions set forth above, Respondents have demonstrated a policy and practice of enforcing the Denial Order and Denial Letters, and other such rules, regulations, guidelines and standards of general application regarding the "medical causation," "report preparation," and the "psychiatric evaluation" complexity billing factors set forth in 8 CCR § 9795, and Respondents' actual denial of Petitioners' applications for reappointment as QMEs before any due process hearing is held, which are void and illegal underground regulations that were issued in direct violation of the APA, all of which has been set forth above in detail. Petitioners are informed and believe, and on that basis allege, that Respondents will continue to enforce the Denial Order and the Denial Letters, and other such rules, regulations, guidelines and standards of general application in violation of the APA, unless enjoined from doing so by an order of the Court.

116. Respondents' refusal to comply with the aforementioned provisions of California law has caused and threatens to cause Petitioners irreparable and substantial harm. In California it is unlawful for a physician to perform evaluations as a QME, or to bill for a comprehensive medical evaluation, unless the physician has been appointed, or reappointed, by Respondents as a QME. (Labor Code §§ 139.2 and 4062.2.) If the Court does not issue the relief requested

herein, Petitioners will continue to lose all their QME work, their reputation in the community will continue to be harmed, including not receiving referrals for new evaluations, supplemental evaluations and depositions, because they have been denied reappointment to the QME panel without any due process hearing. All of this is based on Respondents' imposition and enforcement of new and different criteria for the medical-legal fee schedule, which are all underground regulations in violation of the APA. The denial of Petitioners' QME reappointments before any administrative hearing will severely disrupt their practices and livelihoods, and irreparably impair their very ability to pursue their legal remedies and rights. Further, as long as Respondents continue to refuse to reappoint qualified, experienced, ethical QMEs through the promulgation and enforcement of Respondents' underground regulations, uncertainty will continue to exist in the entire workers' compensation system such that other physicians will refuse to apply or re-apply to serve as QMEs, thereby greatly reducing the number of QMEs available. Such consequences place at risk the continued viability of the QME system, thereby potentially jeopardizing thousands of workers' compensation cases. Without the substantial medical evidence provided by QMEs reports, injured workers will lose their ability to obtain access to necessary medical treatment as well as other workers' compensation benefits including temporary and permanent disability indemnity payments. No amount of monetary damages or other legal remedies can adequately compensate Petitioners or other interested parties for the irreparable harm that they have suffered, or will suffer, from the violations of law described herein.

117. Petitioners have no plain, speedy, and adequate remedy at law because, unless Respondents are enjoined by this Court from enforcing their new and different criteria for application of the "medical causation," "report preparation" and "psychiatric evaluation" complexity billing factors set forth in 8 CCR § 9795, and from actually denying Petitioners' QME status before any due process hearing is concluded, as set forth in the Denial Letters, Respondents will continue to violate the APA by continuing to enforce their void and illegal underground regulations, all of which will result in the wrongful and illegal denials of QME reappointments to Petitioners and literally hundreds of other QMEs. Further, Respondents must

also be ordered to immediately reappoint Petitioners, including any other similarly affected QMEs, pending the conclusion of a final hearing on the merits regarding the existence *vel non* of any billing code mistakes. Respondents must be further enjoined from denying the reappointments of all other QMEs pending the conclusion of a final hearing on the merits regarding the existence *vel non* of any billing code mistakes. Finally, Respondents must be specifically ordered to set a hearing within 30 days after Respondent's issue their final Denial Orders, according to the APA, Government Code § 11340.5 *et seq*.

FOURTH CAUSE OF ACTION

(Violation of United States Constitution, Amendment XIV, Due Process Clause Against All Respondents)
(Declaratory And Injunctive Relief)

118. Petitioners re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 117 as though fully setforth herein.

119. The Fourteenth Amendment Due Process Clause commands that no state shall "deprive any person of life, liberty, or property without due process of law." The procedural component of the due process clause ensures a fair adjudicatory process before a person is deprived of life, liberty, or property.

120. Petitioners had QME appointments for many years and were entitled to be reappointed as QMEs pursuant Labor Code § 139.2(b) and (d), unless they are proven not to be in compliance with "applicable regulations" after a due process hearing that is devoid of Respondents' imposition and enforcements of new and different criteria applicable to the medical-legal fee schedule set forth in 8 CCR § 9795, all of which constitute underground regulations in violation of the APA. Thus, Petitioners each had, and have, a vested right in being reappointed and in maintaining their QME reappointment licenses.

121. By doing the things alleged herein, including without limitation, the unilateral denial of Petitioners' QME status without full notice and a hearing, Respondents have deprived Petitioners of this procedural due process rights in violation of the United States Constitution.

122. While engaging in the conduct described herein, Respondents and Defendants acted at all times under the color and authority of law.

123. As a direct and proximate result of Respondents' violation of Petitioners' procedural due process rights, Petitioners have and continue to suffer damages. Petitioners pray for preliminary and permanent injunctive and declaratory relief, and for a writ of mandate to protect such constitutional rights, as alleged hereinabove.

FIFTH CAUSE OF ACTION

(Violation Of The California Constitution, Article I, Section 7(A) Against All Respondents)
(Declaratory And Injunctive Relief)

124. Petitioners re-allege and incorporate by reference the allegations set forth in paragraphs 1 through 123 as though fully setforth herein.

125. Article I, Section 7(a) of the California Constitution provides "[a] person may not be deprived of life, liberty, or property without due process of law...." The procedural component of the due process clause ensures a fair adjudicatory process before a person is deprived of life, liberty, or property.

126. Petitioners had QME appointments for many years and were entitled to be reappointed as QMEs pursuant Labor Code § 139.2(b) and (d), unless they are proven not be in compliance with "applicable regulations" after a due process hearing and procedural safeguards. Thus, Petitioners each had, and have, a vested right in being reappointed and in maintaining their QME reappointment licenses.

127. By doing the things alleged herein, including without limitation, the unilateral denial of Petitioners' QME licenses without full notice and a hearing, Respondents have deprived Petitioners of this procedural due process rights in violation of the California Constitution.

128. While engaging in the conduct described herein, Respondents acted at all times under the color and authority of law.

129. As a direct and proximate result of Respondents' violation of Petitioners' procedural due process rights, Petitioners have suffered damages. Petitioners pray for preliminary and permanent injunctive and declaratory relief, and for a writ of mandate to protect such constitutional rights.

WHEREFORE, Petitioners pray for judgment on all causes of action, as follows:

1. That this Court issue a peremptory writ of mandate commanding Respondents to immediately cease and desist from implementing, utilizing, enforcing, or attempting to enforce 8 CCR § 63 to deny Petitioners' reappointment as QMEs without first providing a due process hearing, and from implementing, utilizing, enforcing, or attempting to enforce their new and different criteria for application of the "medical causation," "report preparation" and "psychiatric evaluation" complexity billing factors under 8 CCR § 9795, pursuant to their Denial Order and Denial Letters (attached hereto as Exhibits "A," "D" and "F"), and other underground regulations.

2. That this Court declare that Respondents' imposition and enforcement of (1) a due process hearing exception to 8 CCR § 63 to deny Petitioners' reappointment as QMEs without a hearing, and (2) Respondents' Denial Order and Denial Letters (attached hereto as Exhibits "A," "D" and "F") as new and different criteria regarding the "medical causation," "report preparation" and "psychiatric evaluation" complexity billing factors under 8 CCR § 9795, each constitutes a void and illegal underground regulation that may not be implemented, utilized, or enforced by Respondents until Respondents comply with the APA.

3. That this Court issue an injunction compelling Respondents to immediately cease and desist from implementing, utilizing, enforcing or attempting to enforce: (1) 8 CCR § 63 to deny Petitioners' reappointment licenses as QMEs without first providing a due process hearing; and (2) to declare Respondents' Denial Order and Denial Letters (attached hereto as Exhibits "A," "D" and "F") and other new and different criteria regarding the "medical causation," "report preparation" and "psychiatric evaluation" complexity billing factors under 8 CCR § 9795, as void and illegal underground regulations.

4. That this Court issue an injunction: (a) compelling Respondents to immediately reappoint Petitioners, including other similarly situated QMEs, pending the conclusion of a DWC hearing on the merits whether Petitioners' applications for reappointment should be granted for an additional two-year term; and (b) prohibiting Respondents from using or enforcing their underground regulations regarding the "medical causation," "report preparation" and

"psychiatric evaluation" complexity billing factors under 8 CCR § 9795, at such hearing.

5. That this Court issue an injunction compelling Respondents to set a hearing within 30 days after Respondent's issue their final Denial Order, and according to the APA, Government Code § 11340.5 *et seq*.

6. That this Court issue a declaratory judgment in Petitioners' favor declaring that Respondents' Denial Order and Denial Letters (attached hereto as Exhibits "A," "D" and "F") and other underground regulations were issued in violation of Petitioners' procedural due process rights and therefore may not be enforced.

7. That this Court award Petitioners their costs of suit herein, including out-of-pocket expenses and reasonable attorneys' fees under Code of Civil Procedure § 1021.5, and any other applicable statute.

8. That this Court grant Petitioners' such other, or further relief as the Court may deem just and proper.

DATE: September 26, 2017

ROXBOROUGH, POMERANCE, NYE & ADREANI, LLP

BY: _____
Nicholas P. Roxborough
Burton E. Falk
David A. Carman
Attorneys for Plaintiffs and Petitioners

REQUEST FOR JURY TRIAL

Plaintiffs hereby request a trial by jury for all issues so triable.

DATE: September 26, 2017

ROXBOROUGH, POMERANCE, NYE & ADREANI, LLP

BY: _____
Nicholas P. Roxborough
Burton E. Falk
David A. Carman
Attorneys for Plaintiffs and Petitioners

Exhibit "A"

STATE OF CALIFORNIA — Edmund G. Brown, *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
1515 Clay Street, Suite 1700
Oakland, California 94612
Tel (800) 794-6900 Fax (510) 286-0693

MAILING ADDRESS:
P. O. Box 71010
Oakland, California 94612

Via Certified Mail – Return Receipt Requested

June 1, 2017

Timothy C. Howard, M.D.
143 Kingswood Circle
Danville, CA 94506-6051

Re: Denial of application for QME reappointment

Dear Dr. Howard:

Please be informed that your February 19, 2017 application for reappointment as a Qualified Medical Evaluator will be denied. The reasons for this denial are explained below.

VIOLATION OF THE MEDICAL-LEGAL FEE SCHEDULE

On or about October 16, 2015 the Discipline Unit of the Division of Workers' Compensation (DWC) received a complaint with regard to your medical-legal evaluation of injured worker Aurora Bonilla. The complaint involved an allegation that you asked the injured worker an inordinate amount of questions regarding her country of origin and English-speaking ability. This made the injured worker feel that you would be incapable of producing and unbiased report with regard to the evaluation.

In the course of the investigation of the above referenced complaint, it was discovered that your billing for the evaluation violated the medical legal fee schedule medical-legal fee schedule as contained in Title 8, California Code of Regulations, (CCR), §9795. Specifically, you billed this evaluation as an ML 104 when at best there were only two complexity factors involved. In addition, you billed time for report preparation which is only allowed under ML 104 billing when the parties have agreed prior to the evaluation that the evaluation will involve extraordinary circumstances. The report was overbilled in the amount of $1,062.50

As a result of the discipline file opened pursuant to the above referenced complaint, the Discipline Unit performed an audit of 10 of your medical legal evaluations. The audit revealed additional instances of prima facie evidence of violation of the medical-legal fee schedule as contained in 8CCR §9795.

In the case of injured worker Alexander Potter you billed the evaluation performed on February 23, 2017 as an ML 104. A review of that report indicates that only two complexity factors for record review and face to face time were present in the evaluation. Therefore, the evaluation should have been billed as an ML 102.

In the case of injured worker Audrey Middleton, you billed the evaluation performed on January 2, 2017 as an ML 104. A review of the report indicates that only two complexity factors for record review and face-to-face time were present in the evaluation. Therefore, the evaluation should have been billed as an ML 102.

In the case of injured worker Linda Roseman, you billed the evaluation performed on January 2, 2017 as an ML 104. A review of the report indicates that only two complexity factors for record review and face-to-face time were present in the evaluation. Therefore, the evaluation should have been billed as an ML 102.

In the case of injured worker Martha Riverside, you billed the evaluation performed on January 18, 2017 as an ML 104. A review of the report indicates that only two complexity factors for record review and face-to-face time were present in the evaluation. Therefore, the evaluation should have been billed as an ML 102.

In addition, two more evaluations submitted for the audit, involving injured workers Timothy McLoughlin and Pamela Valker were overbilled in some fashion.

The apparent violations of 8 CCR §§9795 and Labor Code 4628 prevent your reappointment as a Qualified Medical Evaluator pursuant to Labor Code §§139.2(j) (6) & 139.2(k) (1).

Accordingly, your application for reappointment will be denied and your check number 1748, in the amount of $550.00 will be returned to you herewith.

Please be advised that notice of your rights with respect to this denial pursuant to 8 CCR §63 is attached hereto.

Please be further advised that you cannot participate in any panel qualified medical evaluations that require a face-to-face evaluation of the injured worker after receipt of this letter.

Sincerely,

Raymond Meister, M.D., MPH
Executive Medical Director
Division of Workers' Compensation
Department of Industrial Relations

Enc.

NOTICE OF RESPONSE AND REVIEW RIGHTS

California Code of Regulations, title 8; §63

(a) Whenever the Administrative Director determines that an application for appointment or reappointment as a Qualified Medical Evaluator will be denied, the Administrative Director shall:

(1) Notify the applicant in writing of the decision to deny the application and the reasons for the denial; and

(2) Provide notice that if the applicant submits a specific, written response to the notice of denial within thirty (30) days, the Administrative Director will review the decision to deny the application, and within sixty (60) days of receipt of the response notify the applicant of the Administrative Director's final decision.

(b) If the applicant fails to submit a specific, written response to the notice of denial within thirty (30) days, the decision to deny shall become final without any further notice.

(c) If the applicant submits a specific, written response, and the Administrative Director's final decision is that the application should be denied, notice of the final decision shall be provided to the applicant by means of a statement of issues and notice of right to hearing under Chapter 5 (commencing with section 11500) of Title 2 of the Government Code.

(d) All notices and response under this section shall be made by certified mail.

Note: Authority cited: Sections 133, 139.2(f) and 5307.3, Labor Code; Section 11500 et seq., Government Code. Reference: Section 139.2, Labor Code.

Exhibit "B"

SACRAMENTO, CA
SACRAMENTO OFFICE
TEL: (916) 442-2415

LOS ANGELES, CA
WESTWOOD OFFICE
TEL: (310) 470-1869
FAX: (310) 470-9648

DAMON M. RIBAKOFF
(1970-2007)

R P N A
ROXBOROUGH
POMERANCE
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5820 CANOGA AVENUE,
SUITE 250
WOODLAND HILLS, CA 91367
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NICHOLAS P. ROXBOROUGH
DREW E. POMERANCE
GARY A. NYE
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DAVID R. GINSBURG
MARINA N. VITEK
BURTON E. FALK
JOSEPH C. GJONOLA
DAVID A. CARMAN
RYAN R. SALSIG
DARON A. BARSAMIAN
JACLYN D. GROSSMAN
TREVOR R. WITT

OF COUNSEL
CHARLES R. RONDEAU

June 29, 2017

Via Certified Mail – Return Receipt Requested
Via Fax: (510) 286-0693

Raymond Meister, MD, MPH
Acting Executive Medical Director
Division of Workers' Compensation
Department of Industrial Relations
Medical Unit
1515 Clay Street, Suite 1700
Oakland, California 94612

Re: Response to DWC's Denial of Application for QME Reappointment of Dr. Timothy C. Howard Pursuant to 8 CCR §63

Dear Dr. Meister:

Dr. Howard has asked us to respond to your June 1, 2017 letter denying his application for reappointment ("denial letter") as a Qualified Medical Evaluator ("QME"), which he submitted on February 19, 2017. Dr. Howard was stunned to receive your denial letter as he has served as an appointed QME since 2005 without any issue regarding his medical billing. Now, after eleven unblemished years of QME reports and billing codes, the DWC purports to have found a few billing errors from the first couple months of 2017 and, without affording Dr. Howard any hearing or Due Process, you have stripped him of his accreditation as a QME and his sole livelihood. It is obvious from the facts set forth herein, which confirm that Dr. Howard was an independent contractor for another medical practice that was solely responsible for all invoicing, that Dr. Howard had no intent to mislead or defraud, and should not be punished for any alleged billing errors. In essence, the DWC seeks to revoke – not renew – Dr. Howard's QME license based upon an alleged billing error with which he had nothing to do. And, without dispute, this alleged billing error is something that had been done for years without anyone questioning the propriety of the manner in which Dr. Howard time was billed. Now, without any

reasonable investigation into the underlying facts, the DWC seeks to use an isolated billing issue to deny a medical professional such as Dr. Howard with an outstanding track record of over half a century of work the right to practice in this state as a QME. To be clear, your denial is in violation of Dr. Howard's Due Process rights and also factually inaccurate. You denied the application before allowing Dr. Howard the opportunity to respond to the allegations made in your letter. Needless to say, he was not provided a hearing or opportunity to challenge any evidence you relied on for your decision.

This is a *de facto* suspension of Dr. Howard's QME status without affording him the most basic procedural protections. Your actions, and the manner in which they have been taken, violate the Due Process rights of Dr. Howard, as guaranteed by the Fourteenth Amendment to the United States Constitution and Article I, section 7 of California Constitution, as well as Labor Code requirements mandating a hearing before taking such action. In addition, your denial letter violates the California common law doctrine of fair procedure, which protects Dr. Howard from arbitrary decisions such as yours. Under these circumstances, your preliminary denial must be withdrawn, and reappointment should be approved, retroactive to June 1, 2017.

I. Dr. Howard Did Not Commit ANY "Violation Of The Medical-Legal Fee Schedule" Because He Played No Part Whatsoever In The Billing Process.

To be clear, your denial letter sets forth one and only one ground for denial of Dr. Howard's reappointment, which is "Violation Of The Medical-Legal Fee Schedule" under 8 CCR § 9795, Labor Code § 4628, and Labor Code §§ 139.2(j)(6) and 139.2(k)(1). Your failure to afford Dr. Howard even a rudimentary opportunity to be heard prevented Dr. Howard from advising you that he did not participate in any aspect of the billing process whatsoever and therefore cannot be faulted for any putative billing error.

Dr. Howard is an independent contractor for the Adelberg Associates Medical Group ("Adelberg"). This fact is indisputable and can be proven by the testimony of multiple people (including without limitation Dr. Howard and Adelberg) and the existence of the independent contractor Agreement between Adelberg and Dr. Howard ("independent contractor agreement"). Dr. Adelberg is in charge of that group. Pursuant to that independent contractor agreement, Adelberg has sent QME referrals to Dr. Howard since 2005. Dr. Howard then reviewed medical records, examined the injured worker ("IW"), prepared the QME med-legal reports, itemized his hours, and sent them to Adelberg.

However, Dr. Howard had absolutely nothing to do with the billing for these reports because only Adelberg handled that aspect. Dr. Howard's reports merely quantify the hours he spent on: (a) face-to-face time with the IW obtaining the IW's medical history, and performing the physical examination, (b) medical record review, and (c) dictation and preparation of the report. Dr. Howard's reports also often addressed causation, apportionment, and other complexity factors when requested and/or appropriate. However, Dr. Howard never quantifies the complexity factors in his reports, which are determinative of the appropriate billing code. Instead, he always leaves that analysis solely up to Adelberg. Adelberg never sent the billing

code to Dr. Howard to review; rather, Adelberg determined how to bill Dr. Howard's reports, applied Dr. Howard's electronic signature to Adelberg's invoices, and submitted them without Dr. Howard's knowledge of the billing code used. The uncontroverted evidence is that Dr. Howard was totally uninvolved in Adelberg's billing practices.

Had Dr. Howard been afforded the opportunity to discuss your allegations, the DWC would have learned that Dr. Howard has no training in billing and therefore agreed to an independent contractor arrangement in part, because he would have no responsibility for or input into the billing codes used for his reports. When Dr. Howard got paid by Adelberg, he did not even know how much he was receiving for each report or whether the billing codes that Adelberg assigned to Dr. Howard's reports affected his compensation. Therefore, Dr. Howard had no incentive to try to determine the complexity factors attributable to his reports. To this day, Dr. Howard does not know how much he was compensated by Adelberg for each of his reports. You could not have wrongly penalized a more innocent party than Dr. Howard.

That Dr. Howard did not commit any intentional or unintentional violations of the medical-legal fee schedule is a fact that cannot be reasonably debated. Regardless of your preliminary opinion of Adelberg's billing codes, Dr. Howard cannot be made to suffer the consequences of any billing practices about which he had no knowledge and for which he played no part. You have simply alleged billing violations against the wrong party. Therefore, even assuming *arguendo* that any billing violations occurred, such cannot taint Dr. Howard because he was completely divorced from the quantifying of complexity factors and the entire billing process. Accordingly, the DWC's sole ground for denying reappointment to Dr. Howard is invalid and non-existent. Therefore, on this factual mistake alone, the DWC must rescind its denial of reappointment.

II. Adelberg's Invoicing of Dr. Howard's QME Reports Are Correct. The DWC Has The Burden of Proving Otherwise At A Hearing.

Your denial letter *alleges* five billing violations in an extremely conclusory and vague fashion for: (1) Aurora Bonilla ("Bonilla"), (2) Alexander Potter ("Potter"), (3) Audrey Middleton ("Middleton"), (4) Linda Roseman ("Roseman"), and (5) Martha Riverside ("Riverside"). In fact, your vague conclusions are identical for all five claimants. You allege in each instance that only two complexity factors for record review and face-to-face patient time were present in each of the five evaluations, and therefore Dr. Howard's five reports should have been billed under code ML 102 instead of ML 104. You have ignored Dr. Howard's analyses of causation and apportionment that represent two additional complexity factors.

Only Adelberg can fully address your one-sided conclusions and only at a hearing. For purposes of this letter, we can only offer preliminary refutations of your conclusions based upon information supplied to Dr. Howard by Adelberg who is being copied on this letter.

As a preliminary matter, 8 CCR § 9795, upon which you premise your allegations of billing violations, provides that a QME report may be billed under Code ML 104 for: (1) "An evaluation which requires four or more of the complexity factors listed under ML 103…."; (2)

"An evaluation involving prior multiple injuries to the same body part or parts and which requires three or more complexity factors listed under ML 103, including three or more hours of record review by the physician;" or (3) "a comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves "extraordinary circumstances." 8 CCR § 9795(c) (emphasis added).

The ML 103 complexity factors incorporated into ML 104 are, in pertinent part, as follows:

> "(1) Two or more hours of face-to-face time by the physician with the injured worker;
>
> (2) Two or more hours of record review by the physician;
>
> (3) Two or more hours of medical research by the physician;
>
> (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;
>
> (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;
>
> (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;
>
> (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
>
> . . . ."

8 CCR § 9795(c) (emphasis added).

The seven cases cited by the DWC each present sufficient "complexity" factors for the billing code assigned to them by Adelberg, according to Adelberg's analysis.

Bonilla. Causation was addressed at the written request of the parties. Apportionment due to an aggravation of a pre-existing disease was requested and appropriate as well. Over four hours were spent by Dr. Howard on a combination of face-to-face time and record review,

counting as two additional complexity factors. Four complexity factors were presented. Accordingly, the report was properly billed as ML 104.

Potter. More than four hours were spent on a combination of record review and face-to-face time, counting as two complexity factors. Analysis of causation was included at the parties' request. An apportionment analysis was appropriate because of the worker's multiple claim history for the left knee. Four complexity factors were presented. Accordingly, the report was properly billed as ML 104.

Middleton. More than four hours were spent on a combination of record review and face-to-face time, counting as two complexity factors. A causation analysis was included at the parties' request. An apportionment analysis was appropriate because of the worker's multiple injuries. Four complexity factors were presented. Accordingly, the report was properly billed as ML 104.

Roseman. Roseman was properly billed as ML 103, not as ML 104 as you erroneously allege, so the premise for your allegation of a billing violation is factually incorrect. Four or more hours were spent on a combination of face-to-face time and record review. Causation was addressed at the parties' request presented in multiple questions in a cover letter. Three complexity factors were presented. Accordingly, the report was properly billed as ML 103.

Riverside. You misidentify the claimant's first name as "Martha." It is "Martin." More than four hours were spent on a combination of record review and face-to-face time, counting as two complexity factors. A causation analysis was specified as an issue by the cover letter, and an apportionment analysis was appropriate due to multiple prior different body part injuries. Four complexity factors were presented. Accordingly, the report was properly billed as ML 104.

McLoughlin and Valker. Your allegations that Timothy McLoughlin and Pamela Valker were overbilled "in some fashion" are so egregiously vague as to be beneath attribution to the DWC. Until the DWC comports with Due Process, common law fair procedure, and fundamental fairness as to these throw-away allegations, these mysterious and vague alleged violations cannot be addressed fully. However, we are informed by Adelberg that the record proves that Valker was properly billed as ML 104 and McLoughlin as ML 103. Valker involved four hours spent on a combination of record review and face-to-face time, counting as two complexity factors. A causation analysis was requested in three questions in a cover letter. Separate, prior injuries made the apportionment analysis appropriate. Four complexity factors were presented. The report was properly billed as ML 104. McLoughlin involved four hours spent on a combination of record review and face-to-face time, counting as two complexity factors. Causation was addressed at the written request of the parties in a cover letter. Three complexity factors were presented. Accordingly, the report was properly billed as ML 103.

The precise time billed for each claimant listed above is included in each invoice, according to Adelberg. All seven of the claimants discussed above were billed properly pursuant to the express terms of 8 CCR § 9795, according to the specific language of ML 104, which also incorporates the language of ML 103. However, in each instance, you used boilerplate language

to declare that an ML 104 code should have been billed under the much lower ML102 code. You even used his boilerplate language where Dr. Howard's report was billed as code ML 103, evidencing a lack of careful or even any good faith analysis. This pattern also shows a lack of true discretion exercised by the DWC as well as a failure to apply the law as written to the specific facts of Dr. Howard's case.

To add insult to injury, the DWC admits that it is skating on thin ice with its unsupported conclusions by referring to the alleged billing violations as "apparent violations" of 8 CCR § 9795, Labor Code § 4628, and Labor Code §§ 139.2(j)(6) and 139.2(k)(1).

Only a hearing will permit Adelberg to present evidence supporting its billing of the above claims. Regardless of the outcome of that hearing, the DWC cannot punish Dr. Howard for the *alleged* billing mistakes allegedly committed by Adelberg. Dr. Howard can, if necessary, submit invoices for his reports through another entity. However, Dr. Howard is confident that Adelberg's billing of Dr. Howard's reports is correct and that Adelberg can prove the propriety of its billings. We respectfully request that, at a minimum, the DWC renew Dr. Howard's QME status pending a hearing on this issue. To be clear, the nonrenewal of a QME license based upon, at best, an *alleged* mistake by an outside billing source (i.e., the Adelberg medical group), is an act that would be dangerously unprecedented in the State of California and would require the closest of scrutiny from outside agencies and organizations as to the motivation and propriety of the DWC's preliminary letter denying Dr. Howard's application for reappointment as a QME.

III. There Is No Authority To Deny Reappointment Under These Circumstances.

Your reliance on 8 CCR § 9795 and Labor Code sections 139.2(j)(6), and 139.2(k)(1) to prevent Dr. Howard' reappointment as a QME is misplaced. Labor Code section 139.2(k)(1) specifically prohibits the Medical Director from suspending or terminating the QME status of a physician unless and until a hearing takes place. In relying on §139.2(k), you acknowledge the denial of Dr. Howard's reappointment is, in effect, a suspension or termination of Dr. Howard's QME status.

While Labor Code section 139.2(j)(6) authorizes the adoption of regulatory standards for a QME to meet as a condition of reappointment, your letter does not cite to any regulatory standard that Dr. Howard has not met, which would support the denial of his reappointment.

We understand you have alleged an apparent violation of 8 CCR § 9795, but that regulation contains no language authorizing denial of reappointment as a QME. In addition, 8 CCR § 9795 is not part of the applicable QME regulations and evaluation guidelines referenced in Labor Code section 139.2 The applicable QME regulations are contained in Articles 1-15 of Chapter 1, Division 1, Title 8 of the California Code of Regulations, entitled "Qualified Medical Evaluator Regulations." You have not cited to or alleged that Dr. Howard is not in compliance with any of these regulations.

These QME regulations contain language authorizing denial of reappointment only under specific facts. For example, reappointment may be denied if the QME "has filed notification for unavailability under section 33 for more than 90 calendar days during the calendar year." These specific regulations make clear that the Administrative Director has the ability to, and has, approved regulations authorizing denial of reappointment under specific circumstances. There is, however, no regulation that has been promulgated or approved by the Administrative Director authorizing the denial of reappointment if an error is found in a settled bill for a medical evaluation.

You have not, therefore, followed any regulation in denying, suspending and/or terminating Dr. Howard's appointment as a QME.

IV. Denying Reappointment Prior To Allowing Dr. Howard The Ability To Address The Allegations Made Against Him Violates Due Process, Statutory Protections and Common Law Fair Procedure.

Labor Code section 139.2(k), which you relied on in your denial letter, mandates an administrative procedure and hearing prior to the suspension or termination of a physician's QME status. The proceedings are to be conducted pursuant to 8 CCR § 61 and Government Code section 11500, *et seq*. These statutes and regulations mandate a written statement of findings and proposed decision at the conclusion of the hearing. This decision is to include specific findings in accordance with section 8 CCR § 60(b). The hearing procedure must also include submission of a statement of issues, discovery, the taking of witness testimony, presentation of admissible evidence, and the ability to present one's case, and respond to and rebut allegations.

Courts have repeatedly held that the withholding or taking away of an individual's ability to practice in an area subject to certification, without a hearing, violates basic Due Process as well as specific statutes implemented to protect against such arbitrary and one-sided actions. For example, in *Sahlolbei v. Providence Healthcare, Inc.* (2003) 112 Cal. App. 4th 1137, 1142, the defendant denied the reappointment of Dr. Sahlolbei to the medical staff of Palo Verde Hospital without a hearing. The Court of Appeal found this denial to be improper, and granted an injunction against the hospital. The Court of Appeal concluded that Palo Verde Hospital "was required to provide plaintiff with a hearing prior to, not after, terminating his staff membership, and that plaintiff was entitled to an injunction reinstating his membership pending such a hearing." *See also Slaughter v. Edwards* (1970) 11 Cal.App.3d 285, 294 (Due Process is violated when real estate license is suspended or revoked prior to granting a hearing to the licensee.)

Since your denial of reappointment is no different from suspending or terminating Dr. Howard' QME status, the provisions of Labor Code section 139.2(k) must be followed. They were not. To the extent the Medical Unit claims that 8 CCR § 63 authorizes a denial of reappointment prior to a hearing or even an opportunity to respond, the regulation, as applied in this manner, is void. It violates the Due Process rights of Dr. Howard, as guaranteed by the United States and California Constitutions.

Further, California recognizes and enforces the common law doctrine of fair procedure against arbitrary decisions by private or quasi-public organizations such as State Compensation Insurance Fund ("SCIF"). *See Palm Medical Group, Inc. v. State Compensation Ins. Fund* (2008) 161 Cal.App.4th 206. In *Palm Medical Group, Inc.*, a case successfully argued by my firm, the court held that SCIF may not expel or exclude qualified persons without acting in a manner that is substantively rational and procedurally fair when the decision affects the public interest, particularly when there are "substantial economic ramifications" from exclusion. *Palm Medical Group, Inc.*, *supra* at 274.

> The doctrine, recognized in California since the late 19th century, has evolved through a series of cases summarized and most recently reaffirmed in *Potvin*. (*Potvin, supra*, at pp. 1063–1064, 1066–1071, 95 Cal.Rptr.2d 496, 997 P.2d 1153 [doctrine has been applied to labor unions that exercise a monopoly over the supply of labor; professional associations that determine the standards for the practice of the profession; managed care organizations that hold substantial economic power over physicians and their patients].)

Id. The *Palm Medical Group, Inc.* court held that the fair procedure doctrine applied equally to exclusions as well as the refusal to admit an individual to a group that impacts the public interest. *Id.* at 275. A refusal to admit is indistinguishable from a refusal to re-admit or reappoint. For a procedure to be fair, it must include adequate notice and an opportunity to be heard. *Id.* at 276 ("a basic ingredient of the 'fair procedure' required under the common law is that an individual who will be adversely affected by a decision be afforded some meaningful opportunity to be heard in his defense"). *Id.* Violation of this doctrine can be judicially reviewed and the remedy is injunctive relief. *See James v. Marinship Corp.* (1944) 25 Cal. 721.

The alleged 2015 Bonilla complaint against Dr. Howard upon which you based your subsequent billing audit investigation, was made in secret and raised in a suspiciously dilatory fashion. The timing of DWC's investigation is therefore also suspect. The DWC cites an October 16, 2015 complaint allegedly received from Bonilla. The DWC claims that the 2015 complaint involved an allegation that Dr. Howard asked Bonilla "an inordinate amount of questions regarding her country of origin and English-speaking ability," which made her "feel" that Dr. Howard would be "incapable of producing and (sic) unbiased report with regard to the evaluation."

First, your use of "inordinate" concedes that there is an appropriate amount of questions that can and should be asked about these two topics. Where is the vague, mysterious dividing line between an inordinate and acceptable amount of questions about the claimant's country of origin? Your very phrasing offends Due Process and fundamental fairness. Second, Bonilla's alleged 19-month old complaints were stale and completely frivolous when you focused on them. It is an essential, well-established medical practice for a physician to inquire about a claimant's country of origin to determine if the worker comes from an environment with endemic problems

critical to the medical evaluation and apportionment issues, e.g., the Zika virus originating in South America. Dr. Howard acts consistently with other doctors when he asks patients about their country of origin and/or recent travels abroad. Further, Dr. Howard only suggests that a worker could improve his/her English-speaking ability when the worker asks Dr. Howard how to improve his/her chances of obtaining new, gainful employment, especially when the industrial injury hinders or precludes the worker from returning to his/her prior job. In Bonilla's case, Lumberman's Insurance sent Dr. Howard a letter specifically asking, among other things, what other kind of work Ms. Bonilla could do. Dr. Howard has observed that about 25% of IWs have interpreters from Russia, Philippines, France, Mexico, South America, etc., and many IWs make this inquiry of him. That Dr. Howard merely responds, when asked, with common sense and helpful vocational advice to all people regardless of nationality demonstrates empathy and helpfulness, not bias. Does the DWC have a subdivision for only Russian or Spanish-speaking individuals? We presume not. English is the international language of business, but particularly so in the United States. Finally, Bonilla's "feelings" are subjective, speculative, and not a rational basis for your decision.

Your investigation of a 2015 complaint was clearly a pretext for contriving to find "apparent" billing violations in order to deny Dr. Howard's QME reappointment. The reason appears clear. The Medical Unit wanted to try to use 8 CCR § 63 as a regulatory loophole to terminate Dr. Howard' status as a QME without having to provide him a hearing and other procedural protections that it would have had to provide him if it sought to suspend or terminate his QME status under Labor Code section 139.2(k). But the denial of reappointment is no different from termination of QME status. The effect on Dr. Howard' ability to continue to serve as a QME is the same. He must therefore be provided an opportunity to be heard prior to terminating his status as a QME, even if that termination is ostensibly accomplished by a denial of his application for reappointment.

Dr. Howard has served as a QME for 12 years. In all that time, he never received any billing complaints regarding his approximately 1,200 or more QME evaluation reports. This is a spotless record for 12 years. His application for reappointment was in order and should have been approved. Instead, he has now been subjected to a denial made prior to allowing him any opportunity to respond, based on a stale complaint submitted in secret and "apparent" billing violations that are refuted.

V. The DWC's Preliminary Decision To Deny Dr. Howard's Reappointment Is Based Upon A Regulatory Misinterpretation and Underground Regulation.

The sheer number of California QMEs suddenly being denied reappointment based on old complaints, incomplete investigations, and vague, contrived findings of "apparent violations" of the medical-legal fee schedule, has become staggering. This massive and inexplicable wave of denials belies any notion that Adelberg's invoices for Dr. Howard's QME reports were examined with an open mind and in good faith. Instead, it appears that Dr. Howard's rights are being swept away in a tsunami of "underground regulation" pursuant to a hidden agenda.

For example, it has become apparent to numerous lawyers at multiple law firms that the DWC has fundamentally misinterpreted 8 CCR § 9795(c) regarding code ML 104 and is engaged in underground regulation. The DWC has left a trail of rubber-stamped denials of reappointments based on alleged billing errors that reject the time that a provider spends preparing a QME report. In addition, the DWC is interpreting "extraordinary circumstances" too narrowly. The DWC's denials are based on a misinterpretation of section (3) under ML 104. The DWC is erroneously limiting the record preparation billing factor and "extraordinary circumstances" in code ML 104 to subsection (3) instead of to subsections (1), (2) and (3). But this interpretation is wrong for three reasons. First, ML 104's title indicates that all time billed under that code section falls under "extraordinary circumstances" by definition. (*See* title to ML 104: "*Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances.*") Second, section (3) is a catch-all provision that allows parties who cannot satisfy the defined "extraordinary circumstances" of sections (1) and (2) to merely "agree" that their evaluation involves extraordinary circumstances. Third, the language of section (3) beginning with "When billing under this **code** for extraordinary circumstances…" (emphasis added) is supposed to be a new paragraph entirely, applicable to subsections (1)-(3) of ML 104 equally, as recently amended. A printing or other error mistakenly combined this separate, final, omnibus paragraph with section (3). However, the rule-making history of the provisions of 8 CCR § 9795 pertaining to procedure code ML-104 show quite clearly that "extraordinary circumstances" refers to subsections (1)-(3) equally; and further, that time spent reviewing medical records, face-to-face time with the injured worker, and preparing the report itself, are each billing factors for an ML 104 code under all three subsections. The DWC should know this rule-making history. Thus, the DWC's misinterpretation of § 9795 is an improper standard adopted by the DWC to interpret 8 CCR § 9795(c), i.e., an "underground regulation" under Gov. Code §11342.600 and the APA, and it also does not withstand Due Process scrutiny. The sheer volume of the DWC's recent cookie-cutter denials of QME reappointments belies the fairness of the denial of Dr. Howard's reappointment.

In addition, the DWC's disturbing trend toward denying reappointment to QMEs over the age of 40 is of particular concern. Dr. Howard falls into that protected class. If the DWC is engaging in a policy of "cleaning house" of senior QMEs, it should be greatly concerned about its own actions. Therefore, it is especially incumbent upon you to reappoint Dr. Howard as a QME. Alternatively, the QME must afford Dr. Howard his full Due Process rights with a hearing that permits him to rebut the tenuous grounds for your bad faith denial of his reappointment.

Finally, your denial letter jeopardizes several open workers' compensation cases for which Dr. Howard served as the QME. Counsel in those cases have noticed Dr. Howard's deposition so that he can be examined about his QME reports. What is Dr. Howard to do now? Is he permitted to provide deposition testimony regarding his reports, or have you now disqualified him from doing so, thereby causing tremendous harm to each of Dr. Howard's cases for which his services are still needed? If Dr. Howard can provide deposition testimony, is he entitled to be paid for his services now that he is no longer a QME? These and many other questions persist for Dr. Howard and they must be addressed by the DWC immediately.

VI. Conclusion.

As the foregoing demonstrates, the denial of reappointment in this manner and under these circumstances is a gross injustice that cannot withstand legal scrutiny and should be reversed without a hearing. To allow otherwise violates Constitutional and statutory protections, and constitutes a clear abuse of discretion. We therefore respectfully request that the denial of reappointment be withdrawn forthwith, and that within one week, reappointment be approved retroactive to June 1, 2017.

We also request that the complaint submitted to the Medical Unit, and which served as the basis for the denial letter, be immediately produced in its entirety, as well as any documents or other evidence upon which you or the Medical Unit relied upon to deny Dr. Howard's reappointment. We additionally request the production of any documents related to the Bonilla complaint, including those that may rebut or contradict your allegations.

Since we are operating largely in the dark in responding to the DWC's denial letter, and the complaint and allegations upon which it is based, this response is not exhaustive and should not be construed to limit our rights in any manner.

We remain hopeful that after reviewing this response, the reappointment denial will be withdrawn and reappointment approved, retroactive to June 1, 2017, within one week of receipt of this response.

As always, if you'd like to discuss these issues further, please feel free to contact me or, in my absence, Burton Falk, to discuss any of the issues raised herein. It remains our hope that upon the presentation of this rather detailed letter setting forth the facts as we have been able to quickly ascertain them, the DWC will reconsider the content of its June 1, 2017 denial letter and reinstate Dr. Howard's QME status forthwith. I look forward to resolving this issue in a professional and courteous fashion.

Sincerely,

ROXBOROUGH, POMERANCE, NYE & ADREANI, LLP

NICHOLAS P. ROXBOROUGH

cc: Dr. Howard (via email)
Burton Falk, Esq.
Debbie Ortega (via email - dortega@adelbergassociates.com)

Exhibit "C"

BEFORE THE ADMINISTRATIVE DIRECTOR
DIVISION OF WORKERS' COMPENSATION
STATE OF CALIFORNIA

In the Matter of the QME Application of Timothy C. Howard, M.D. 143 Kingswood Circle Danville, CA 94506-6051 Medical Board of California Physician and Surgeon License No. C30756 Division of Workers' Compensation Qualified Medical Evaluator No. 112569 *Applicant.*	AD Case No. **2016-51378** **ORDER ON RECONSIDERATION AND STATEMENT OF ISSUES REGARDING DENIAL OF APPOINTMENT**

George P. Parisotto issues this Order and Statement of Issues solely in his capacity as the Acting Administrative Director of the Division of Workers' Compensation, Department of Industrial Relations, State of California ("Acting Administrative Director").

ORDER

IT IS ORDERED that the application of Timothy C. Howard, Medical Board of California Physician and Surgeon license number C30756 for appointment as a Qualified Medical Evaluator ("QME") is hereby denied.

Dated: August 29, 2017

GEORGE P. PARISOTTO
Acting Administrative Director
Division of Workers' Compensation

STATEMENT OF ISSUES

PARTIES

1. Timothy C. Howard, M.D., Medical Board of California Physician and Surgeon license number C30756, having applied to the Division of Workers' Compensation ("DWC") for certification as a QME and, having met the statutory criteria required for appointment, was most recently certified under QME No. 112569 for the appointment period ending on April 15, 2017.

2. On June 1, 2017, the DWC Executive Medical Director Raymond Meister, M.D., M.P.H., sent Dr. Howard notice by certified mail that his February 15, 2017 application for reappointment as a QME would be denied, together with notice of his right to submit and request a review of the denial by the Administrative Director. Dr. Howard submitted such a request by mail.

JURISDICTION

3. The Acting Administrative Director brings this Statement of Issues under the authority of the following statutes and regulations:

4. Labor Code § 139.2(a) provides that the Administrative Director shall appoint qualified medical evaluators in specialties as required for the evaluation of medical issues.

5. If a medical-legal evaluation is needed for an injured worker who is represented by an attorney, an evaluator is selected by the process specified in Labor Code § 4062.2. If the parties agree on an evaluator, the evaluator is designated as an Agreed Medical Evaluator ("AME") for billing purposes.

6. Labor Code § 5307.6(a) authorizes the Administrative Director to adopt a fee schedule for medical-legal expenses as defined by Labor Code § 4620, consisting of a series of procedure codes, relative values, and a conversion factor for the calculation of fees, which provides remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for reasonably comparable work, and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report.

7. Pursuant to Labor Code § 5307.6(a), the Administrative Director has adopted California Code of Regulations, title 8 ("8 CCR"), § 9795 as the fee schedule applicable to QMEs and AMEs, which provides in relevant part that:

- A "basic comprehensive medical-legal evaluation" is designated by the code **ML-102**, with a relative value of RV 50, meaning that an evaluation, without the use of an interpreter, is to be billed at a flat rate of $625.00 for a QME and $781.25 for an AME (ML-102-94).
- A "complex comprehensive medical-legal evaluation" is designated by the code **ML-103**, with a relative value of RV 75, meaning that such an evaluation, without the use of an interpreter, is to be billed at a flat rate of $937.50 for a QME and $1,171.88 for an AME (ML-103-94).

In order for an evaluation to rise to the level of "complex," it must involve at least three of the following "complexity factors:"

Factor 1. Two or more hours of face-to-face time with the injured worker;

Factor 2. Two or more hours of record review;

Factor 3. Two or more hours of medical research;

Factor 4. Four or more hours spent on any combination of two of the complexity factors numbers 1-3, which will count as two complexity factors. No factor used in such a combination counts as a separate complexity factor.

Factor 5. Six or more hours spent on any combination of the three complexity factors numbers 1-3, which will count as three complexity factors. No factor used in such a combination counts as a separate complexity factor.

Factor 6. Addressing the issue of medical causation (i.e. whether the injury is industrial in origin) upon written request, or if the issue is discovered during the evaluation;*

Factor 7. Addressing the issue of apportionment to different employers or different injuries;*

Factor 8. A psychiatric or psychological evaluation;

Factor 9. For injuries occurring before 1/1/13 and evaluations performed before 6/30/13, addressing the issue of denial or modification of treatment following utilization review.

1. A "comprehensive medical-legal evaluation involving extraordinary circumstances" involves at least one of the following:

    1. Four or more of the complexity factors listed under ML-103*; or
    2. An evaluation involving multiple prior injuries including 3 or more of the complexity factors listed under ML-103, including 3 or more hours of record review; Or
    3. An evaluation for which the parties and the evaluator agree that extraordinary circumstances are involved.

* Although Labor Code sections 4663(b) and 4663(c) require that causation and apportionment be addressed in medical-legal reports that address permanent disability, this does not mean that these issues are billable as *complexity factors* unless they qualify as such under the fee schedule. Under Labor Code §§ 4620 & 4621, costs of medical-legal evaluations are not billable except to the extent that they are capable of proving or disproving a disputed medical fact, the determination of which is essential to the adjudication of a claim for benefits.

The report is designated by the code **ML-104**, with a relative value of RV 5, meaning that such an evaluation is to be billed at an hourly rate of $250 and no more than $312.50 (ML-104-94: AME).

4. A "follow up medical-legal evaluation" is a follow-up, face-to-face medical-legal examination of an injured worker, which occurs within nine months of the date on which the prior face-to-face medical-legal examination was performed by the same physician. Such an evaluation is designated by the code **ML-101**, with a relative value of RV 5, meaning that it is to be billed at an hourly rate of $250 and no more than $312.50 (ML-101-94).

5. A "supplemental evaluation" for a review of records or test results, without any face-to-face examination, is designated by the code **ML-106**, with a relative value of RV 5, meaning that such an evaluation is to be billed at an hourly rate of $250 and no more than $312.50 (ML-106-94: AME).

8. Labor Code § 5307.6(b) prohibits an evaluator from receiving fees in excess of those set forth in the fee schedule, unless the evaluator provides an itemized explanation showing that the fee is both reasonable and justified by extraordinary circumstances relating to the medical condition being evaluated.

9. Labor Code § 5307.6(d) prohibits an evaluator from either requesting or accepting any compensation for medical-legal expenses except as authorized under Labor Code § 5307.6.

10. Labor Code § 4628(a)(1) requires that a physician signing a medical-legal report shall take a complete history of the injured employee being examined. Labor Code § 4628(a)(1) requires that the history be taken by the physician personally or by a nurse.

11. Labor Code § 4628(j) requires that a medical-legal report contain a declaration by the physician signing the report, under penalty of perjury, stating:

> "I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

The declaration must be dated and signed by the reporting physician and indicate the county where it was signed.

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* Billing under this code requires that the physician, in a separate section at the beginning of the report, shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation.

12. Labor Code § 5307.3 authorizes the Administrative Director to adopt any rules or regulations that are reasonably necessary to enforce the programs under the direction of the Division of Workers' Compensation. All of the regulations cited herein were adopted pursuant to Labor Code § 5307.3 and/or some other enabling statute in the Labor Code.

13. Upon a determination that a QME has violated any material statutory or administrative duty, the Administrative Director has discretion under Labor Code §§ 139.2(d)(1) and 139.2(k)(1) and 8 CCR §§ 60 and 65, to impose discipline, up to and including termination of certification, denial of reappointment, and requiring restitution of funds improperly received.

FIRST CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker A.P. —
February 23, 2017 Comprehensive Evaluation
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

14. A.P., who was employed by California Automotive Retailing as a laborer, filed a workers' compensation claim for injuries to his left knee, sustained as a result of a specific injury on July 15, 2014. The employer's claims administrator is Travelers Insurance.

15. The parties selected Dr. Howard to serve as the panel QME to evaluate A.P.'s injuries. The parties arranged for a medical-legal examination to take place on February 23, 2017.

16. On March 7, 2017, Dr. Howard submitted a report on the February 23, 2017 evaluation and billed Travelers Insurance in the total amount of $3,250.00 under code ML-104 and indicated that the report included the following complexity factors:

1.5 hours of face-to-face time with the injured worker;
5.5 hours of record review;
3.5 hours of report preparation;
addressed the issue of causation and
addressed the issue of apportionment.

17. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been prior agreement between the

parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

18. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

19. Billing this evaluation under code ML-104 was clearly inappropriate in that arguably only three complexity factors were involved:

(Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 1.5 hours of face-to-face time combined with 5.5 hours of record review = 2 complexity factors.

(Factor 7) Addressing the issue of apportionment = 1 complexity factor.

20. The proper billing for this evaluation would be under code ML-103, in the amount of $937.50, not including tests.

21. In overbilling this evaluation by $2,312.50, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to Travelers Insurance in the amount that was overbilled.

SECOND CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker A.M. —
January 10, 2017 Comprehensive Evaluation
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

22. A.M., who was employed by Healthcare Resource Group as a laborer, filed a workers' compensation claim for injuries to her left knee, sustained as a result of a specific injury on September 7, 2015. The employer's claims administrator is Zurich American Insurance Company.

23. The parties selected Dr. Howard to serve as the panel QME to evaluate A.M.'s injuries. The parties arranged for a medical-legal examination to take place on January 10, 2017.

24. On February 2, 2017, Dr. Howard submitted a report on the January 10, 2017 evaluation and billed Zurich American Insurance Company in the total amount of $2,375.00 under code ML-104 and indicated that the report included the following complexity factors:

1.5 hours of face-to-face time with the injured worker;
4.5 hours of record review;
3.5 hours of report preparation;
addressed the issue of causation; and
addressed the issue of apportionment.

25. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been prior agreement between the parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

26. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

27. Billing this evaluation under code ML-104 was clearly inappropriate in that arguably only three complexity factors were involved:

(Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 1.5 hours of face-to-face time combined with 4.5 hours of record review = 2 complexity factors.

(Factor 7) Addressing the issue of apportionment = 1 complexity factor.

28. The proper billing for this evaluation would be under code ML-103, in the amount of $937.50, not including tests.

29. In overbilling this evaluation by $1,437.50, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60

and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to Zurich American Insurance Company in the amount that was overbilled.

THIRD CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker A.B. —
July 23, 2015 Comprehensive Evaluation
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

30. A.B., who was employed by Tri State Employment Service (Diamond Staffing) as a laborer, filed a workers' compensation claim for injuries to her right shoulder and arm, sustained as a result of cumulative trauma injury ending on May 25, 2013. The employer's claims administrator is Lumbermen's Underwriting Alliance.

31. The parties selected Dr. Howard to serve as the panel QME to evaluate A.B.'s injuries. The parties arranged for a medical-legal examination to take place on July 23, 2015.

32. On August 20, 2015, Dr. Howard submitted a report on the July 23, 2015 evaluation and billed Lumbermen's Underwriting Alliance in the total amount of $1,687.50 under code ML-104 and indicated that the report included the following complexity factors:

1.25 hours of face-to-face time with the injured worker;
3 hours of record review;
2.5 hours of report preparation;
addressed the issue of causation; and
addressed the issue of apportionment.

33. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been prior agreement between the parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

34. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

35. As to the cited complexity factor that the report addressed apportionment, the report did not indicate that the injured worker was employed by three or more employers, or that the physician was required to evaluate three or more injuries to the same body system or body region, or evaluate two or more injuries involving two or more body systems or body regions. Therefore, apportionment could not be claimed as a complexity factor in this circumstance.

36. Billing this evaluation under code ML-104 was clearly inappropriate in that arguably only two complexity factors were involved:

> (Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 3 hours of record review combined with 1.25 hours of face-to-face time = 2 complexity factors.

37. The proper billing for this evaluation would be under code ML-102, in the amount of $687.50 (interpreter modifier), not including tests.

38. In overbilling this evaluation by $1,000.00, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to Lumbermen's Underwriting Alliance in the amount that was overbilled.

FOURTH CAUSE FOR DENIAL OF REAPPOINTMENT

— Injured Worker P.W. —

January 18, 2017 Comprehensive Evaluation

(Overbilling)

[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

39. P.W., who was employed by the Linden Unified School District as a bus driver, filed a workers' compensation claim for injuries to her low back, neck, and right upper extremity as a result of a slip and fall injury on March 31, 2014. The employer's claims administrator is Keenan and Associates.

40. The parties selected Dr. Howard to serve as the panel QME to evaluate P.W.'s injuries. The parties arranged for a medical-legal examination to take place on January 18, 2017.

41. On February 13, 2017, Dr. Howard submitted a report on the January 18, 2017 evaluation and billed Keenan and Associates in the total amount of $1,687.50 under code ML-104 and indicated that the report included the following complexity factors:

1.25 hours of face-to-face time with the injured worker;
3 hours of record review;
2.5 hours of report preparation;
addressed the issue of causation; and
addressed the issue of apportionment.

42. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been prior agreement between the parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

43. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

44. As to the cited complexity factor that the report addressed apportionment, the report did not indicate that the injured worker was employed by three or more employers, or that the physician was required to evaluate three or more injuries to the same body system or body region, or evaluate two or more injuries involving two or more body systems or body regions. Therefore, apportionment could not be claimed as a complexity factor in this circumstance.

45. Billing this evaluation under code ML-104 was clearly inappropriate in that arguably only two complexity factors were involved:

(Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 3 hours of record review combined with 1.25 hours of face-to-face time = 2 complexity factors.

46. The proper billing for this evaluation would be under code ML-102, in the amount of $687.50 (interpreter modifier), not including tests.

47. In overbilling this evaluation by $1,000.00, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to Keenan and Associates in the amount that was overbilled.

FIFTH CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker T.M. —
January 10, 2017 Comprehensive Evaluation
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

48. T.M., who was employed by Interior Commercial Installation, Inc. as a laborer, filed a workers' compensation claim for injury to the left upper extremity as a result of a specific injury on February 6, 2015. The employer's claims administrator is AmTrust North America.

49. The parties selected Dr. Howard to serve as the panel QME to evaluate T.M.'s injuries. The parties arranged for a medical-legal examination to take place on January 10, 2017.

50. On February 8, 2017, Dr. Howard submitted a report on the January 10, 2017 evaluation and billed AmTrust North America in the total amount of $937.50 under code ML-103 and indicated that the report included the following complexity factors:

1.5 hours of face-to-face time with the injured worker;
3.5 hours of record review;
3.5 hours of report preparation;
addressed the issue of causation.

51. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-103. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

52. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

53. Billing this evaluation under code ML-103 was clearly inappropriate in that arguably only two complexity factors were involved:

> (Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 3.5 hours of record review combined with 1.5 hours of face-to-face time = 2 complexity factors.

54. The proper billing for this evaluation would be under code ML-102, in the amount of $625.00, not including tests.

55. In overbilling this evaluation by $312.50, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to AmTrust North America in the amount that was overbilled.

SIXTH CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker D.C. —
December 22, 2016 Comprehensive Evaluation
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

56. D.C., who was employed by Sandia National Laboratories, filed a workers' compensation claim for bilateral carpal tunnel and back injuries as a result of a specific injury on April 3, 2014. The employer's claims administrator is Cannon Cochran Management Services, Inc.

57. The parties selected Dr. Howard to serve as the panel QME to evaluate D.C.'s injuries. The parties arranged for a medical-legal examination to take place on December 22, 2016.

58. On January 16, 2017, Dr. Howard submitted a report on the December 22, 2016 evaluation and billed Cannon Cochran Management Services, Inc. in the total amount of $2,250.00 under code ML-104 and indicated that the report included the following complexity factors:

1.5 hours of face-to-face time with the injured worker;
3 hours of record review;
4.5 hours of report preparation;
2 hours of medical research
addressed the issue of causation; and
addressed the issue of apportionment.

59. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been prior agreement between the parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

60. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

61. As to the cited complexity factor of medical research, the physician did not provide a list of citations to the sources reviewed and excerpt or include copies of the medical evidence relied upon. Therefore, medical research could not be claimed as a complexity factor in this circumstance.

62. Billing this evaluation under code ML-104 was clearly inappropriate in that arguably only three complexity factors were involved:

(Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 3 hours of record review combined with 1.5 hours of face-to-face time = 2 complexity factors.

(Factor 7) Addressing the issue of apportionment = 1 complexity factor

63. The proper billing for this evaluation would be under code ML-103, in the amount of $937.50, not including tests.

64. In overbilling this evaluation by $1,312.00, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME

certification and an order requiring him to make restitution to Cannon Cochran Management Services, Inc. in the amount that was overbilled.

SEVENTH CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker J.V. —
May 22, 2014 Supplemental Report
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

65. J.V., who was employed by Home Depot as a laborer, filed a workers' compensation claim for injuries to the neck and right upper extremity as a result of a specific injury on March 30, 2012. The employer's claims administrator is Helmsman Management Services, LLC.

66. The parties selected Dr. Howard to serve as the panel QME to evaluate J.V.'s injuries. Defendant requested a supplemental report from Dr. Howard on April 9, 2014.

67. On May 22, 2014, Dr. Howard submitted a supplemental report based on the April 9, 2014 request and billed Liberty Mutual/Helmsman Management Services, LLC in the total amount of $750.00 under code ML-106.

68. The review of medical records must occur in order to bill for an ML-106. There is no indication in the report that medical records were reviewed as required by Labor Code § 4628(a)(2). Therefore, in the absence of a summary of medical records, review of medical records cannot be claimed as an activity that would justify ML-106 billing.

69. The proper characterization for this report would be considered correspondence to the parties.

70. In overbilling by $750.00, Dr. Howard violated Labor Code §§ 4620, 4628, and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to Liberty Mutual/Helmsman Management Services, LLC in the amount that was overbilled.

EIGTH CAUSE FOR DENIAL OF REAPPOINTMENT
— Injured Worker J.V. —
October 15, 2014 Comprehensive Re-Evaluation
(Overbilling)
[Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795]

71. J.V., who was employed by Home Depot as a laborer, filed a workers' compensation claim for injuries to the neck and right upper extremity as a result of a specific injury on March 30, 2012. The employer's claims administrator is Helmsman Management Services, LLC.

72. The parties selected Dr. Howard to serve as the panel QME to evaluate J.V.'s injuries. The parties arranged for a medical-legal examination to take place on October 15, 2014.

73. On November 10, 2014, Dr. Howard submitted a report on the October 15, 2014, evaluation and billed Liberty Mutual/Helmsman Management Services, LLC in the total amount of $2,250.00 under code ML-104 and indicated that the report included the following complexity factors:

1 hour of face-to-face time with the injured worker;
5.5 hours of record review;
2.5 hours of report preparation;
addressed the issue of causation; and
addressed the issue of apportionment.

74. As to the cited complexity factor of report preparation, 8 CCR § 9795 does not allow the QME to bill for report preparation under code ML-104, unless there has been prior agreement between the parties that the evaluation involves extraordinary circumstances. There is no evidence of prior agreement for this evaluation. Therefore, the amount charged for report preparation cannot be allowed in this circumstance, and it cannot count as a complexity factor.

75. As to the cited complexity factor that the report addressed causation, Dr. Howard stated in his report that causation was due to the industrial injury. There is no indication that this was a contested claim putting causation at issue or that either party requested a causation analysis as part of the qualified medical evaluation. Therefore, causation could not be claimed as a complexity factor in this circumstance.

76. As to the cited complexity factor that the report addressed apportionment, the report did not indicate that the injured worker was permanent and stationary and did not assign an impairment rating. The

issue of apportionment involves the assignment of percentages of permanent disability related to the industrial injury. In the absence of a permanent disability rating, there can be no apportionment analysis. Therefore, apportionment could not be claimed as a complexity factor in this circumstance.

77. Billing this evaluation under code ML-104 was clearly inappropriate in that arguably only two complexity factors were involved:

> (Factor 4) Four or more hours spent on any combination of two complexity factors: in this case, 5.5 hours of record review combined with 1 hour of face-to-face time = 2 complexity factors.

78. The proper billing for this evaluation would be under code ML-102, in the amount of $625.00, not including tests.

79. In overbilling this evaluation by $1,625.00, Dr. Howard violated Labor Code §§ 4620 and 5307.6, and 8 CCR § 9795. Therefore under Labor Code §§ 139.2(k)(1) and 139.2(d)(1) and 8 CCR §§ 60 and 65, Dr. Howard is subject to discipline up to and including denial of reappointment of his QME certification and an order requiring him to make restitution to Liberty Mutual/Helmsman Management Services, LLC in the amount that was overbilled.

DENIAL OF REAPPOINTMENT

80. After reconsideration of the denial of the application for reappointment of Timothy C. Howard, M.D., as a Qualified Medical Evaluator, the denial is affirmed.

Dated: August 29, 2017

GEORGE P. PARISOTTO
Acting Administrative Director
Division of Workers' Compensation

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BEFORE THE ADMINISTRATIVE DIRECTOR
DIVISION OF WORKERS' COMPENSATION
QME application of Timothy C. Howard, M.D. - AD Case No. 2017-51378

DECLARATION OF SERVICE BY MAIL

I am employed in the City of Oakland, County of Alameda, California. I am over the age of eighteen years and not a party to the within entitled action. My business address is 1515 Clay Street, 18th Floor, Oakland, California 94612.

On September 12, 2017, in Oakland, California, I served the within:

STATEMENT TO APPLICANT/RESPONDENT
(Gov. Code §§ 11507.5 – 11507.7 attached)
ORDER AND STATEMENT OF ISSUES
REQUEST FOR HEARING
(two copies of form)
REQUEST FOR DISCOVERY

in this action by depositing true copies thereof enclosed in sealed envelopes, with postage fully prepaid thereon, for delivery -- certified mail – by the U.S. Postal Service, and the Statement of Issues only by regular mail to the attorney addressed as follows:

Burton E. Falk, Esq
Roxborough Pomerance Nye & Adreani
5820 Canoga Avenue, Suite 250
Woodland Hills, CA 91367

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed at Oakland, California, on September 18, 2017

URSULA JONES

Exhibit "D"

STATE OF CALIFORNIA — Edmund G. Brown, *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
1515 Clay Street, Suite 1700
Oakland, California 94612
Tel (800) 794-6900 Fax (510) 286-0693

MAILING ADDRESS:
P. O. Box 71010
Oakland, California 94612

Via Certified Mail – Return Receipt Requested

August 11, 2017

Meera Jani, D.C.
9333 baseline Road, Suite 230
Rancho Cucamonga, CA 91730

Re: Denial of application for QME reappointment

Dear Dr. Jani:

Please be informed that your May 29, 2017 application for reappointment as a Qualified Medical Evaluator will be denied. The reasons for this denial are explained below.

VIOLATION OF THE MEDICAL-LEGAL FEE SCHEDULE

On or about March 3, 2017 the Discipline Unit of the Division of Workers' Compensation (DWC) received a complaint with regard to your evaluations possibly being billed as AME evaluations when in fact you performed the evaluations after being selected from a panel generated by the DWC. As a result of the allegations in the complaint, an investigation file was opened by the discipline unit. As part of that investigation, the Discipline Unit requested that you provide 10 of your medical-legal evaluations. You alleged that you had only performed one medical legal evaluation during the time period requested. A review of that medical-legal report and billing revealed prima facie evidence of your violation of the medical-legal fee schedule as contained in Title 8, California Code of Regulations "CCR" § 9795.

In the case of the March 10, 2017 evaluation of injured worker Alma Martinez, you billed the evaluation as an ML 104. However, there were at most only two complexity factors involved in the evaluation consisting of six hours of record review combined with one hour of face-to-face time. Therefore, this evaluation should have been billed as an ML 102. It appears that this evaluation was overbilled in the amount of $2875. There was no indication that this was a denied claim, therefore medical causation was not at issue and could not be claimed as a complexity factor. There was no indication that the injured worker was employed by three or more employers, sustained three or more injuries to the same body part being evaluated, or sustained two or more injuries to two or more body parts being evaluated, therefore apportionment could not be claimed as a complexity factor. In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation, that the evaluation will involve extraordinary circumstances.

Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

As a result of the review of these complaints, a discipline file has been opened by the Discipline Unit, and an investigation with respect to the allegations of overbilling has been initiated. Please be further advised that the results of the current investigations, including a review of any and all records requested from your office, may also affect your ability to be reappointed as a QME.

The apparent violations of 8 CCR §9795 prevent your reappointment as a Qualified Medical Evaluator pursuant to Labor Code §§139.2(j) (6) & 139.2(k) (1).

Accordingly, your application for reappointment will be denied and your check number 4095 in the amount of $1010.00 will be returned to you herewith.

Please be advised that notice of your rights with respect to this denial pursuant to 8 CCR §63 is attached hereto.

Please be further advised that you cannot participate in any panel qualified medical evaluations that require a face-to-face evaluation of the injured worker after receipt of this letter.

Sincerely,

Raymond Meister, M.D., MPH
Executive Medical Director
Division of Workers' Compensation
Department of Industrial Relations

Enc.

NOTICE OF RESPONSE AND REVIEW RIGHTS

California Code of Regulations, title 8; §63

(a) Whenever the Administrative Director determines that an application for appointment or reappointment as a Qualified Medical Evaluator will be denied, the Administrative Director shall:

(1) Notify the applicant in writing of the decision to deny the application and the reasons for the denial; and

(2) Provide notice that if the applicant submits a specific, written response to the notice of denial within thirty (30) days, the Administrative Director will review the decision to deny the application, and within sixty (60) days of receipt of the response notify the applicant of the Administrative Director's final decision.

(b) If the applicant fails to submit a specific, written response to the notice of denial within thirty (30) days, the decision to deny shall become final without any further notice.

(c) If the applicant submits a specific, written response, and the Administrative Director's final decision is that the application should be denied, notice of the final decision shall be provided to the applicant by means of a statement of issues and notice of right to hearing under Chapter 5 (commencing with section 11500) of Title 2 of the Government Code.

(d) All notices and response under this section shall be made by certified mail.

Note: Authority cited: Sections 133, 139.2(f) and 5307.3, Labor Code; Section 11500 et seq., Government Code. Reference: Section 139.2, Labor Code.

Exhibit "E"

SACRAMENTO, CA
SACRAMENTO OFFICE
TEL: (916) 442-2415

LOS ANGELES, CA
WESTWOOD OFFICE
TEL: (310) 470-1869
FAX: (310) 470-9648

DAMON M. RIBAKOFF
(1970-2007)

R P N A
ROXBOROUGH POMERANCE NYE & ADREANI

5820 CANOGA AVENUE,
SUITE 250
WOODLAND HILLS, CA 91367
TEL: (818) 992-9999
FAX: (818) 992-9991

NICHOLAS P. ROXBOROUGH
DREW E. POMERANCE
GARY A. NYE
MICHAEL B. ADREANI
MARINA N. VITEK
JOSEPH C. GJONOLA

DAVID R. GINSBURG
BURTON E. FALK
DAVID A. CARMAN
RYAN R. SALSIG
DARON BARSAMIAN
JACLYN D. GROSSMAN
TREVOR R. WITT

September 6, 2017

Via Certified Mail – Return Receipt Requested
Via Fax: (510) 286-0693

Raymond Meister, M.D., MPH
Executive Medical Director
Division of Workers' Compensation
Department of Industrial Relations
P.O. Box 71010
Oakland, California 94612-7110

Re: Response to DWC's Denial of Application for QME Reappointment of Dr. Dr. Meera Jani and **Request For Hearing** Pursuant to 8 CCR § 63

Dear Dr. Meister:

Dr. Jani has retained our firm and has asked us to respond to your August 11, 2017 letter denying her application for reappointment ("denial letter") as a Qualified Medical Evaluator ("QME"). Accordingly, please direct all future communications to our firm.

When Dr. Jani received your denial letter, she was greatly surprised since she has served as an appointed QME since 2011 and has prepared only four to five QME evaluations. She has never received any notice concerning any complaints about her evaluations or any issues about her billing. Indeed, it is beyond comprehension as to why Dr. Jani was even audited given the limited number of evaluations she has performed, only one of which fell within the November 1 to present audit request period. Yet now, the DWC purports to have found a **single** billing "error" and, without affording Dr. Jani any hearing or due process, it has stripped an excellent doctor of her accreditation as a QME and an important part of her livelihood.

Without any reasonable investigation into the underlying facts, the DWC seeks to use a single billing issue to deny Dr. Jani the right to practice in this state as a QME. To be clear, your

denial is in violation of Dr. Jani's s due process rights, and is egregious as it is factually inaccurate Indeed, you denied the application *before* allowing Dr. Jani the opportunity to respond to the allegations made in your letter. Needless to say, she was not provided a hearing, or an opportunity to challenge any evidence you relied on for your decision.

This is a *de facto* suspension of Dr. Jani's QME status without affording her the most basic procedural protections. Your actions, and the manner in which they have been taken, violate Dr. Jani's due process rights, as guaranteed by the Fourteenth Amendment to the United States Constitution, and by Article I, section 7 of the California Constitution, as well as the Labor Code requirements mandating a hearing when such action is taken. In addition, your denial letter violates the California common law doctrine of fair procedure, which doctrine protects Dr. Jani from arbitrary decisions, such as yours. Under these circumstances, your preliminary denial must be withdrawn forthwith, and Dr. Jani's reappointment should be approved, retroactive to July 31, 2017.

I. There Was No Violation Of The Medical-Legal Fee Schedule Supporting the DWC's Denial Letter for Reappointment.

Incredibly, your denial letter sets forth *one, and only one*, ground for the denial of Dr. Jani's reappointment. That ground is Dr. Jani's alleged violation of the medical-legal fee schedule under title 8, California Code of Regulations ("CCR") section 9795 and Labor Code sections 139.2, subdivision (j)(6) and 139.2, subdivision (k)(1).

Your denial letter *alleges* a billing violation related to a single injured worker, Alma Martinez. You contend that Dr. Jani's s report should not have been billed under code ML 104 because, according to you, "there were at most only two complexity factors involved in the evaluation consisting of six hours of record review combined with one hour of face-to-face time. Therefore, this evaluation should have been billed as an ML 102." We disagree with your contention.

As a preliminary matter, 8 CCR section 9795, upon which you premise the alleged billing violations, provides that a QME report may be billed under Code ML 104 for: (1) "An evaluation which requires four or more of the complexity factors *listed under ML 103*" (emphasis added); (2) "An evaluation involving multiple injuries to the same body part or parts and which requires three or more complexity factors *listed under ML 103*, including three or more hours of record review by the physician" (emphasis added); or (3) "a comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances."

The ML 103 complexity factors incorporated into ML 104 are, in pertinent part:

"(1) Two or more hours of face-to-face time by the physician with the injured worker;

"(2) Two or more hours of record review by the physician;

"(3) Two or more hours of medical research by the physician;

"(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

"(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;

"(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;

"(7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.

"(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation."

(8 CCR § 9795, subdivision (c).)

Dr. Jani met complexity factor (4) under ML 103 for the Alma Martinez claim, because she spent 1.25 hours in face-to-face time and 6.00 hours in record review time, which counts as two complexity factors.

We also believe that Dr. Jani satisfied complexity factor (6) under ML 103 for medical causation. Your denial letter inaccurately states that "There was no indication that this was a denied claim, therefore medical causation was not at issue and could not be claimed as a complexity factor." However, had you read the evidence, this was, in fact, a denied a claim. The employer refused to give Ms. Martinez medical care, and thus this ended up as a UEI claim, which is addressed in Dr. Jani's report and review of records. As you know, medical causation counts as a complexity factor under CCR § 9795, ML 103 and ML 104, if there is a "written request of the party or parties requesting the report[.]" Applicant's attorney wrote to Dr. Jani and specifically requested an analysis of medical causation as follows: "If disability exists, is it industrially caused or aggravated?" CCR § 9795 does not set forth any specific or magical words that are required in an attorney's written request for an analysis of medical causation, and the import of the written request could not be clearer. Thus, a third complexity factor was met.

As to Dr. Jani addressing complexity factor (7) under ML 103 regarding apportionment, there is only the slightest mistake in billing for this fourth factor. Dr. Jani is close to meeting the third subcriterion, "... two or more or more injuries involving two or more body systems or body regions ...." The applicant has two dates of injury, a specific injury and a CT therefore there are two injuries. However Dr. Jani only rated impairment for the spine, which is one body system/region. Had there been a second body system/region, Dr. Jani would have been able to use this complexity factor.

Further, the pretext for investigating Dr. Jani is that her evaluations were "possibly billed as AME evaluations" when Dr. Jani "performed the evaluations after being selected from a panel generated by the DWC." But Dr. Jani denies that she ever billed any of her evaluations as an AME. The Alma Martinez claim was clearly submitted as a PQME. Dr. Jani has only performed three to four other evaluations and you do not cite any of these claims by name as examples where Dr. Jani "possibly" billed her evaluation as an AME. Therefore, the alleged "complaint" that the Discipline Unit of the DWC allegedly received certainly appears to be completely unsubstantiated. We welcome from you, any evidence to the contrary.

Therefore, in the Alma Martinez file, the correct billing code was at least ML 103, not ML 102 as you assert.

Most importantly, your motive in denial of reappointment lacks good faith and your motives are suspect, particularly because you denied reappointment for a single, minute, unintentional billing mistake. Such does not constitute any pattern of misconduct and denial of reappointment is egregiously disproportionate to the alleged infraction. There is no evidence of willful, material or serious violation in this instance warranting a denial of reappointment. The amount arguably overbilled by mistake is, in fact, less than $2,000. Mitigating factors include that Dr. Jani has inexperienced at billing as a QME because she has only performed four or five QME reports in six years. Furthermore, in six years, Dr. Jani has also never received any billing complaints prior to your communications.

Denying reappointment under this circumstance is obviously, to any reasonable lawyer, a gross violation of Dr. Jani's due process rights. If the DWC has any issue with any billing codes, especially with a single and very slight billing mistake, the proper response is to simply reject a bill, with a request to resubmit. Instead, the DWC is engaging in a presumption of guilt and a preordained punishment of denial of the privilege/right of being a QME. This denial is certainly not appropriate in this extraordinary case involving a simple line item in a QME report.

II. There Is No Authority To Deny Reappointment Under These Circumstances.

Your reliance on 8 CCR § 9795, and on Labor Code sections 139.2, subdivisions (j)(6) and (k)(1), to prevent Dr. Jani's s reappointment as a QME is misplaced. Labor Code section 139.2, subdivision (k)(1) specifically prohibits the Medical Director from *suspending or terminating* the QME status of a physician *unless and until* a hearing takes place. In relying on Labor Code §139.2(k), you acknowledge that the denial of Dr. Jani's reappointment is, in effect,

a suspension or termination of Dr. Jani's QME status. Therefore, under this provision, you cannot deny Dr. Jani's reappointment prior to a hearing, which must be provided within 30 days after the QME is "cited"[1] for a violation of Labor Code § 139.2(k)(1)-(6). Therefore, your reliance on Labor Code § 139.2(k)(1) requires you to provide a hearing to Dr. Jani no later than September 10, 2017.

While Labor Code § 139.2(j)(6) authorizes the adoption of regulatory standards for a QME to meet as a condition of reappointment, your letter fails to cite to any "medical or professional standard" that Dr. Jani has not met, which standard would support the denial of her reappointment. Therefore, you cannot rely on Labor Code § 139.2(j)(6) for your denial of reappointment.

We understand you have alleged an "apparent violation" of 8 CCR sections 9795, but that regulation contains no language authorizing denial of reappointment as a QME. In addition, 8 CCR section 9795 is not part of the applicable QME regulations and evaluation guidelines referenced in Labor Code § 139.2. The applicable QME regulations are contained in Articles 1-15 of Chapter 1, Division 1, Title 8 of the California Code of Regulations, entitled "Qualified Medical Evaluator Regulations." You have not alleged that Dr. Jani is not in compliance with any of those regulations.

Those QME regulations contain language authorizing denial of reappointment only when specific facts exist. For example, reappointment may be denied if the QME "has filed notification for unavailability under section 33 for more than 90 calendar days during the calendar year." Those specific regulations make clear that the Administrative Director has the ability to, and has, approved regulations authorizing denial of reappointment under specific circumstances. There is, however, no promulgated regulation, or approved by, the Administrative Director authorizing the denial of reappointment if an error is found in a settled bill for a medical evaluation.

Further, you have not alleged that Dr. Jani lacks the qualifications to serve as a QME, or that there is any reason to believe that she has misdiagnosed any injured worker. Moreover, we are unaware of any complaints about the services that she has rendered as a QME and the DWC has alleged none.

Put simply, you have failed to follow any regulation in denying, suspending, and/or terminating Dr. Jani's appointment as a QME.

III. Denying Reappointment Prior To Allowing Dr. Jani The Ability To Address The Allegations Made Against Her Violates Due Process, Statutory Protections, and Common Law Fair Procedure.

Labor Code §139.2(k), which you relied upon in your denial letter, mandates an

[1] Your August 11, 2017 QME denial of reappointment letter does not clearly cite Dr. Meera for a violation of Labor Code § 139.2(k)(1) because your letter refers to Dr. Jani's single, *alleged* billing mistake as an "apparent violation[]" only. Therefore, you cannot rely on Labor Code § 139.2(k)(1) for your denial of reappointment.

administrative procedure and hearing *prior to* the suspension or termination of a physician's QME status. The proceedings are to be conducted pursuant to 8 CCR section 61 and Government Code section 11500, *et seq*. Those statutes and regulations mandate a written statement of findings and proposed decision at the conclusion of the hearing. The decision is to include specific findings, in accordance with section 8 CCR section 60, subdivision (b). The hearing procedure must also include submission of a statement of issues, discovery, the taking of witness testimony, presentation of admissible evidence, the ability to present one's case, and the ability to respond to, and rebut, allegations.

Courts have repeatedly held that the withholding or taking away of an individual's ability to practice in an area subject to certification, without a hearing, violates basic due process, as well as specific statutes implemented to protect against such arbitrary and one-sided actions. For example, in *Sahlolbei v. Providence Healthcare, Inc.* (2003) 112 Cal.App.4th 1137, 1142, the defendant denied the reappointment of Dr. Sahlolbei to the medical staff of Palo Verde Hospital without a hearing. The Court of Appeal found this denial to be improper, and granted an injunction against the hospital. The Court of Appeal concluded that Palo Verde Hospital "was required to provide plaintiff with a hearing prior to, not after, terminating her staff membership, and that plaintiff was entitled to an injunction reinstating her membership pending such a hearing." (*See also Slaughter v. Edwards* (1970) 11 Cal.App.3d 285, 294 [due process is violated when a real estate license is suspended or revoked prior to granting a hearing to the licensee].)

Since your denial of reappointment is no different from suspending or terminating Dr. Jani's QME status, the provisions of Labor Code section 139.2, subdivision (k) must be followed. To the extent the DWC claims that 8 CCR section 63 authorizes a denial of reappointment prior to a hearing, or even an opportunity to respond, the regulation, as applied in that manner, is void, and is an underground regulation (see Section IV. below). It violates the due process rights of Dr. Jani, as guaranteed by the both the United States Constitution and the California Constitution.

Further, California recognizes and enforces the common law doctrine of fair procedure against arbitrary decisions by private, or quasi-public, organizations, such as the State Compensation Insurance Fund ("SCIF"). (See *Palm Medical Group, Inc. v. State Compensation Ins. Fund* (2008) 161 Cal.App.4th 206.) In *Palm Medical Group, Inc.*, a case successfully argued by my firm, the court held that SCIF may not expel or exclude qualified persons without acting in a manner that is substantively rational and procedurally fair, when the decision affects the public interest, particularly when there are "substantial economic ramifications" from exclusion. (*Id.* at p. 274.)

> The doctrine, recognized in California since the late 19th century, has evolved through a series of cases summarized and most recently reaffirmed in *Potvin*. (*Potvin* [*v. Metropolitan Life Ins. Co.* (2000) 22 Cal.4th 1060] at pp. 1063–1064, 1066–1071, 95 Cal.Rptr.2d 496, 997 P.2d 1153 [doctrine has been applied to labor unions that exercise a monopoly over the supply of labor; professional associations that determine the standards for the practice of the profession; managed care organizations that hold substantial economic power over physicians

and their patients].)

(*Ibid.*) The *Palm Medical Group, Inc.* court held that the fair procedure doctrine applied equally to exclusions, as well as the refusal to admit an individual to a group that impacts the public interest. (*Id.* at p. 275.) A refusal to admit is indistinguishable from a refusal to re-admit or reappoint. For a procedure to be fair, it must include adequate notice and an opportunity to be heard. (*Id.* at p. 276.) "[A] basic ingredient of the 'fair procedure' required under the common law is that an individual who will be adversely affected by a decision be afforded some meaningful opportunity to be heard in her defense." (*Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 555.) Violation of the fair procedure doctrine can be judicially reviewed, and the remedy is injunctive relief. (See *James v. Marinship Corp.* (1944) 25 Cal.2d 721.)

The denial of reappointment is no different from termination of QME status. The effect on Dr. Jani's ability to continue to serve as a QME is identical. She must, therefore, be provided an opportunity to be heard *prior to* terminating her status as a QME, even if that termination is ostensibly accomplished by a denial of her application for reappointment.

As mentioned above, Dr. Jani has never received any billing complaints before. Her application for reappointment was in order, and it should have been approved. Instead, she has now been subjected to a denial made prior to allowing her any opportunity to respond, based on an alleged billing violation that is refuted in substantial part.

IV. The DWC's Preliminary Decision To Deny Dr. Jani's Reappointment Is Based Upon A Regulatory Misinterpretation And An Underground Regulation.

The sheer number of California QMEs suddenly being denied reappointment based on contrived findings of "apparent violations" of the medical-legal fee schedule has become staggering. This massive and inexplicable wave of denials belies any notion that Dr. Jani's single QME report was examined, in good faith. Instead, it appears that Dr. Jani's rights are being swept away in a tsunami of underground regulations pursuant to some hidden agenda.

For example, it has become apparent to numerous lawyers, at multiple law firms, that the DWC has intentionally misinterpreted 8 CCR section 9795, subdivision (c) regarding code ML 104, and that it is engaged in an underground regulation. The DWC has left a trail of rubber-stamped denials of reappointments based on alleged billing errors that reject the time that a provider spends *preparing a QME report*. In addition, the DWC is interpreting "extraordinary circumstances" unreasonably and far too narrowly. The DWC's denials are based on a misinterpretation of section (3) under ML 104. The DWC is erroneously limiting the record preparation billing factor and "extraordinary circumstances" in code ML 104 to subsection (3), instead of to subsections (1), (2), *and* (3). But this interpretation is wrong, for three reasons.

First, ML 104's title indicates that all time billed under that code section falls under "extraordinary circumstances" *by definition*. (See title to ML 104: "*Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances*.") *Second*, section (3) is a catch-all

provision that allows parties who cannot satisfy the *defined* "extraordinary circumstances" of sections (1) and (2) to merely "agree" that their evaluation involves extraordinary circumstances. *Third*, the language of section (3) beginning with "*When billing under this* ***code*** for extraordinary circumstances . . . ." (emphasis added) is supposed to be a new paragraph entirely, applicable to subsections (1)-(3) of ML 104 *equally*, as recently amended. A printing or other error mistakenly combined this separate, final, omnibus paragraph with section (3). However, the rule-making history of the provisions of 8 CCR section 9795 pertaining to procedure code ML 104 shows, quite clearly, that "extraordinary circumstances" refers to subsections (1)-(3) equally, and, further, that time spent reviewing medical records, face-to-face time with the injured worker, and *preparing the report itself*, are each billing factors for an ML 104 code under all three subsections.

To be sure, the DWC should know this rule-making history. Therefore, the DWC's misapplication of section 9795 is highly suspect as it is obviously an improper standard. Indeed, the sheer volume of the DWC's recent cookie-cutter denials of QME reappointments belies the fairness of the denial of Dr. Jani's reappointment.

In addition, the DWC is denying the complexity factor of medical causation despite the existence of a written request for such an evaluation, and even where the claim is not accepted (as in Dr. Jani's QME for Alma Martinez). There is nothing in the language of 8 CCR § 9795 that requires specific words be used in a written request to address medical causation. Further, even if an injury appears to be accepted, a QME may easily discover upon taking a full medical history that a prior, non-industrial event (e.g., a recreational injury) occurred that is more consistent with the injury. This happens all the time. This history may then rebut even accepted claims of industrial causation.

In addition, the DWC's disturbing trend toward denying reappointment to QMEs over the age of 40 is of particular concern. Dr. Jani falls into that protected class. If the DWC is engaging in a policy of "cleaning house" of senior QMEs, it should be greatly concerned about its own actions. Therefore, it is especially incumbent upon you to reappoint Dr. Jani as a QME. Alternatively, the QME must afford Dr. Jani her full Due Process rights with a hearing that permits her to rebut the tenuous grounds for your bad faith denial of her reappointment.

V. Impact On The Injured Worker.

Finally, your denial letter impacts some open workers' compensation cases for which Dr. Jani has been serving as the QME. Specifically, there are cases where Dr. Jani had been scheduled to conduct reevaluations because, when she conducted the initial evaluation, the worker's condition was not permanent and stationary. Now, those reevaluations have had to be cancelled, and the injured worker must start over with a new QME.

Demand is therefore made, that in addition to the request made herein, i.e., that Dr. Jani's reappointment be approved retroactive to August 11, 2017.

VI. Conclusion

As the foregoing demonstrates, the denial of reappointment in this manner, and under these circumstances, is a gross injustice that is unlikely to withstand legal scrutiny, and that you should reverse without a hearing. To allow otherwise violates constitutional, statutory and regulatory protections, and constitutes a clear abuse of discretion. We, therefore, respectfully request that the denial of reappointment be withdrawn forthwith, and that within one week, reappointment be approved retroactive to August 11, 2017.

Since we are operating largely in the dark in responding to the DWC's boilerplate denial letter, and the allegations upon which it is based, this response is not exhaustive, and it should not be construed to limit Dr. Jani's rights in any manner.

We remain hopeful that, after reviewing this response, and within one week of receipt of this response, the reappointment denial will be withdrawn, and reappointment approved, retroactive to August 11, 2017.

As always, if you'd like to discuss these issues further, please feel free to contact me, or in my absence, David Carman or Burton Falk, after you weigh the foregoing. This case cries out for a just resolution that is commensurate with the minute billing infraction that occurred. We hope to resolve this issue promptly, in a professional and courteous fashion, and hopefully before a formal hearing. However, all rights are reserved and a formal hearing is hereby requested.

Sincerely,

ROXBOROUGH, POMERANCE, NYE & ADREANI, LLP

NICHOLAS P. ROXBOROUGH

NPR/lr
File: 17031.01
cc: Dr. Jani (via e-mail)
Burton E. Falk, Esq.
David A. Carman, Esq.

TRANSMISSION VERIFICATION REPORT

TIME : 09/06/2017 12:03
NAME :
FAX :
TEL :
SER.# : BROF4J635062

DATE,TIME	09/06 12:00
FAX NO./NAME	15102860693
DURATION	00:02:54
PAGE(S)	10
RESULT	OK
MODE	STANDARD ECM

RPNA

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FAX

To: Raymond Meister
Fax number: 510-286-0693

From: Nicholas P. Roxborough

Date: **September 6, 2017**
Number of Pages, including cover sheet: __10__

Regarding:
Attached letter dated September 6, 2017 re: Dr. Meera Jani

Comments:

Please contact our office directly with any questions.

Thank you,
Lucy Rodriguez

R P N A

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Regarding:
Attached letter dated September 6, 2017 re: Dr. Meera Jani

Comments:

Please contact our office directly with any questions.

Thank you,
Lucy Rodriguez

Exhibit “F”

STATE OF CALIFORNIA — Edmund G. Brown, *Governor*

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
1515 Clay Street, Suite 1700
Oakland, California 94612
Tel (800) 794-6900 Fax (510) 286-0693

MAILING ADDRESS:
P. O. Box 71010
Oakland, California 94612

Via Certified Mail – Return Receipt Requested

August 7, 2017

Benjamin S. Simon, M.D.
18370 Burbank Boulevard, Suite 707
Tarzana, CA 91356

Re: Denial of application for QME reappointment

Dear Dr. Simon:

Please be informed that your May 23, 2017 application for reappointment as a Qualified Medical Evaluator will be denied. The reasons for this denial are explained below.

VIOLATION OF THE MEDICAL-LEGAL FEE SCHEDULE

On or about March 30, 2017 the Discipline Unit of the Division of Workers' Compensation ("DWC") performed a routine audit with respect to your most recent reports and evaluations. As part of that audit, the Discipline Unit secured 10 of your medical-legal evaluations. A review of some of the medical-legal reports and billing revealed prima facie evidence of your violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the April 20, 2017 evaluation of injured worker José Chan, you billed the evaluation as an ML 104 for $2,000. However, there were at most only three complexity factors involved in the evaluation, consisting of a combination of the face-to-face time and record review along with addressing the issue of causation. Therefore, this evaluation should have been billed as an ML 103 for $937.50. In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the April 20, 2017 evaluation of injured worker Julio Flores, you billed the evaluation as an ML 104 for $5,125. However, there were at most only three complexity factors involved in the evaluation, consisting of a combination of the face-to-face time and record review along with addressing the issue of causation. Therefore, this evaluation should have been billed as an ML 103 for $937.50. In addition, you billed for time spent for report preparation. Please be advised that he medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances.

Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the April 27, 2017 evaluation of injured worker Monica Gonzalez, you billed the evaluation as an ML 103 for $937.50. However, there were at most only two complexity factors involved in the evaluation, consisting of a combination of face-to-face time and record review. Therefore, this evaluation should have been billed as an ML 102 for $625.00. In addition, you billed for time spent for report preparation. Please be advised that he medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the April 27, 2017 evaluation of injured worker John Kehoe, you billed the evaluation as an ML 104 for $2,375. However, there were at most only three complexity factors involved in the evaluation, consisting of a combination of the face-to-face time and record review along with addressing the issue of causation. Therefore, this evaluation should have been billed as an ML 103 for $937.50. In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the March 30 2017 evaluation of injured worker Mike Margarian, you billed the evaluation as an ML 104 for $5,000. However, neither the report nor the bill listed any of the complexity factors involved in the evaluation that would have made it an ML 104. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the April 27, 2017 evaluation of injured worker Norbert Moll, you billed the evaluation as an ML 104 for $2,375. However, there were at most only two complexity factors involved in the evaluation, consisting of a combination of the face-to-face time and record review. Therefore, this evaluation should have been billed as an ML 102 for $625. In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the March 30, 2017 evaluation of injured worker Luis Ponce, you billed the evaluation as an ML 104 for $4,125. However, there were at most only two complexity factors involved in the evaluation, consisting of a combination of the face-to-face time and record review. Therefore, this evaluation should have been billed as an ML 102 for $625. In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and

the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

In the case of the April 6, 2017 evaluation of injured worker Kirk Sandercock, you billed the evaluation as an ML 104 for $2,125. However, there were at most only two complexity factors involved in the evaluation, consisting of a combination of the face-to-face time and record review. Therefore, this evaluation should have been billed as an ML 102 for $625. In addition, you billed for time spent for report preparation. Please be advised that the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances. Therefore, the hours that you billed for report preparation, and the amounts overbilled constitute a violation of the medical-legal fee schedule as contained in 8 CCR §9795.

The apparent violations of 8 CCR §9795 prevent your reappointment as a Qualified Medical Evaluator pursuant to Labor Code §§139.2(j) (6) & 139.2(k) (1).

Accordingly, your application for reappointment will be denied and your check number 1009 in the amount of $950.00 will be returned to you herewith.

Please be advised that notice of your rights with respect to this denial pursuant to 8 CCR §63 is attached hereto.

Please be further advised that you cannot participate in any panel qualified medical evaluations that require a face-to-face evaluation of the injured worker after receipt of this letter.

Sincerely,

Raymond Meister, M.D., MPH
Executive Medical Director
Division of Workers' Compensation
Department of Industrial Relations

Enc.

NOTICE OF RESPONSE AND REVIEW RIGHTS

California Code of Regulations, title 8; §63

(a) Whenever the Administrative Director determines that an application for appointment or reappointment as a Qualified Medical Evaluator will be denied, the Administrative Director shall:

(1) Notify the applicant in writing of the decision to deny the application and the reasons for the denial; and

(2) Provide notice that if the applicant submits a specific, written response to the notice of denial within thirty (30) days, the Administrative Director will review the decision to deny the application, and within sixty (60) days of receipt of the response notify the applicant of the Administrative Director's final decision.

(b) If the applicant fails to submit a specific, written response to the notice of denial within thirty (30) days, the decision to deny shall become final without any further notice.

(c) If the applicant submits a specific, written response, and the Administrative Director's final decision is that the application should be denied, notice of the final decision shall be provided to the applicant by means of a statement of issues and notice of right to hearing under Chapter 5 (commencing with section 11500) of Title 2 of the Government Code.

(d) All notices and response under this section shall be made by certified mail.

Note: Authority cited: Sections 133, 139.2(f) and 5307.3, Labor Code; Section 11500 et seq., Government Code. Reference: Section 139.2, Labor Code.

Exhibit "G"

SACRAMENTO, CA
SACRAMENTO OFFICE
TEL: (916) 442-2415

LOS ANGELES, CA
WESTWOOD OFFICE
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DAMON M. RIBAKOFF
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NICHOLAS P. ROXBOROUGH
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MICHAEL B. ADREANI
MARINA N. VITEK
JOSEPH C. GJONOLA

DAVID R. GINSBURG
BURTON E. FALK
DAVID A. CARMAN
RYAN R. SALSIG
DARON BARSAMIAN
JACLYN D. GROSSMAN
TREVOR R. WITT

September 6, 2017

Via Certified Mail – Return Receipt Requested
Via Fax: (510) 286-0693

Raymond Meister, M.D., MPH
Executive Medical Director
Division of Workers' Compensation
Department of Industrial Relations
P.O. Box 71010
Oakland, California 94612-7110

Re: Response to DWC's Denial of Application for QME Reappointment of Dr. Benjamin S. Simon Pursuant to 8 CCR § 63

Dear Dr. Meister:

Dr. Simon has retained our firm and has asked us to respond to your August 7, 2017 letter denying his application for reappointment ("denial letter") as a Qualified Medical Evaluator ("QME"). Accordingly, please direct all future communications to our firm.

When Dr. Simon received your denial letter, he was stunned, as he has served as an appointed QME for two years without any notice concerning any complaints about his evaluations, and without anyone raising any issues about his billing. Yet now, the DWC purports to have found some billing "errors" and, without affording Dr. Simon any hearing or due process, it has stripped an excellent doctor of his accreditation as a QME and an important part of his livelihood.

Without any reasonable investigation into the underlying facts, the DWC seeks to use alleged billing issues to deny Dr. Simon the right to practice in this state as a QME. To be clear, your denial is in violation of Dr. Simon's due process rights, and is egregious as it is factually inaccurate. Indeed, you denied the application *before* allowing Dr. Simon the opportunity to respond to the allegations made in your letter. Needless to say, he was not provided a hearing, or an opportunity to challenge any evidence you relied on for your decision.

This is a *de facto* suspension of Dr. Simon 's QME status without affording him the most basic procedural protections. Your actions, and the manner in which they have been taken, violate Dr. Simon's due process rights, as guaranteed by the Fourteenth Amendment to the United States Constitution, and by Article I, section 7 of the California Constitution, as well as the Labor Code requirements mandating a hearing when such action is taken. In addition, your denial letter violates the California common law doctrine of fair procedure, which doctrine protects Dr. Simon from arbitrary decisions, such as yours. Under these circumstances, your preliminary denial must be withdrawn forthwith, and Dr. Simon's reappointment should be approved, retroactive to August 7, 2017.

There Were No Violations Of The Medical-Legal Fee Schedule.

Incredibly, your denial letter sets forth *one, and only one*, ground for the denial of Dr. Simon's reappointment. That ground is Dr. Simon's alleged violation of the medical-legal fee schedule under title 8, California Code of Regulations ("CCR") section 9795 and Labor Code sections 139.2, subdivision (j)(6) and 139.2, subdivision (k)(1).

Your denial letter *alleges* billing violations related to eight injured workers: (1) José Chan ("Chan"); (2) Julio Flores ("Flores"); (3) Monica Gonzalez ("Gonzalez"); (4) John Kehoe ("Kehoe"); (5) Mike Margarian ("Margarian"); (6) Norbert Moll ("Moll"); (7) Luis Ponce ("Ponce"); and (8) Kirk Sandercock ("Sandercock"). In every instance but one, you contend that Dr. Simon's reports should not have been billed under code ML 104 because of an insufficient number of complexity factors. In the only other instance, you contend that Dr. Simon's report should not have been billed under code ML 103 because, according to you, "there were at most only two complexity factors involved in the evaluation."

As a preliminary matter, 8 CCR section 9795, upon which you premise the alleged billing violations, provides that a QME report may be billed under Code ML 104 for: (1) "An evaluation which requires four or more of the complexity factors *listed under ML 103*" (emphasis added); (2) "An evaluation involving multiple injuries to the same body part or parts and which requires three or more complexity factors *listed under ML 103*, including three or more hours of record review by the physician" (emphasis added); or (3) "a comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances."

The ML 103 complexity factors incorporated into ML 104 are, in pertinent part:

"(1) Two or more hours of face-to-face time by the physician with the injured worker;

"(2) Two or more hours of record review by the physician;

"(3) Two or more hours of medical research by the physician;

"(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

> "(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;
>
> "(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;
>
> "(7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
>
> "(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation."

(8 CCR § 9795, subdivision (c).)

In each of the instances where you allege a billing violation, the correct billing code was, in fact, used.

Chan. We disagree with your contention that, "at most only three complexity factors" were present. We believe that you have ignored the medical research. And we believe that four complexity factors were present, so the report was properly billed under code ML 104. We also disagree with your contention that "the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances." We believe that, in any instance where an evaluation is properly billed under ML 104, the QME is entitled to bill for report preparation.

Flores. We disagree with your contention that, "at most only three complexity factors" were present. We believe that you have ignored the medical research. And we believe that four complexity factors were present, so the report was properly billed under code ML 104. We also disagree with your contention that "the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances." We believe that, in any instance where an evaluation is properly billed under ML 104, the QME is entitled to bill for report preparation.

Gonzalez. We disagree with your contention that, "at most only two complexity factors" were present. We believe that you have ignored the fact that Dr. Simon was asked to address, and that he did address, causation. And we believe that three complexity factors were present, so the report was properly billed under code ML 103. You also indicate that you believe that Dr. Simon billed for report preparation, when, in fact, he did not.

Kehoe. We disagree with your contention that, "at most only three complexity factors" were present. We believe that you have ignored the medical research. And we believe that four complexity factors were present, so the report was properly billed under code ML 104. We also disagree with your contention that "the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances." We believe that, in any instance where an evaluation is properly billed under ML 104, the QME is entitled to bill for report preparation.

Margarian. We believe that this is evaluation was properly billed under code ML 104. As we understand it, there was a separate time declaration addressing the complexity factors applicable to this evaluation. Perhaps the DWC did not receive or review that time declaration. In any event, if the DWC would like to see the time declaration, we will be happy to forward it to the DWC for its review.

Moll. We disagree with your contention that, "at most only two complexity factors" were present. We believe that you have ignored the fact that Dr. Simon was asked to address, and that he did address, causation. And we believe that you have ignored the medical research. In addition, we believe that four complexity factors were present, so the report was properly billed under code ML 104. We also disagree with your contention that "the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances." We believe that, in any instance where an evaluation is properly billed under ML 104, the QME is entitled to bill for report preparation.

Ponce. We disagree with your contention that, "at most only two complexity factors" were present. We believe that you have ignored the fact that Dr. Simon was asked to address, and that he did address, causation. And we believe that you have ignored the medical research. In addition, we believe that four complexity factors were present, so the report was properly billed under code ML 104. We also disagree with your contention that "the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances." We believe that, in any instance where an evaluation is properly billed under ML 104, the QME is entitled to bill for report preparation.

Sandercock. We disagree with your contention that, "at most only two complexity factors" were present. We believe that you have ignored the fact that Dr. Simon was asked to address, and that he did address, causation. And we believe that you have ignored the apportionment issues. In addition, we believe that four complexity factors were present, so the report was properly billed under code ML 104. We also disagree with your contention that "the medical legal fee schedule only allows billing for report preparation under ML 104 when the parties have agreed **before** the evaluation that the evaluation will involve extraordinary circumstances." We believe that, in any instance where an evaluation is properly billed under ML 104, the QME is entitled to bill for report preparation.

There Is No Authority To Deny Reappointment Under These Circumstances.

Your reliance on 8 CCR § 9795, and on Labor Code sections 139.2, subdivisions (j)(6) and (k)(1), to prevent Dr. Simon's reappointment as a QME is misplaced. Labor Code section

139.2, subdivision (k)(1) specifically prohibits the Medical Director from *suspending or terminating* the QME status of a physician *unless and until* a hearing takes place. In relying on Labor Code section 139.2, subdivision (k), you acknowledge the denial of Dr. Simon's reappointment is, in effect, a suspension or termination of Dr. Simon's QME status.

While Labor Code section 139.2, subdivision (j)(6) authorizes the adoption of regulatory standards for a QME to meet as a condition of reappointment, your letter fails to cite to any regulatory standard that Dr. Simon has not met, which standard would support the denial of his reappointment.

We understand you have alleged an apparent violation of 8 CCR section 9795, but that regulation contains no language authorizing denial of reappointment as a QME. In addition, 8 CCR section 9795 is not part of the applicable QME regulations and evaluation guidelines referenced in Labor Code section 139.2. The applicable QME regulations are contained in Articles 1-15 of Chapter 1, Division 1, Title 8 of the California Code of Regulations, entitled "Qualified Medical Evaluator Regulations." You have not alleged that Dr. Simon is not in compliance with any of those regulations.

Those QME regulations contain language authorizing denial of reappointment only when specific facts exist. For example, reappointment may be denied if the QME "has filed notification for unavailability under section 33 for more than 90 calendar days during the calendar year." Those specific regulations make clear that the Administrative Director has the ability to, and has, approved regulations authorizing denial of reappointment under specific circumstances. There is, however, no promulgated regulation approved by the Administrative Director authorizing the denial of reappointment if an error is found in a settled bill for a medical evaluation.

Further, you have not alleged that Dr. Simon lacks the qualifications to serve as a QME, or that there is any reason to believe that he has misdiagnosed any injured worker. Moreover, we are unaware of any complaints about the services that he has rendered as a QME, and the DWC has alleged none.

Put simply, you have failed to follow any regulation in denying, suspending, and/or terminating Dr. Simon's appointment as a QME.

Denying Reappointment Prior To Allowing Dr. Simon The Ability To Address The Allegations Made Against Him Violates Due Process, Statutory Protections, and Common Law Fair Procedure.

Labor Code section 139.2, subdivision (k), which you relied on in your denial letter, mandates an administrative procedure and hearing *prior to* the suspension or termination of a physician's QME status. The proceedings are to be conducted pursuant to 8 CCR section 61 and Government Code section 11500, et seq. Those statutes and regulations mandate a written statement of findings and proposed decision at the conclusion of the hearing. The decision is to include specific findings, in accordance with section 8 CCR section 60, subdivision (b). The hearing procedure must also include submission of a statement of issues, discovery, the taking of witness testimony, presentation of admissible evidence, the ability to present one's case, and the ability to respond to, and rebut, allegations.

Courts have repeatedly held that the withholding or taking away of an individual's ability to practice in an area subject to certification, without a hearing, violates basic due process, as well as specific statutes implemented to protect against such arbitrary and one-sided actions. For example, in *Sahlolbei v. Providence Healthcare, Inc.* (2003) 112 Cal.App.4th 1137, 1142, the defendant denied the reappointment of Dr. Sahlolbei to the medical staff of Palo Verde Hospital without a hearing. The Court of Appeal found this denial to be improper, and granted an injunction against the hospital. The Court of Appeal concluded that Palo Verde Hospital "was required to provide plaintiff with a hearing prior to, not after, terminating his staff membership, and that plaintiff was entitled to an injunction reinstating his membership pending such a hearing." (See also *Slaughter v. Edwards* (1970) 11 Cal.App.3d 285, 294 [due process is violated when a real estate license is suspended or revoked prior to granting a hearing to the licensee].)

Since your denial of reappointment is no different from suspending or terminating Dr. Simon's QME status, the provisions of Labor Code section 139.2, subdivision (k) must be followed. To the extent the Medical Unit claims that 8 CCR section 63 authorizes a denial of reappointment prior to a hearing, or even an opportunity to respond, the regulation, as applied in that manner, is void. It violates the due process rights of Dr. Simon, as guaranteed by the both the United States Constitution and the California Constitution.

Further, California recognizes and enforces the common law doctrine of fair procedure against arbitrary decisions by private, or quasi-public, organizations, such as the State Compensation Insurance Fund ("SCIF"). (See *Palm Medical Group, Inc. v. State Compensation Ins. Fund* (2008) 161 Cal.App.4th 206.) In *Palm Medical Group, Inc.*, a case successfully argued by my firm, the court held that SCIF may not expel or exclude qualified persons without acting in a manner that is substantively rational and procedurally fair, when the decision affects the public interest, particularly when there are "substantial economic ramifications" from exclusion. (*Id.* at p. 274.)

> The doctrine, recognized in California since the late 19th century, has evolved through a series of cases summarized and most recently reaffirmed in *Potvin*. (*Potvin* [*v. Metropolitan Life Ins. Co.* (2000) 22 Cal.4th 1060] at pp. 1063–1064, 1066–1071, 95 Cal.Rptr.2d 496, 997 P.2d 1153 [doctrine has been applied to labor unions that exercise a monopoly over the supply of labor; professional associations that determine the standards for the practice of the profession; managed care organizations that hold substantial economic power over physicians and their patients].)

(*Ibid.*) The *Palm Medical Group, Inc.* court held that the fair procedure doctrine applied equally to exclusions, as well as the refusal to admit an individual to a group that impacts the public interest. (*Id.* at p. 275.) A refusal to admit is indistinguishable from a refusal to re-admit or reappoint. For a procedure to be fair, it must include adequate notice and an opportunity to be heard. (*Id.* at p. 276.) "[A] basic ingredient of the 'fair procedure' required under the common law is that an individual who will be adversely affected by a decision be afforded some meaningful opportunity to be heard in his defense." (*Pinsker v. Pacific Coast Society of Orthodontists* (1974) 12 Cal.3d 541, 555.) Violation of the fair procedure doctrine can be judicially reviewed, and the remedy is injunctive relief. (See *James v. Marinship Corp.* (1944) 25 Cal.2d 721.)

The denial of reappointment is no different from termination of QME status. The effect on Dr. Simon's ability to continue to serve as a QME is identical. He must, therefore, be provided an opportunity to be heard *prior to* terminating his status as a QME, even if that termination is ostensibly accomplished by a denial of his application for reappointment.

As mentioned above, Dr. Simon has never received any billing complaints before. His application for reappointment was in order, and it should have been approved. Instead, he has now been subjected to a denial made prior to allowing him any opportunity to respond, based on alleged billing violations that are refuted.

The DWC's Preliminary Decision To Deny Dr. Simon's Reappointment Is Based Upon A Regulatory Misinterpretation And An Underground Regulation.

The sheer number of California QMEs suddenly being denied reappointment based on contrived findings of "apparent violations" of the medical-legal fee schedule has become staggering. This massive and inexplicable wave of denials belies any notion that Dr. Simon's QME reports were examined in good faith. Instead, it appears that Dr. Simon's rights are being swept away in a tsunami of underground regulation pursuant to some hidden agenda.

For example, it has become apparent to numerous lawyers, at multiple law firms, that the DWC has intentionally misinterpreted 8 CCR section 9795, subdivision (c) regarding code ML 104, and that it is engaged in an underground regulation. The DWC has left a trail of rubber-stamped denials of reappointments based on alleged billing errors that reject the time that a provider spends *preparing a QME report*. In addition, the DWC is interpreting "extraordinary circumstances" unreasonably and far too narrowly. The DWC's denials are based on a misinterpretation of subsection (3) under ML 104. The DWC is erroneously limiting the record preparation billing factor and "extraordinary circumstances" in code ML 104 to subsection (3), instead of to subsections (1), (2), *and* (3). But this interpretation is wrong, for three reasons.

First, ML 104's title indicates that all time billed under that code section falls under "extraordinary circumstances" *by definition.* (See title to ML 104: "*Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances.*") *Second*, section (3) is a catch-all provision that allows parties who cannot satisfy the *defined* "extraordinary circumstances" of sections (1) and (2) to merely "agree" that their evaluation involves extraordinary circumstances. *Third*, the language of section (3) beginning with "*When billing under this **code*** for extraordinary circumstances . . . ." (emphasis added) is supposed to be a new paragraph entirely, applicable to subsections (1)-(3) of ML 104 *equally*, as recently amended. A printing or other error mistakenly combined this separate, final, omnibus paragraph with section (3). However, the rule-making history of the provisions of 8 CCR section 9795 pertaining to procedure code ML 104 shows, quite clearly, that "extraordinary circumstances" refers to subsections (1)-(3) equally, and, further, that time spent reviewing medical records, face-to-face time with the injured worker, and *preparing the report itself*, are each billing factors for an ML 104 code under all three subsections.

To be sure, the DWC should know this rule-making history. Therefore, the DWC's misapplication of section 9795 is highly suspect, as it is obviously an improper standard. Indeed, the sheer volume of the DWC's recent cookie-cutter denials of QME reappointments belies the

fairness of the denial of Dr. Simon's reappointment.

In addition, the DWC's disturbing trend toward denying reappointment to QMEs over the age of 40 is of *particular concern.* Dr. Simon falls into that protected class. If the DWC is engaging in a policy of "cleaning house" of senior QMEs, it should be greatly concerned about its own actions. Therefore, it is especially incumbent upon you to reappoint Dr. Simon as a QME. Alternatively, the DWC must afford Dr. Simon his full due process rights by providing him with a hearing that permits him to rebut the tenuous grounds for your bad faith denial of his reappointment.

Impact On The Injured Worker

Finally, your denial letter impacts some open workers' compensation cases for which Dr. Simon has been serving as the QME. Specifically, there are cases where Dr. Simon may need to conduct reevaluations because, when he conducted the initial evaluation, the worker's condition was not permanent and stationary. Now, if reevaluations are needed, the injured worker must start over with a new QME.

Additionally, your August 7, 2017 letter denying reappointment calls into question certain scenarios about which you probably have not considered the impact that your denial letter has had, and will continue to have. For example, what if counsel in cases where Dr. Simon served as the QME notice Dr. Simon's deposition. Is he permitted to provide deposition testimony regarding his reports, or have you now disqualified him from doing so, thereby causing tremendous harm to each of Dr. Simon's cases for which his services are still needed? If Dr. Simon can provide deposition testimony, is he entitled to be paid for his services, in light of your August 7, 2017 letter? Again, these are just some of the issues that have been created by your August 7, 2017 letter. Demand is therefore made that, in addition to the request made herein, i.e., that Dr. Simon's reappointment be approved retroactive to August 7, 2017, the DWC clarify what Dr. Simon's role can be on these outstanding workers compensation claims that we have generally described herein.

Conclusion

As the foregoing demonstrates, the denial of reappointment in this manner, and under these circumstances, is a gross injustice that is unlikely to withstand legal scrutiny, and that you should reverse without a hearing. To allow otherwise violates constitutional and statutory protections, and constitutes a clear abuse of discretion. We, therefore, respectfully request that the denial of reappointment be withdrawn forthwith, and that, within one week, reappointment be approved retroactive to August 7, 2017.

Since we are operating largely in the dark in responding to the DWC's boilerplate denial letter, and the allegations upon which it is based, this response is not exhaustive, and it should not be construed to limit Dr. Simon's rights in any manner.

We remain hopeful that, after reviewing this response, and within one week of receipt of this response, the reappointment denial will be withdrawn, and reappointment approved, retroactive to August 7, 2017.

As always, if you'd like to discuss these issues further, please feel free to contact me, or, in my absence, David Carman or Burton Falk, after you weigh the foregoing. We hope to resolve this issue promptly and in a professional and courteous fashion.

Sincerely,

ROXBOROUGH, POMERANCE, NYE & ADREANI, LLP

NICHOLAS P. ROXBOROUGH

NPR/DAC
File: 17029.01
cc: Dr. Simon (via e-mail)
Burton E. Falk, Esq.
David A. Carman, Esq.

TRANSMISSION VERIFICATION REPORT

TIME : 09/06/2017 12:07
NAME :
FAX :
TEL :
SER.# : BROF4J635062

DATE,TIME	09/06 12:04
FAX NO./NAME	15102860693
DURATION	00:03:00
PAGE(S)	10
RESULT	OK
MODE	STANDARD ECM

R P N A

ROXBOROUGH POMERANCE NYE & ADREANI

5820 Canoga Avenue, Suite 250
Woodland Hills, CA 91367
Telephone: (818) 992-9999
Facsimile: (818) 992-9991
www.rpnalaw.com

F A X

To: Raymond Meister
Fax number: 510-286-0693

From: Nicholas P. Roxborough

Date: **September 6, 2017**
Number of Pages, including cover sheet: __10__

Regarding:
Attached letter dated September 6, 2017 re: Dr. Simon

Comments:

Please contact our office directly with any questions.

Thank you,
Lucy Rodriguez

R P N A

ROXBOROUGH
POMERANCE
NYE & ADREANI

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Woodland Hills, CA 91367
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Number of Pages, including cover sheet: __10__

Regarding:
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Comments:

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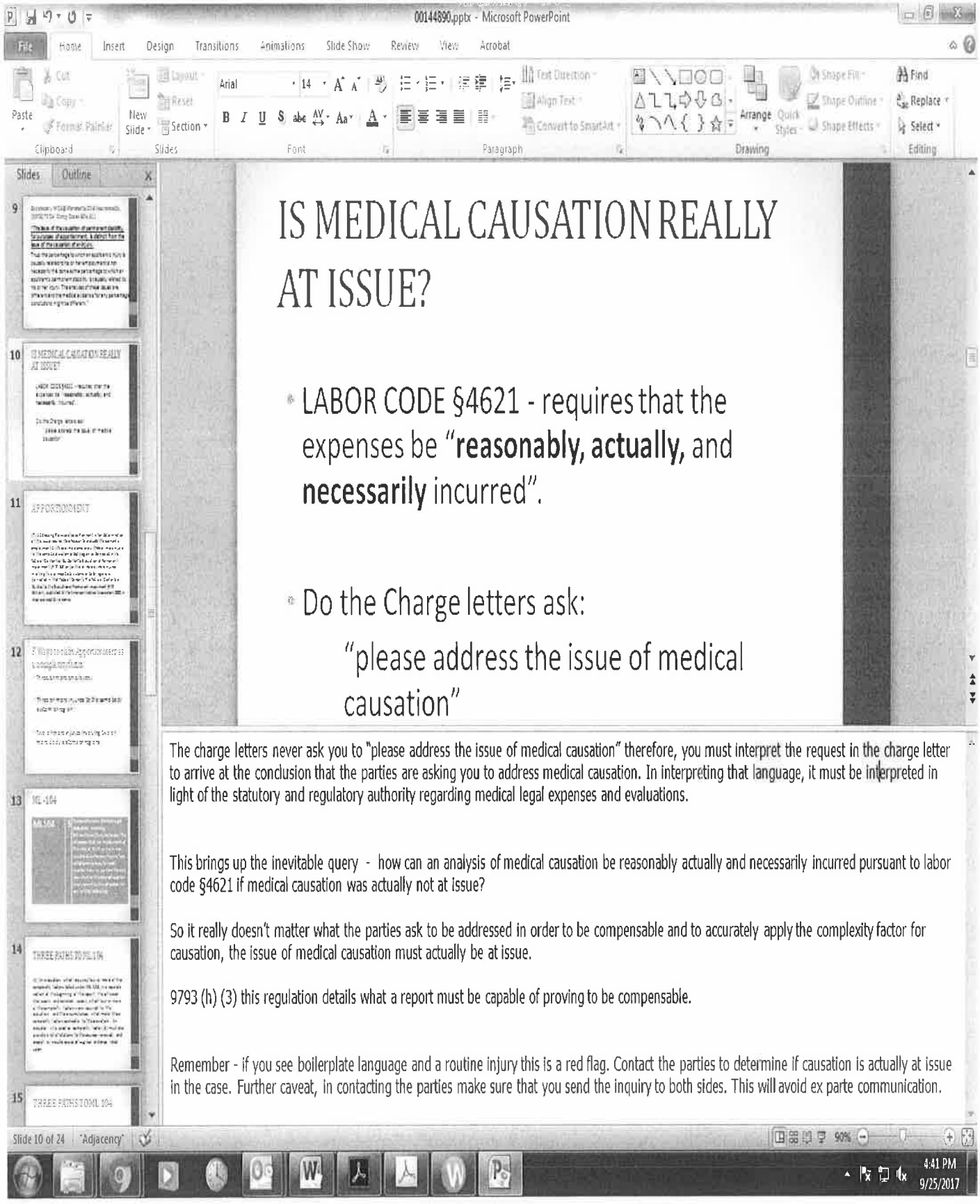
Thank you,
Lucy Rodriguez

Exhibit "H"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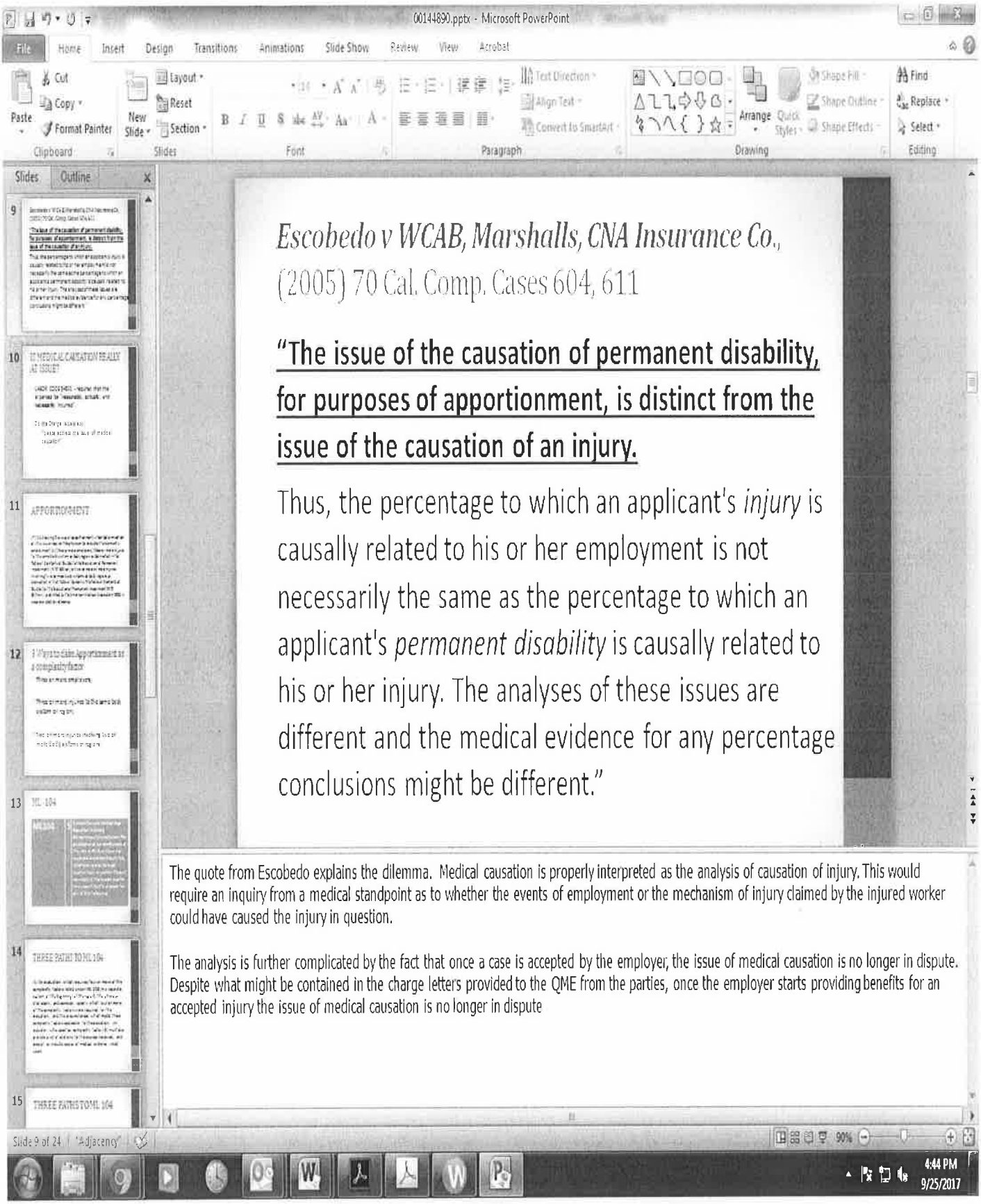
Acrobat
Slides
Outline
IS MEDICAL CAUSATION REALLY AT ISSUE?
LABOR CODE §4621 - requires that the expenses be "reasonably, actually, and necessarily incurred".
Do the Charge letters ask:
"please address the issue of medical causation"
The charge letters never ask you to "please address the issue of medical causation" therefore, you must interpret the request in the charge letter to arrive at the conclusion that the parties are asking you to address medical causation. In interpreting that language, it must be interpreted in light of the statutory and regulatory authority regarding medical legal expenses and evaluations.
This brings up the inevitable query - how can an analysis of medical causation be reasonably actually and necessarily incurred pursuant to labor code §4621 if medical causation was actually not at issue?
So it really doesn't matter what the parties ask to be addressed in order to be compensable and to accurately apply the complexity factor for causation, the issue of medical causation must actually be at issue.
9793 (h) (3) this regulation details what a report must be capable of proving to be compensable.
Remember - if you see boilerplate language and a routine injury this is a red flag. Contact the parties to determine if causation is actually at issue in the case. Further caveat, in contacting the parties make sure that you send the inquiry to both sides. This will avoid ex parte communication.
Slide 10 of 24
"Adjacency"
4:41 PM
9/25/2017

Exhibit "I"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Design
Transitions
Animations
Slide Show
Review
View
Acrobat
Slides
Outline
Escobedo v WCAB, Marshalls, CNA Insurance Co., (2005) 70 Cal. Comp. Cases 604, 611
"The issue of the causation of permanent disability, for purposes of apportionment, is distinct from the issue of the causation of an injury.
Thus, the percentage to which an applicant's injury is causally related to his or her employment is not necessarily the same as the percentage to which an applicant's permanent disability is causally related to his or her injury. The analyses of these issues are different and the medical evidence for any percentage conclusions might be different."
The quote from Escobedo explains the dilemma. Medical causation is properly interpreted as the analysis of causation of injury. This would require an inquiry from a medical standpoint as to whether the events of employment or the mechanism of injury claimed by the injured worker could have caused the injury in question.
The analysis is further complicated by the fact that once a case is accepted by the employer, the issue of medical causation is no longer in dispute. Despite what might be contained in the charge letters provided to the QME from the parties, once the employer starts providing benefits for an accepted injury the issue of medical causation is no longer in dispute
Slide 9 of 24
"Adjacency"
4:44 PM
9/25/2017

Exhibit "J"

CALIFORNIA OFFICE OF ADMINISTRATIVE LAW
SACRAMENTO, CALIFORNIA

In re: WORKERS' COMPENSATION REGULATORY ACTION: Title 08 California Code of Regulations Amend 9793, 9794, and 9795	NOTICE OF APPROVAL FOR PRINTING (Gov. Code, Sec. 11349.3) OAL File No. 93-1231-03 P

SUMMARY OF REGULATORY ACTION

These regulations define terms and establish limitations on reimbursement for medical-legal expenses. Their promulgation is exempt from OAL review pursuant to Government Code section 11351.

OFFICE OF ADMINISTRATIVE LAW DECISION

OAL approves the printing of this filing which is exempt from review by OAL.

Comments:

DATE: 12/31/93

David Potter
Senior Staff Counsel

for: JOHN D. SMITH
Director

Original: Casey L. Young, Administrative Director
cc: Jackie Schaner

State of California

Office of Administrative Law

Memorandum

To: All Regulation Coordinators

Date : 1/4/94

Telephone: (916) 323-6812

From: Carol Kearney

Subject: Return of Rulemaking Materials

OAL hereby returns the rulemaking file your agency submitted for review.

Included with an approved file is a copy of the regulation stamped "ENDORSED FILED" by the Secretary of State.

The effective date of an approved regulation is specified on the form STD 400 facesheet (see item B.4.) Note: The 30th day after filing with the Secretary of State is calculated from the date the regulation facesheet was stamped "ENDORSED FILED" by the Secretary of State.

Enclosures

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

STD. 400 (REV. 3-91)

PRINT REGULAR

AGENCY: Department of Industrial Relations, Div. Workers' Comp.

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z93-0928-01	93-1231-03	

FILED IN THE OFFICE OF SECRETARY OF STATE OF CALIFORNIA
93 DEC 31 PM 4:02

For use by Office of Administrative Law (OAL) only

NOTICE	REGULATIONS
RECEIVED FOR FILING: SEP 28 '93	ENDORSED APPROVED FOR FILING AND PUBLICATION DEC 31 1993 Office of Administrative Law
PUBLICATION DATE: OCT 8 '93	

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. TOPIC OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
WORKERS' COMPENSATION	8	9770	October 8, 1993

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER
[X] Notice re Proposed Regulatory Action [X] Exempt per Other GC 11351	Richard Newman	

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	[X] Approved as Submitted [ ] Approved as Modified [ ] Disapproved/ Withdrawn	93, 41Z	10/8/93

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics-related)

TITLE(S)	
8	ADOPT
SECTIONS AFFECTED	AMEND 9793, 9794, 9795
	REPEAL

2. TYPE OF FILING

[ ] Regular Rulemaking (Gov. Code, § 11346) [ ] Resubmittal [ ] Changes Without Regulatory Effect (Cal. Code Regs., title 1, § 100) [ ] Emergency (Gov. Code, § 11346.1(b))

[ ] Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Government Code §§ 11346.4 - 11346.8 prior to, or within 120 days of, the effective date of the regulations listed above.

[X] Print Only [X] Other (specify) EXEMPT PER GOVERNMENT CODE § 11351

3. DATE(S) OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §§ 44 and 48)

4. EFFECTIVE DATE OF REGULATORY CHANGES (Gov. Code § 11346.2)

[ ] Effective 30th day after filing with Secretary of State [ ] Effective on filing with Secretary of State [X] Effective other (Specify) January 1, 1994 or upon filing with secretary of state, whichever is later.

5. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

[ ] Department of Finance (Form STD. 399) [ ] Fair Political Practices Commission [ ] State Fire Marshal

[ ] Other (Specify)

6. CONTACT PERSON	TELEPHONE NUMBER
Sackie Schaner	8-593-5261

7. *I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.*

SIGNATURE OF AGENCY HEAD OR DESIGNEE	DATE
12/30/93	9/28/93

TYPED NAME AND TITLE OF SIGNATORY: CASEY L. YOUNG, Administrative Director, Division of Workers' Compensation

Article 5.6
~~Fees For~~ Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

§9793. Definitions.

As used in this article:

(a) "Claim" means a claim for compensation as evidenced by either the filing of a claim form pursuant to Section 5401 of the Labor Code or notice or knowledge of an injury under Section 5400 or 5402 of the Labor Code.

(b) "Contested claim" means any of the following:

(1) Where the ~~employer~~ claims administrator has rejected liability for a claimed benefit.

(2) Where the ~~employer~~ claims administrator has failed to accept liability for a claim and the claim has become presumptively compensable under Section 5402 of the Labor Code.

(3) Where the ~~employer~~ claims administrator has failed to respond to a demand for the payment of compensation after the expiration of any time period fixed by statute for the payment of indemnity benefits, including where the ~~employer~~ claims administrator has failed to either commence the payment of temporary disability indemnity or issue a notice of delay within 14 days after knowledge of an employee's injury and disability as provided in Section 4650 of the Labor Code.

(4) Where ~~(A)~~ the ~~employer~~ claims administrator has accepted liability for a claim~~,~~ ~~(B) more than 60 days have elapsed following the filing of a claim form,~~ and ~~(C)~~ a disputed medical fact exists.

(c) "Comprehensive medical-legal evaluation" means an evaluation of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (B) is either:

(1) performed by a Qualified Medical Evaluator pursuant to subdivision (h) of Section 139.2 of the Labor Code, or

(2) performed by a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician for the purpose of proving or disproving a contested claim, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivison (g).

~~(c)~~ (d) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority.

~~(d)~~ (e) "Disputed medical fact" means an issue in dispute, including an objection to a medical determination made by a treating physician under Section 4062 of the Labor

Code , concerning (1) the employee's medical condition, (2) the cause of the employee's medical condition, (3) treatment for the employee's medical condition, (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition, or (5) the employee's medical eligibility for rehabilitation services.

~~(e) "Employer" means an employer as defined in Section 3300 of the Labor Code, a workers' compensation insurer, a self-insured employer, a third-party claims administrator or a joint powers authority.~~

(f) "Follow-up medical-legal evaluation" means an evaluation which includes an examination of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606, (B) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician within one year following the evaluator's examination of the employee in a comprehensive medical-legal evaluation and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive medical- legal evaluation.

~~(f)~~ (g) "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:

(1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.

(2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.

(3) The report is capable of proving or disproving a disputed medical fact essential to the resolution of a contested claim, considering the substance as well as the form of the report, as required by applicable statutes, regulations, and case law.

(4) The medical-legal examination is performed prior to receipt of notice by the physician, the employee, or the employee's attorney, that the disputed medical fact or facts for which the report was requested have been resolved.

(5) In the event the comprehensive medical-legal evaluation report is served on the ~~employer~~ claims administrator after the disputed medical fact or facts for which the report was requested have been resolved, the report is served within the time frame specified in Section 139.2(j)(1) of the Labor Code.

~~(6) The report is prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10978.~~

(h) "Medical-legal testimony" means expert testimony provided by a physician at a deposition or workers' compensation appeals board hearing, regarding the medical opinion submitted by the physician.

(i) "Primary treating physician" is the treating physician primarily responsible for managing the care of the injured worker in accordance with Section 9785.5.

~~(f)~~ (j) "Reports and documents required by the administrative director" means an itemized billing, a copy of the medical-legal evaluation report, and any verification required under Section 9795 (c).

(k) "Supplemental medical-legal evaluation" means an evaluation which (A) does not involve an examination of the patient, (B) is based on the physician's review of records, test results or other medically relevant information which was not available to the physician at the time of the initial examination, (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

Note: Authority cited: Sections 133, 4627, 5307.3, 5307.6, Labor Code. Reference: Sections 4061, 4061.5, 4062, 4620, 4621, 4622, 4625, 4628, 4650, 5307.6, 5402, Labor Code.

§9794. Reimbursement of Medical-Legal Expenses

(a) The cost of comprehensive , follow-up and supplemental medical-legal evaluation reports, ~~and~~ diagnostic tests, and medical-legal testimony, regardless of whether incurred on behalf of the employee or ~~employer~~ claims administrator, shall be billed and reimbursed as follows:

(1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the official medical fee schedule adopted pursuant to Labor Code Section 5307.1. In no event shall the ~~employer~~ claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report. Additionally, the ~~employer~~ claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the ~~employer~~ claims administrator, if adequate medical information is already in the medical record provided to the physician.

(2) The cost of comprehensive , follow-up and supplemental medical-legal evaluations, and medical-legal testimony ~~reports~~ shall be billed and reimbursed in accordance with the schedule set forth in Section 9795.

(b) All medical-legal expenses shall be paid within 60 days after receipt by the claims administrator of the reports and documents required by the administrative director unless the ~~employer~~, claims administrator, within this period, contests its liability for such payment. ~~or the reasonableness or necessity of incurring these expenses~~.

~~Unless the claims administrator denies liability for the entire amount billed under Section 9795, the employer shall pay, within this period, not less than (A) the amount billed, (B) the fee required under procedure code ML 102, or (C) in the case of a supplemental or follow-up report, the fee required under procedure code ML 101. The employer may contest the reasonableness of charges it has paid under Section 9795 by filing a petition with the appeals board to obtain reimbursement of the charges from the physician that are considered unreasonable.~~

(c) ~~An employer~~ claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative director. Any notice of objection shall include or be accompanied by all of the following:

(1) An explanation of the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or other provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator, and shall include the claim's administrator's rationale as to why its code more accurately reflects the service provided. If the ~~employer~~ claims administrator denies liability for the entire medical-legal expense, the objection shall set forth the legal, medical or factual basis for the denial.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement that the physician or other provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

A form objection which does not identify the specific deficiencies of the report in question shall not satisfy the requirements of this subdivision.

(d) All reports and documents required by the administrative director shall be included in or attached to the medical-legal report when it is filed and served on the parties pursuant to Section 10608 or served on the parties pursuant to Section 4061 or 4062 of the Labor Code.

(e) Physicians shall keep and maintain for three years, and shall make available to the administrative director by date of examination upon request, copies of all billings for medical-legal expense, ~~by date of examination~~.

(f) A physician may not charge, nor be paid, any fees for services in violation of Section 139.3 of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;

(g) Claims administrators shall retain, for three years, the following information for each comprehensive medical evaluation for which the claims administrator is billed:

(1) name and specialty of medical evaluator;

(2) name of the employee evaluated;

(3) date of examination ;

(4) the amount billed for the evaluation;

(5) the date of the bill;
(6) the amount paid for the evaluation, including any penalties and interest;
(7) the date payment was made.
This information may be stored in paper or electronic form and shall be made available to the administrative director upon request. This information shall also be made available, upon request, to any party to a case, where the requested information pertains to an evaluation obtained in the case.

(h) Annually, not later than March 1, each claims administrator shall provide the administrative director a report of medical evaluation expenses for the previous year showing, by physician, the total amount billed and the total amount paid by evaluation type, including any modifiers, billed (e.g., ML 102, ML 103, ML 104, or ML 104-96).

Note: Authority cited: Sections 133, 4627, 5307.3, 5307.6, Labor Code. Reference: Sections 129.5, 139.2, 139.3, 3702, 4620, 4621, 4622, 4625, 4626, 4628, 5307.6, Labor Code.

§9795. Reasonable Level Of Fees For Medical-Legal Expenses, Follow- up, Supplemental and Comprehensive Medical-Legal Evaluations ~~Reports,~~ and Medical-Legal Testimony.

(a) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for follow-up, supplemental and comprehensive medical-legal evaluation reports, and fees for medical-legal testimony. ~~Additionally, this schedule of fees shall be prima facie evidence of the reasonableness of fees charged for medical evaluations obtained pursuant to subdivision (h) of Section 139.2 of the Labor Code, regardless of whether the evaluations are medical-legal expenses as defined in this article. However, employee selected physician r~~

Reports ~~required under Section 9785, and comparable reports~~ by a treating or consulting physicians, ~~selected by either an employer or employee,~~ other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each procedure is calculated by multiplying the relative value by $10.00, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure is all inclusive, and includes reimbursement for the examination, review of records, preparation of a medical-legal report, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures ~~set forth in the procedure descriptions may be~~ is expected to vary due to clinical circumstances, and ~~are~~ is therefore not the controlling factor in determining the appropriate level of service.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

CODE	RV	PROCEDURE DESCRIPTION
ML 101	25	~~Supplemental or~~ **Follow-up Medical- Legal Evaluation.** ; Limited to a ~~supplemental or~~ follow-up medical-legal evaluation by a physician. ~~which includes an examination of the patient and which occurs within one year following the initial evaluation~~. ~~Physicians typically spend 75 minutes on these evaluations.~~
ML 102	50	**Basic Comprehensive Medical-Legal Evaluation.** Includes all comprehensive medical-legal evaluations other than ~~supplemental or follow-up evaluations, or evaluations~~ those included under ML 103 or ML 104. ~~Physicians typically spend 150 minutes on these evaluations.~~
ML 103	75	**Complex Comprehensive Medical-Legal Evaluation.** Includes evaluations which require three or more of the following: (i) two or more hours of face-to-face time by the physician with the patient; (ii) two or more hours of record review by the physician; (iii) two or more hours of medical research by the physician; (iv) addressing the issue of medical causation, upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation; (v) addressing the issue of apportionment, upon written request of the party or parties requesting the report, or if a bona fide issue of apportionment is discovered in the evaluation. (vi) addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances. ~~Physicians typically spend 4 hours on these evaluations.~~ The physician shall, in a separate section at the beginning of the report, clearly and concisely specify the three or more complexity factors which were required in the evaluation and the circumstances which made these complexity factors applicable in the evaluation.
ML 104	5	Comprehensive **Medical-Legal Evaluation Involving**

Extraordinary Circumstances; Medical-Legal Testimony; Supplemental Medical-Legal Evaluations.

The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof spent by the physician for any of the following:

(1) Fees for comprehensive medical-legal evaluations ~~This procedure code may be used in lieu of ML 101, ML102, or ML 103,~~where there are extraordinary circumstances relating to the medical condition being evaluated. ~~requires significantly more time than contemplated for the procedure codes ML 101, ML102, or ML 103, which would otherwise be applicable. Where such circumstances justify a higher fee, the physician shall be reimbursed at the rate of RV 5 for each quarter hour or portion thereof spent by the physician on the evaluation.~~

Evaluations which typically involve extraordinary circumstances include the following examples as well as evaluations of comparable complexity:

(a) An evaluation which requires at least four of the six factors listed under ML 103;

(b) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, or a complex issue of medical causation, and which requires at least three of the six factors listed under ML 103, including three or more hours of record review by the physician;

(c) An agreed medical evaluation which is obtained after each party has obtained its own evaluation, which involves complex issues of medical causation or apportionment;

(d) An agreed medical evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances.

When billing under this code for extraordinary circumstances, ~~T~~the physician shall include ~~with~~ in his or her ~~billing~~ report (1) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (2) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the patient, preparing the report and, if applicable, any other activities.

(2) Fees for medical-legal testimony. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of one hour for a scheduled deposition.

(3) Fees for supplemental medical-legal evaluations. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

(d) The services described by Procedure Codes ML 101 through ML 104 may be modified under the circumstances described in this subdivision. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

-92 Performed by a primary treating physician. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by .80, except where services are performed under ML 104.

-93 Interpreter needed at time of examination, or other circumstance which significantly increases the time necessary to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall not be applicable to ML 104.

-94 Evaluation performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. If modifier -93 is also applicable, the value of the procedure is modified by multiplying the normal value by 1.35.

-95 Evaluation performed by a Qualified Medical Evaluator for an uncontested claim. This modifier should be added to the code reflecting the appropriate level of evaluation performed. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

-96 Modifier for medical-legal testimony. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-97 Modifier for supplemental medical-legal evaluations. This modifier is added solely for identification purposes, and does not change the normal value of the procedure.

(e) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. Amendments to this section shall apply to medical-legal evaluation reports where the examination to which the report refers occurs on or after the effective date of the amendments and to medical-legal testimony where such testimony occurs on or after the effective date of the amendments.

Note: Authority cited: Sections 133, 4627, 5307.3, 5307.6, Labor Code. Reference: Sections 139.2, 4061, 4061.5, 4620, 4621, 4622, 4625, 4626, 4628, 5307.6, Labor Code.

Exhibit "K"

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File Home Insert Design Transitions Animations Slide Show Review View Acrobat

Slides Outline

16 THREE PATHS TO ML 104

17 COMMON DWC COMPLIANCE ISSUES

18 OFFICE LOCATIONS

19 OFFICE LOCATIONS

20 REPORTING REQUIREMENTS

DISCIPLINARY ACTIONS AGAINST YOUR LICENSE

21 CURRENT MEDICAL TREATMENT

22

THREE PATHS TO ML 104

3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

This is the method that basically represents the regulatory embodiment of Labor Code §5307.6 which allows for billing in excess of the medical legal fee schedule when there are extraordinary circumstances. That labor code allows for billing in excess of the medical legal fee schedule when there are extraordinary circumstances relating to the medical condition being evaluated. This regulatory embodiment of those principles simply requires prior agreement of the parties that the evaluation involves extraordinary circumstances. Also be aware that this is the ML 104 billing method that explicitly allows for report preparation. The basic analysis is the fee schedule allows for billing for certain enumerated activities. Report preparation is allowed under ML 101, ML 106, and ML 104 for this method.

If you receive three banker boxes full of records, this is the method that you want to employ to legitimately get to the ML 104 billing. However, you must request permission to bill at the ML 104 level, or agreement that the evaluation involves extraordinary circumstances. This does not mean that you can refuse to do the evaluation itself if agreement is not forthcoming. Therefore, your standard letter should be carefully worded so as not to be viewed as extortion.

As you all are currently aware the DWC is engaged in careful screening upon receipt of applications for reappointment. We are rigorously enforcing the regulations that have always been in place with respect to the QME program. Incidences of billing violations account for the majority of the denials issued, and the majority of the cases currently in litigation before the Office of Administrative Hearings.

The current interpretation of the regulations by the DWC may or may not be a standard interpretation upheld by all the administrative law judges. However you can be assured that if you follow the current interpretation of the regulations with respect to billing, you will not receive a letter from the discipline unit, and you will in all likelihood be a reappointed upon submission of your application.

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