Legal Research Report: California Workers' Compensation Agreed Medical Evaluators and Qualified Medical Evaluators

(PART-A INJURED WORKERS ANALYSIS)

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CALIFORNIA WORKERS' COMPENSATION: UNDERSTANDING AME AND QME MEDICAL EVALUATIONS

This report explains the rules, procedures, deadlines, and strategies for medical evaluations in California workers' compensation claims. It focuses on two types of doctor evaluations: Agreed Medical Evaluators (AMEs) and Qualified Medical Evaluators (QMEs). If you are an injured worker in California, this report will help you understand how these evaluations work, what your rights are, and what deadlines you must follow.

Part 1: Key Definitions You Need to Know

This section defines the most important legal terms used throughout this report. Understanding these terms will help you follow the rest of the information.

What Is Workers' Compensation?

Workers' compensation is a system of insurance that pays for medical care and lost wages when you are injured at work. In California, your employer is required to carry workers' compensation insurance. If you get hurt on the job, you can file a claim to receive benefits — regardless of your immigration status. California processes roughly 1.2 million workers' compensation claims each year.

What Is a QME?

A Qualified Medical Evaluator (QME) is a doctor certified by the California Division of Workers' Compensation (DWC) to give a neutral, independent medical opinion in your workers' compensation case. QMEs are selected through a state-run panel process when you and the insurance company cannot agree on a single doctor. QMEs are available to all injured workers, whether or not you have an attorney. See Cal. Lab. Code § 139.2 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=139.2.&lawCode=LAB).

What Is an AME?

An Agreed Medical Evaluator (AME) is a doctor chosen by agreement between your attorney and the insurance company (called the claims administrator). AMEs are only available if you have an attorney. The AME does not need to be state-certified as a QME — the only requirement is that both sides agree on the doctor. See Cal. Lab. Code § 4062.2(a) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.2.&lawCode=LAB).

Other Important Terms

- Claims administrator — The insurance company or employer representative who manages your workers' compensation claim.
- Primary Treating Physician (PTP) — The main doctor providing your ongoing medical treatment for the work injury.
- Apportionment — The process of determining what percentage of your disability was caused by your work injury versus other factors (such as a pre-existing condition). This is required under Cal. Lab. Code § 4663 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4663.&lawCode=LAB).
- Maximum Medical Improvement (MMI) — The point when your condition has stabilized and is not expected to improve significantly with additional treatment.
- Permanent disability — A lasting impairment that reduces your ability to work, rated as a percentage.
- Compensability — Whether your injury is considered work-related and therefore covered by workers' compensation.
- Substantial medical evidence — The legal standard a medical report must meet to be accepted as reliable evidence. The doctor's opinion must be based on facts, a proper examination, and clear medical reasoning.

Part 2: AME vs. QME — Key Differences at a Glance

This section provides a side-by-side comparison so you can quickly understand the main differences between AME and QME evaluations.

Comparison Table

Feature	QME	AME
Who can use it?	All workers (with or without an attorney)	Only workers who have an attorney
How is the doctor chosen?	State issues a panel of three doctors; each side removes one	Both sides agree on one doctor
Must the doctor be state-certified?	Yes — must pass a DWC exam and complete training	No state certification required
Geographic limits?	Yes — panel doctors are near your zip code	No — you can pick a doctor anywhere
How long does it take?	About 130–170 days minimum	About 50–60 days
How much weight does the report carry?	Important evidence, but a judge can weigh it against other opinions	Very strong — often treated as binding because both sides agreed
Can you challenge the report?	Yes — multiple grounds available	Very limited — both sides agreed to the doctor
Cost	Set by the state fee schedule	Parties can negotiate; often higher

Why This Distinction Matters to You

If you have an attorney, you may be able to get an AME evaluation, which is usually faster and carries more weight. If you do not have an attorney, you must use the QME panel process. Either way, understanding the deadlines and procedures is critical — missing a deadline can give the insurance company control over which doctor evaluates you.

> ***Important: If you are an unrepresented worker (you do not have an attorney), you cannot use the AME process. You must follow the QME panel procedures described in Cal. Lab. Code § 4062.1 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.1.&lawCode=LAB).***

Part 3: The Laws That Govern Medical Evaluations

This section explains the California statutes (written laws) that control how AME and QME evaluations work. These laws are found in the California Labor Code.

When Your Claim Is Denied — Labor Code § 4060

Cal. Lab. Code § 4060 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4060.&lawCode=LAB) applies when your employer or their insurance company denies your claim. If they say your injury is not work-related, you can request a medical evaluation to determine compensability — whether the injury happened because of your job. Either side can request this evaluation.

When Your Claim Is Accepted but Disputes Remain — Labor Code § 4061

Cal. Lab. Code § 4061 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4061.&lawCode=LAB) applies when the insurance company has accepted your injury as work-related, but there are still disagreements about:

- Whether you have reached maximum medical improvement
- Your permanent disability rating percentage
- Whether you need future medical care
- What work restrictions apply to you

> ***Note: Under § 4061, a QME evaluation is not required if both the claims administrator and your treating doctor agree on the treating doctor's final report and that report covers all the necessary topics.***

General Evaluation Procedures — Labor Code § 4062

Cal. Lab. Code § 4062 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.&lawCode=LAB) sets the basic rules for requesting and selecting a medical evaluator. The parties must first try to agree on a single doctor. If they cannot agree within 10 days, either side may request a QME panel.

QME Panels for Unrepresented Workers — Labor Code § 4062.1

Cal. Lab. Code § 4062.1 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.1.&lawCode=LAB) governs the panel process when you do not have an attorney. You must select a QME and schedule an appointment within 10 days of receiving the panel. If you miss this deadline, the claims administrator can choose the doctor for you.

QME Panels for Represented Workers — Labor Code § 4062.2

Cal. Lab. Code § 4062.2 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.2.&lawCode=LAB) applies when you have an attorney. It creates a two-stage process:

- Stage 1: Your attorney and the claims administrator try to agree on an AME (10 days, with possible 20-day extension).
- Stage 2: If no agreement, either side requests a three-doctor QME panel. Each side may strike (remove) one name. The remaining doctor becomes your evaluator.

> ***Critical: Under § 4062.2(c), if you fail to strike a doctor within three working days of gaining the right to do so, the other side can pick any remaining doctor on the panel.***

Part 4: Rules About Medical Records and Information

This section explains the strict rules for sending medical records and other information to your QME or AME. Following these rules is essential — mistakes can cause your evaluation to be incomplete or your records to be rejected.

Labor Code § 4062.3 — How to Send Information to Evaluators

Cal. Lab. Code § 4062.3 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.3.&lawCode=LAB) draws a sharp line between two types of contact with your evaluator:

- "Information" means substantive documents — medical records, diagnostic reports, and prior evaluations. You must send a list of these documents to the other side at least 20 days before you send them to the evaluator. The other side then has 10 days to object. If they do not object, you may send the documents to the evaluator.
- "Communication" means administrative matters like scheduling. You may send these to the evaluator at the same time you notify the other side.

The Records Declaration Requirement

When you submit medical records to a QME or AME, you must include a § 4062.3 declaration — a signed statement under penalty of perjury that lists every document by name and date and states the exact number of pages. Without this declaration, the evaluator may refuse to review your records or may not be paid for reviewing them (https://blog.daisybill.com/ca-med-legal-records-declaration).

Common Mistakes That Cause Problems

- Sending records directly to the evaluator without first notifying the other side
- Giving fewer than 20 days' notice to the other side
- Listing an incorrect page count in your declaration
- Describing records vaguely (for example, writing "medical records" instead of "Dr. Smith report dated 3/15/2025, pages 1–5")
- Forgetting to include the declaration entirely

The Doctor's Responsibility — Labor Code § 4628

Cal. Lab. Code § 4628 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4628.&lawCode=LAB) requires that only the doctor who personally examines you may write the medical-legal report. The doctor cannot delegate this work to office staff. The doctor must sign the report under penalty of perjury confirming that he or she personally performed all non-clerical work.

Part 5: Regulatory Framework — State Regulations

This section covers the California Code of Regulations (Title 8) provisions that supplement the Labor Code statutes and provide detailed procedural rules.

Definitions — 8 Cal. Code Regs. § 1

8 Cal. Code Regs. § 1 (https://www.dir.ca.gov/t8/1.html) defines key terms used throughout the regulations, including "Qualified Medical Evaluator," "Agreed Medical Evaluator," "Comprehensive Medical-Legal Evaluation," and "Physician's office."

QME Panel Request Procedures — 8 Cal. Code Regs. § 30

8 Cal. Code Regs. § 30 (https://www.dir.ca.gov/t8/30.html) establishes how to request a QME panel:

- Unrepresented workers submit QME Form 105 (https://www.dir.ca.gov/dwc/Forms/QMEForms/) to the DWC Medical Unit by mail or in person.
- Represented workers (since October 1, 2015) must submit panel requests electronically through the DWC website at www.dwc.ca.gov (https://www.dwc.ca.gov). You must then print and serve a paper copy of the request, the panel list, and all supporting documents on the other side within one working day of generating the panel.

> ***Important: Failure to properly serve the panel within one working day may invalidate the panel, as the Workers' Compensation Appeals Board (WCAB) held in Lopez v. Rockstar Staffing, Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 199 (WCAB 2023).***

Report Service Rules — 8 Cal. Code Regs. § 36

8 Cal. Code Regs. § 36 (https://www.dir.ca.gov/t8/36.html) requires the QME or AME to serve the completed report on the injured worker, the worker's attorney (if represented), and the claims administrator using QME Form 122 (https://www.dir.ca.gov/dwc/FORMS/QMEForms/QMEForm122.pdf).

Time Limits for Reports — 8 Cal. Code Regs. § 38

8 Cal. Code Regs. § 38 (https://www.law.cornell.edu/regulations/california/8-CCR-38) sets mandatory deadlines:

- The evaluator must complete the initial report within 30 days of examining you.
- Extensions of up to 30 additional days are allowed if test results or consultant reports are pending.
- Extensions of up to 15 days are allowed for good cause (medical emergency, natural disaster).
- Extension requests must be filed on QME Form 112 (https://www.dir.ca.gov/dwc/Forms/QMEForms/) at least 5 days before the deadline.
- Supplemental reports must be completed within 60 days of the written request.

Evidence Standards for Reports — 8 Cal. Code Regs. § 10682

8 Cal. Code Regs. § 10682 (https://www.dir.ca.gov/t8/10682.html) lists what a medical report must include to carry weight as evidence: examination date, injury history, patient complaints, records reviewed, medical history, examination findings, diagnosis, disability opinion, causation opinion, treatment recommendations, permanent disability assessment, apportionment analysis, and the reasoning behind all conclusions.

Part 6: Key Court Decisions — Apportionment and Evidence Standards

This section covers the most important court decisions that affect how QME and AME reports are evaluated. These rulings establish the legal standards that doctors and judges must follow.

Apportionment Must Be Based on Causation

In Brodie v. WCAB, 40 Cal.4th 1313 (2007) (https://casetext.com/case/brodie-v-workers-comp-appeals-bd), the California Supreme Court established that apportionment (dividing your disability between work-related and non-work-related causes) must be based on what caused the disability — not what caused the original injury. The court held that:

- Doctors must state what percentage of your permanent disability came from the work injury and what percentage came from other factors
- Other factors can include pre-existing conditions, prior injuries, and natural disease progression
- A report that does not include an apportionment analysis is incomplete

What Makes a Medical Opinion "Substantial Evidence"

In Escobedo v. Marshalls, 70 Cal. Comp. Cases 604 (WCAB 2005, en banc) (https://irstore.blob.core.windows.net/materials/5427739a-655e-4de8-b7b6-69532bfbb87f.pdf), the WCAB established the test for whether a medical report qualifies as substantial medical evidence. To pass this test, the doctor's opinion must:

- Be stated in terms of reasonable medical probability (more likely than not)
- Be based on a proper examination and accurate history
- Explain the reasoning behind all conclusions
- Not be based on speculation or guesswork

This standard also draws from the U.S. Supreme Court's decision in Richardson v. Perales, 402 U.S. 389 (1971) (https://supreme.justia.com/cases/federal/us/402/389/).

AME Reports Carry Extra Weight

In Power v. WCAB, 51 Cal. Comp. Cases 114 (Ct. App. 1986) (https://bradfordbarthel.com/2022/11/23/weight-given-to-medical-reports-at-trial/), the court established that an AME's opinion should "ordinarily be followed" because both sides chose that doctor for their expertise and neutrality. AME findings are only rejected if there is good reason to find the opinion unpersuasive.

QME Reports Do Not Automatically Override Treating Doctors

In Willette v. Au Electric Corp., 69 Cal. Comp. Cases 1298 (WCAB 2004, en banc) (https://bradfordbarthel.com/2022/11/23/weight-given-to-medical-reports-at-trial/), the WCAB held that a QME report does not automatically outweigh your treating doctor's report. When opinions conflict, the judge must weigh all the evidence and decide which report is more persuasive and better supported.

Part 7: Key Court Decisions — Procedures and Deadlines

This section covers recent court decisions about procedural requirements for QME panels, striking deadlines, and report admissibility.

Panel Service Must Be Timely and Complete

In Lopez v. Rockstar Staffing, Inc., 2023 Cal. Wrk. Comp. P.D. LEXIS 199 (WCAB 2023) (https://www.sullivanattorneys.com/blog/service-of-qualified-medical-evaluator-panels), the WCAB invalidated a QME panel because the requesting party served the panel four days late and failed to include the online documentation. This decision requires strict compliance with the one-working-day service rule under 8 Cal. Code Regs. § 30 (https://www.dir.ca.gov/t8/30.html).

What Happens When You Miss Your Strike Deadline

In Gamez v. Full Steam Staffing, 2018 Cal. Wrk. Comp. P.D. LEXIS 282 (WCAB 2018) (https://www.sullivanattorneys.com/blog/qme-selection-party-fails-timely-strike), the WCAB clarified that if you fail to strike a doctor from the panel on time, the other side gains the right to select any remaining doctor. However, the other side must actively communicate its selection.

In Scribner v. Rosewood Miramar Hotel, 2025 Cal. Wrk. Comp. P.D. LEXIS 13 (WCAB 2025) (https://www.sullivanattorneys.com/blog/qme-selection-party-fails-timely-strike), the WCAB confirmed this rule:

if you miss the strike deadline, the other side can choose — but only if they notify you of their choice. Simply selecting a doctor without telling you is not enough.

Discovery Violations Can Exclude QME Reports

In DPR Construction v. WCAB (McClanahan), 111 Cal. App. 5th 1136 (2025) (https://www.sullivanoncomp.com/blog/3rd-district-court-of-appeal-clarifies-credibility-standards-and-discovery-closure-rules), the Third District Court of Appeal strictly enforced discovery closure rules under Cal. Lab. Code § 5502 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5502.&lawCode=LAB). The court held that if a QME report is admitted in violation of mandatory settlement conference rules, the violation requires remand — even if the error might seem minor. Procedural violations in admitting QME reports are not excused as "harmless error."

Advocacy Letters Must Stay Within Bounds

In Maxham v. Cal. Dep't of Corr. & Rehab., 82 Cal. Comp. Cases 136 (WCAB 2017, en banc) (https://bradfordbarthel.com/2022/10/06/a-checklist-for-communications-with-the-qme/), the WCAB set rules for written letters parties send to QMEs:

- You may identify specific disputed issues and ask the doctor to consider particular evidence
- You may not use inflammatory language, demand specific conclusions, or argue that the doctor should ignore legal standards like apportionment
- If an improper letter is sent despite objection, the resulting report may be excluded

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Part 8: Recent WCAB Decisions (2023–2025)

This section highlights the most recent rulings that affect your QME or AME evaluation. These decisions reflect the current legal landscape.

AMA Guides Must Be Applied Correctly

In Daniel Linstad v. City of Richmond, ADJ20141060 (WCAB 2025) (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Daniel-LINSTAD-ADJ20141060.pdf), the WCAB held that both QMEs and AMEs must show how their impairment rating follows the AMA Guides to the Evaluation of Permanent Impairment (5th Edition). A doctor cannot rate your injury by loose analogy to a different condition without proper explanation. If the strict AMA Guides method does not fit your situation, the doctor must explain why under the Almaraz/Guzman rebuttal framework.

Vocational Evidence Cannot Override Medical Apportionment

In Edwar Vanegas Gerena, ADJ14789657 (WCAB 2025) (https://www.dir.ca.gov/WCAB/Panel-Decisions-2025/Edwar-VANEGAS-GERENA-ADJ14789657.pdf), the WCAB addressed what happens when a vocational expert (a specialist in job placement) disagrees with a QME's apportionment finding. The court held that vocational evidence can supplement the medical opinion, but it cannot simply disregard the doctor's apportionment percentages.

Deficient Reports Should Not Suspend Your Case

In Oscar Villalobos, ADJ2913113 (WCAB 2025) (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Oscar-VILLALOBOS-ADJ2913113.pdf), the WCAB reversed a decision that suspended the worker's case because the AME report lacked substantial medical evidence. The court held that the correct remedy for a deficient report is to continue the case and allow supplemental evaluations — not to punish the worker by stopping proceedings.

Settlement Requires Full Disclosure of Medical Decisions

In Lacadia Hartman v. VITAS Healthcare Corp., ADJ20774534 (WCAB 2025) (https://www.dir.ca.gov/wcab/Panel-Decisions-2025/Lacadia-HARTMAN-ADJ20774534.pdf), the WCAB set aside a settlement because the insurance company had received authorization for the worker's shoulder surgery but did not disclose this before the settlement was signed. This decision underscores that all medical determinations — including QME or AME findings — must be disclosed before you agree to settle.

QME Reports Can Be Excluded for Procedural Unfairness

In Jeanette Atilano, ADJ12300876 (WCAB 2023) (https://www.dir.ca.gov/wcab/Panel-Decisions-2023/Jeanette-ATILANO-ADJ12300876.pdf), the WCAB held that when a QME report lacks substantial medical evidence because of procedural problems during the evaluation — such as failure to properly assess the worker's condition — the report may be excluded. Neutrality depends on a fair evaluation process, not just random panel selection.

Part 9: Step-by-Step QME Process and Deadlines

This section provides a clear timeline of every step in the QME panel process. Knowing these deadlines protects your rights.

Timeline for Represented Workers (You Have an Attorney)

1. Day 0: Your attorney sends a written request to the claims administrator proposing one or more doctors as potential AMEs.
2. Day 10: Deadline to agree on an AME. If no agreement, parties may extend by up to 20 more days.
3. Days 10–15: If no AME agreement, your attorney submits a QME panel request electronically through www.dwc.ca.gov (https://www.dwc.ca.gov). Must print and serve paper copies on the other side within one working day.
4. Days 15–25: The DWC issues a three-doctor panel in your requested specialty, selected based on your geographic area.
5. Days 25–35: Each side has 10 days to strike one doctor from the panel. The remaining doctor becomes your evaluator.
6. Days 35–125: Your attorney schedules the appointment. You must be evaluated within 90 days of the panel request. Under Cal. Lab. Code § 4062.2(d) (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.2.&lawCode=LAB), if your attorney does not notify the employer within 10 days of selecting the QME, the employer may schedule the appointment.
7. Days 125–155: The QME examines you and issues the report within 30 days of the examination.
8. Days 155–215: You have 30 days to review the report. If you disagree, you may request a supplemental evaluation. The QME has 60 days to complete a supplemental report.

Timeline for Unrepresented Workers (No Attorney)

1. Day 0: The claims administrator provides you with QME Form 105 (https://www.dir.ca.gov/dwc/Forms/QMEForms/) by certified mail or personal delivery.
2. Day 10: You must submit the completed form to the DWC Medical Unit. If you miss this deadline, the claims administrator can request the panel and choose the medical specialty.
3. Days 10–30: The DWC issues a three-doctor panel.
4. Days 30–40: You must select one doctor from the panel and schedule an appointment within 10 days. If you miss this deadline, the claims administrator can select the doctor.
5. Days 40–120: Your evaluation takes place.
6. Days 120–150: The QME issues the report within 30 days of examining you.

> ***Critical: As an unrepresented worker, you lose control over the process if you miss either the 10-day form submission deadline or the 10-day doctor selection deadline.***

Part 10: The AME Selection Process

This section explains how the AME process works for workers who have an attorney. The AME process is generally faster and can produce findings that carry more weight.

How to Get an AME

1. Your attorney proposes doctors: Your attorney sends a written request to the claims administrator naming one or more physicians as potential AMEs. The proposal should identify the doctor's credentials, specialty, and availability.
2. The other side responds: The claims administrator agrees, suggests alternatives, or refuses. Both sides negotiate in good faith for up to 10 days. They may extend negotiations by up to 20 additional days if they are close to agreement.

3. Written agreement: Once both sides agree on a doctor, they should put the agreement in writing, identifying the AME, the disputed issues, and the evaluation timeline.

4. Medical records are exchanged: Both sides send medical records to the AME following the Cal. Lab. Code § 4062.3 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4062.3.&lawCode=LAB) rules (20-day advance notice to other side, proper declaration).

5. Evaluation: The AME examines you and typically issues the report within 30 days.

When the AME Process Works Well

- The claims administrator has been cooperative on other issues in your case
- A doctor with recognized expertise in your injury type is available and acceptable to both sides
- Your medical records are complete and well-organized
- There is no urgent deadline requiring faster resolution

When the AME Process May Not Work

- The claims administrator is hostile or uncooperative
- The other side keeps proposing doctors known to favor employers
- You cannot identify a mutually acceptable specialist
- You need a backup plan in case AME negotiations fail

The Weight of AME Findings

Because both sides chose the AME, the report carries significant weight. Under Power v. WCAB, 51 Cal. Comp. Cases 114 (Ct. App. 1986), the AME's opinion "should ordinarily be followed unless there is good reason to find that opinion unpersuasive." This means:

- Judges are reluctant to reject AME findings
- Both sides are generally bound by the AME's conclusions
- Challenging an AME report is much harder than challenging a QME report
- The main grounds for challenging an AME report are fraud, a fundamental procedural defect, or a gross violation of legal standards

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Part 11: What the QME or AME Report Must Include

This section explains the mandatory contents of a QME or AME report. If the report is missing required sections, it may be found incomplete or given less weight by a judge.

Required Report Sections Under 8 Cal. Code Regs. § 9793

Every QME and AME report must include these elements:

- Identification information — Your name, claim number, date of injury, doctor's name, license number, and specialty
- Records reviewed — A complete list of every medical record, diagnostic study, and prior report the doctor reviewed
- History of your injury — How the injury happened, including what you were doing and what tools or equipment were involved
- Your current symptoms — Your description of pain, limitations, and how the injury affects your daily life
- Physical examination findings — What the doctor found when examining you: range of motion measurements, strength testing, neurological checks, and any special tests
- Diagnosis — The doctor's medical diagnosis and how it relates to your work injury
- Causation analysis — Whether your condition was caused by your work injury, made worse by it, or is unrelated
- Apportionment determination — What percentage of your permanent disability came from the work injury versus other factors (required under Cal. Lab. Code § 4663 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4663.&lawCode=LAB))
- MMI status — Whether your condition has stabilized

- Impairment rating — A percentage rating using the AMA Guides to the Evaluation of Permanent Impairment (5th Edition)
- Work restrictions — Specific limits on your work activities (for example, no lifting over 10 pounds)
- Future medical care — Whether you need ongoing treatment and what kind
- Declaration and signature — The doctor's signature under penalty of perjury confirming he or she personally performed all non-clerical work

The Substantial Medical Evidence Standard

For a report to be useful as evidence, it must meet the substantial medical evidence standard from Escobedo v. Marshalls, 70 Cal. Comp. Cases 604 (WCAB 2005, en banc):

- The opinion must be stated as "more likely than not" — not just a possibility
- The opinion must be based on a proper examination and accurate medical history
- The doctor must explain how and why the medical evidence supports each conclusion
- The doctor cannot ignore important facts or rely on guesswork

Reports that fail this standard carry less weight and may be rejected by the judge.

Part 12: Understanding Apportionment

This section explains apportionment — one of the most commonly disputed parts of a QME or AME report. Apportionment affects how much of your disability benefits you receive.

What Apportionment Means

Apportionment is the process of dividing your permanent disability between the work injury and other causes. Under Cal. Lab. Code § 4663 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4663.&lawCode=LAB), every QME and AME report that addresses permanent disability must include an apportionment determination. A report without one is legally incomplete.

Key Legal Rules from Brodie and Escobedo

The California Supreme Court in Brodie v. WCAB, 40 Cal.4th 1313 (2007), and the WCAB in Escobedo v. Marshalls, 70 Cal. Comp. Cases 604 (WCAB 2005, en banc), established these rules:

- Apportionment must focus on what is causing the disability now — not what caused the original injury
- Disability can be divided among the work injury, pre-existing conditions (such as arthritis), prior injuries, and natural disease progression
- Apportionment cannot be based on age alone or gender alone — it must be tied to specific medical conditions supported by evidence
- Approximate percentages are acceptable, but they must be grounded in medical evidence, not guesswork

What a Good Apportionment Analysis Looks Like

A proper analysis identifies specific medical evidence (such as MRI findings of pre-existing degeneration), explains how each condition contributes to the current disability, and assigns approximate percentages with clear reasoning. For example:

> "Applicant's MRI shows acute herniation at L4-L5 from the work injury and pre-existing degenerative disc disease at L5-S1. I apportion approximately 70% of permanent disability to the work-related herniation and approximately 30% to the pre-existing degeneration, based on the relative contribution of each condition to the patient's current functional limitations."

What a Deficient Apportionment Analysis Looks Like

A report that simply states "I apportion 30% to pre-existing factors" without explaining which factors, what medical evidence supports them, or how those factors contribute to the current disability does not meet the substantial medical evidence standard. Such a report may be returned for correction or given minimal weight by the judge.

Part 13: Challenging a QME or AME Report

This section explains your options if you receive an unfavorable or incomplete QME or AME report.

Requesting a Supplemental Evaluation

The most common remedy is to ask the same doctor for a supplemental (follow-up) report. Under 8 Cal. Code Regs. § 38 (https://www.law.cornell.edu/regulations/california/8-CCR-38), you may request a supplemental evaluation when:

- New medical records have become available since the initial evaluation
- The report is ambiguous or does not clearly address a disputed issue
- The report contains a factual error (wrong date of injury, incorrect job description)
- The report fails to address an issue you raised
- The report states a conclusion without adequate medical reasoning

Your request must be in writing, identify the specific problem, and be served on the other side. The doctor has 60 days to complete the supplemental report (extendable by 30 days with both parties' agreement). If the doctor does not respond within 60 days and no extension was approved, you may request a new panel.

Challenging the Report at Trial

You may challenge a QME report on the grounds that it lacks substantial medical evidence under the Escobedo standard. To do this:

- Identify specific portions of the report that lack medical reasoning or contradict the medical records
- Present alternative evidence, such as a detailed report from your treating physician
- Argue to the Workers' Compensation Judge (WCJ) that the treating physician's report is more persuasive

Under Willette v. Au Electric Corp., 69 Cal. Comp. Cases 1298 (WCAB 2004, en banc), a QME report does not automatically outweigh a treating physician's report — the judge decides which opinion is better supported.

Challenging Based on Procedural Violations

Under DPR Construction v. WCAB (McClanahan), 111 Cal. App. 5th 1136 (2025), if a QME report was not properly disclosed before the Mandatory Settlement Conference, you may move to exclude it from evidence. Procedural violations are not treated as harmless error.

Challenging Based on Bias (QME Only)

You may challenge a QME's neutrality only with objective evidence — not a mere feeling that the doctor is unfair. Valid grounds include a documented financial relationship between the QME and the insurance company, a pattern of consistently favoring one side, or procedural violations during the evaluation.

> ***Important: Challenging an AME report is much more difficult because both sides agreed to the doctor. The only grounds are fraud, a fundamental procedural defect, or a gross violation of applicable legal standards.***

Part 14: Risk Assessment and Strategic Considerations

This section helps you understand which situations create the most risk and which strategies are most likely to lead to a favorable outcome.

High-Risk Situations

These circumstances create a significant risk of an unfavorable outcome:

- Missing the 10-day deadline to request a QME panel specialty — the claims administrator can then choose the specialty

- Failing to strike an unfavorable doctor from the panel within the required timeframe — you may lose your ability to influence which doctor evaluates you
- Submitting incomplete or disorganized medical records without a proper § 4062.3 declaration — the doctor may refuse to review them
- Selecting the wrong medical specialty — a doctor outside the relevant area of expertise may produce an incomplete analysis
- Failing to submit written issue statements to the QME within allowed timeframes — the doctor may rely only on the claims administrator's version of disputed facts

Medium-Risk Situations

- Sending an advocacy letter that crosses the line into impermissible persuasion (violating the Maxham standard) — this could expose the report to a bias challenge
- Relying only on your treating doctor's report without getting a QME or AME evaluation — the other side may argue your doctor's opinion is not independent
- Requesting a supplemental evaluation after the 60-day window has passed — this may require a new panel and cause significant delays

Lower-Risk Situations (Favorable Conditions)

- Both sides agree in good faith on an AME with recognized expertise in your type of injury
- You submit well-organized medical records with proper declarations and accurate page counts
- Your written submissions to the QME clearly identify disputed issues without crossing into advocacy
- Your treating doctor provides supplemental reports that address apportionment, causation, and work limitations with specific medical detail

Choosing Between AME and QME

Consider pursuing an AME when:

- The claims administrator has been cooperative
- You can identify a doctor both sides will accept
- Your case does not require an urgent evaluation
- Your medical records are complete

Consider requesting a QME panel when:

- The claims administrator has been uncooperative or hostile
- You need a specialist in a specific area (for example, neurosurgery or psychiatry)
- You want the statutory protections of a neutral, state-selected evaluator
- Your case timeline allows for the 130+ day process

Consider a parallel approach when:

- Your claim involves significant money and the cost of two evaluations is justified
- You are negotiating for an AME but want a backup plan
- Complex injuries might benefit from two independent medical opinions

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Part 15: California's Exclusive Remedy Doctrine and Other Considerations

This section covers additional legal principles that affect your workers' compensation claim.

The Exclusive Remedy Doctrine

California law recognizes workers' compensation as the exclusive remedy for workplace injuries. This means that in most cases, you cannot sue your employer in regular civil court for a work injury — instead, your only option is the workers' compensation system. In exchange, your employer provides workers' compensation benefits regardless of who was at fault. This doctrine shapes the entire QME and AME process because these evaluations exist within this specialized system.

> ***Note: There are limited exceptions, such as injuries caused by a third party (someone other than your employer) or injuries resulting from your employer's intentional misconduct.***

QME Qualifications and Certification

To serve as a QME, a doctor must meet specific requirements under Cal. Lab. Code § 139.2 (https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=139.2.&lawCode=LAB):

- Be licensed to practice in California (as a physician, chiropractor, psychologist, dentist, acupuncturist, optometrist, or podiatrist)
- For MDs and DOs: be board-certified in a recognized specialty or have completed an accredited residency
- Complete 16 hours of training in disability evaluation report writing
- Pass a competency exam given by the DWC
- Complete at least 12 hours of continuing education every 24 months
- Maintain a clean disciplinary record

QMEs are appointed for two-year terms and must follow all DWC regulations.

Remote Evaluations

Under 8 Cal. Code Regs. § 46.3 (https://www.dir.ca.gov/t8/46_3.html), video evaluations are now permitted in some circumstances. Both parties should agree on whether a remote evaluation is appropriate for your situation.

Scheduling Location

The evaluation should take place at a location within reasonable geographic proximity to your residence. If the parties cannot agree, the DWC Medical Unit may designate the location.

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Legal Research Report: California Workers' Compensation Agreed Medical Evaluators and Qualified Medical Evaluators

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

Facilitated by: The Law Offices of Fernando Hidalgo, Inc.

March 1, 2026

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Comprehensive Legal Research Report: California Workers' Compensation Agreed Medical Evaluators and Qualified Medical Evaluators

Procedural Framework, Strategic Analysis, and Litigation Guidelines

Generated by: Legal AI Assistant | Date: March 1, 2026

Executive Summary

This comprehensive legal research report addresses the statutory framework, procedural mechanisms, evidentiary standards, and strategic considerations governing Agreed Medical Evaluators (AMEs) and Qualified Medical Evaluators (QMEs) in California workers' compensation claims. The distinction between AMEs and QMEs fundamentally shapes litigation strategy, timing, and outcome predictability in California's workers' compensation system, which processes approximately 1.2 million claims annually with QME involvement affecting a substantial majority of disputed medical-legal issues.[1][5] AMEs are physician-evaluators mutually selected by represented workers' attorneys and claims administrators under California Labor Code Section4062.2(a), while QMEs are state-certified physicians selected through mandatory panel procedures governed by Labor Code SectionSection4060-4064 and California Code of Regulations Title 8, Sections 1-159.[1][9][12] The AME process offers potentially faster resolution with mutually binding findings, whereas the QME process provides statutory neutrality safeguards for both unrepresented and represented workers when parties cannot agree on a single evaluator.[6][15] Key risk assessment factors include representation status (unrepresented workers cannot access AMEs), procedural deadlines (10-day panel selection windows, 30-day report deadlines), report compliance standards (substantial medical evidence requirements under Labor Code Section4628 and California Code of Regulations Section10682), and post-report remedies (supplemental evaluations, petitions to challenge findings, requests for record development). The strategic analysis presented here identifies medium-to-high likelihood of favorable outcomes when QME/AME evidence is properly prepared and presented, with material risks arising from missed deadlines, incomplete medical records submission, selection of inappropriate medical specialties, and inadequate response to adverse report findings.

Part I: Title and Overview

California Workers' Compensation AME and QME Reports: Statutory Framework, Procedural Requirements, Strategic Implications, and Litigation Guidelines

Purpose and Scope

This report provides comprehensive guidance on the legal, procedural, and strategic dimensions of Agreed Medical Evaluators (AMEs) and Qualified Medical Evaluators (QMEs) in California workers' compensation practice. The analysis covers the statutory and regulatory foundation, current legal landscape including recent appellate decisions, detailed procedural roadmaps for both represented and unrepresented workers, evidentiary standards, risk assessment frameworks, and appellate preservation strategies. The report emphasizes Northern California implementation details including San Francisco Immigration Court (note: this heading references the immigration law office personalization, but this report addresses workers' compensation matters outside that primary practice area), local procedural variations, and applicable federal/state law interactions where relevant.

Part II: Executive Summary (Expanded)

Key Findings

California workers' compensation law distinguishes sharply between two categories of medical-legal evaluators based on whether the injured worker has legal representation and whether both parties agree on a single evaluator.[9][15] An Agreed Medical Evaluator (AME) is available exclusively to represented workers under Labor Code Section4062.2(a) when the injured worker's attorney and the claims administrator or employer mutually agree on a physician to conduct the comprehensive medical evaluation without using the state's random panel selection process.[9][28] A Qualified Medical Evaluator (QME) is a state-certified physician selected through mandatory panel procedures under Labor Code SectionSection4062.1-4062.2 (depending on representation status) when parties cannot agree or when representation status precludes AME selection.[1][12][28] The weight accorded to each type of report differs significantly in litigation: AME findings are often characterized as "highly persuasive" or potentially binding on both parties due to mutual

selection, while QME findings carry substantial evidentiary value but remain non-binding opinions subject to judicial weighing alongside treating physician reports and other evidence.[24][63]

Risk Assessment (Qualitative Bands)

High-Risk Scenarios (Likelihood of Unfavorable Outcome: Medium-to-High)

The following circumstances create material risk of adverse QME/AME findings or procedural barriers to effective evaluation:

Missing the 10-day deadline to request a QME panel specialty (resulting in claims administrator's unilateral specialty selection)[6][19]

Failing to strike an unfavorable QME physician within the mandated striking period (resulting in loss of opportunity to exclude biased or unsuitable evaluator)[65]

Submitting incomplete, disorganized, or untimely medical records without proper Labor Code Section4062.3 declarations (resulting in QME refusal to review, incomplete evaluations, or payment denial)[31]

Selecting an inappropriate medical specialty for the disputed issues (resulting in QME outside relevant expertise, incomplete analysis)[56]

Failing to provide supplemental written submissions or advocacy letters within statutory timelines (resulting in QME reliance solely on claims administrator's framing of disputed issues)[46][49]

Medium-Risk Scenarios (Likelihood of Adverse Outcome: Medium)

Submitting advocacy letters to QME/AME that are objectionable (inflammatory, legally conclusory, advocating non-compliant ratings methodologies) without securing claims administrator agreement (exposing report to defense challenge for bias)[46][49]

Relying exclusively on treating physician reports without supplemental QME/AME evidence when treating physician findings conflict with claims administrator's position (QME/AME may weigh equally or find PTP report incomplete on statutory issues like apportionment)[24][27]

Requesting supplemental QME evaluations beyond the 60-day statutory window without proper agreement or valid cause (resulting in new panel requirement, delay, potential adverse specialist selection)[17][39]

Lower-Risk Scenarios (Likelihood of Favorable Outcome: Medium-to-High)

Engaging mutual agreement process to select AME when both parties demonstrate good-faith willingness to share selection authority (resulting in binding or highly persuasive findings acceptable to both parties)

Submitting comprehensive, well-organized medical records package with proper Section4062.3 declarations and page counts (enabling QME to conduct thorough, defensible analysis)

Providing written submissions to QME that identify specific disputed medical-legal issues, frame questions clearly, and avoid advocacy language or improper methodological arguments (resulting in focused, responsive evaluation addressing core disputes)

Securing treating physician collaboration in supplemental reports that address apportionment, causation, and functional limitations with medical specificity (resulting in QME/AME findings supported by multiple consistent sources)

Strategic Options Framework

Option 1: Pursue AME Agreement (Represented Workers Only)

Qualitative Risk Level: Low-to-Medium

Key Advantages:

Mutually binding findings reduce likelihood of subsequent disputes

Allows selection of physician with recognized expertise in specific injury type

Faster resolution than QME panel process (no striking period, no geographic limitation)

Both parties have reputational incentive to enforce agreement

Key Drawbacks:

Requires claims administrator good-faith participation; not available if claims administrator refuses

No guarantees that AME findings will be favorable; both parties equally bound

Eliminates ability to challenge report on grounds of bias (both sides agreed)

Strategic risk if claims administrator selects overly defense-friendly physician and applicant's counsel provides inadequate independent vetting

Option 2: Request QME Panel with Strategic Specialty and Striking Selection (All Workers)

Qualitative Risk Level: Medium

Key Advantages:

Available to all workers (represented and unrepresented)

Statutory safeguards against bias through random panel generation

Geographic proximity considered in panel generation

Clear procedures for requesting supplemental evaluations if needed

Key Drawbacks:

Longer timeline (panel generation, 10-day striking period, 90-day scheduling window, 30-day report deadline = minimum 130+ days)

Geographic limitations on physician selection may exclude specialists

Unrepresented workers lose control of specialty designation if they miss 10-day window (claims administrator chooses)

Three-physician panel may include physicians with limited or biased track records; striking process limits control

Option 3: Parallel Strategy (Represented Workers)

Qualitative Risk Level: Medium-to-High (depends on implementation)

Key Advantages:

Securing agreement in principle to AME while simultaneously requesting QME panel preserves optionality

Demonstrates good-faith attempt to resolve dispute if AME agreement fails

Creates pressure on claims administrator to complete AME selection promptly

Provides backup evaluation if AME process stalls

Key Drawbacks:

Duplication of evaluations increases costs and timeline

QME panel request may signal weakness if AME agreement is close to completion

Conflicting findings from AME and QME create new disputes requiring judicial resolution

Strategic risk of appearing non-cooperative if both processes proceed simultaneously

Decision-Making Framework for Selecting Strategy

Criteria for AME Pursuit (Option 1):

Claims administrator has demonstrated willingness to cooperate on other procedural issues

Injured worker has attorney with established relationship with claims administrator's counsel

Specific physician with recognized expertise in worker's injury type can be identified and mutually acceptable

Case timing permits delay for agreement negotiation (no urgent appeal deadlines)

Medical record documentation is comprehensive (no gaps requiring supplemental investigation)

Criteria for QME Panel Request (Option 2):

Claims administrator has been obstructive, uncooperative, or has previously selected adverse evaluators

Injured worker is unrepresented or attorney lacks cooperative relationship with defense

Specific disputed issues require narrow specialty expertise (cardiology, neurosurgery, psychiatry) with high priority

Geographic location limits available AME physicians

Timeline permits 130+ day process from request to report

Criteria for Parallel Strategy (Option 3):

High-value claim where cost of dual evaluations is justified

Significant evidentiary disputes likely to benefit from two independent assessments

Relationship with claims administrator is cooperative but past experience suggests AME agreement may not reach conclusion

Timeline permits extended process

Case settlement is not imminent

Part III: Legal Framework

A. Statutory Authority

California Labor Code Sections Governing Medical Evaluations

California Labor Code Section4060: Evaluations to Determine Compensability [44]

Labor Code Section4060 applies when an injured worker's claim has been denied and the compensability (work-relatedness) of the injury is disputed. The statute provides:

> If an employee is injured and the employer or insurer denies the claim, the employee may request a medical evaluation to determine whether the injury is compensable. The employer shall provide a form prescribed by the administrative director with which the employee may request an evaluation.

Under Section4060, either party may request a comprehensive medical evaluation (QME or AME) to resolve the disputed issue of whether the injury arose out of and occurred in the course of employment. The requesting party designates the medical specialty, and the evaluation must address causation-specifically, whether the employee's condition resulted from the claimed injury.[44]

California Labor Code Section4061: Evaluations Following Acceptance of Claim [44]

Labor Code Section4061 governs evaluations when a compensable injury has been accepted but medical-legal disputes remain regarding permanent disability ratings, future medical care needs, or work restrictions. The statute applies to:

Disputes over whether the employee has reached maximum medical improvement (MMI)

Disputes over the percentage of permanent disability rating

Disputes over whether future medical care is necessary

Disputes over work restrictions or accommodations

Importantly, Section4061 provides that for injuries on or after January 1, 1994, a QME evaluation is not required if both the claims administrator and the primary treating physician agree with the treating physician's final evaluation and that report is ratable (addresses all necessary components).[17][44]

California Labor Code Section4062: Evaluation Procedures for Disputes Under Section4060, Section4061, and Section4062 [20]

Labor Code Section4062 establishes baseline procedures for requesting and selecting medical evaluators when disputes arise under Section4060 or Section4061. The statute requires that parties first attempt to agree on an evaluator (termed an "Agreed Medical Evaluator" under Section4062.2 for represented workers) before requesting a panel of QMEs. If agreement cannot be reached within 10 days of the initial request for evaluation, either party may request a QME panel.

California Labor Code Section4062.1: Panel Selection Procedures for Unrepresented Workers [19]

Section 4062.1 governs QME panel selection when an injured worker is not represented by an attorney. The statute provides:

Within 10 days of receiving a QME panel, the unrepresented worker must select a QME and arrange an appointment

If the worker fails to select within 10 days, the claims administrator may select from the remaining panel members

The QME must conduct an evaluation within 90 days of the panel request

The unrepresented worker receives the complete report and the claims administrator or employer

Critically, under Section4062.1(c), the unrepresented worker or the claims administrator initiates the panel request and designates the specialty. If the worker does not submit the request within the statutory window, the claims administrator retains the right to request and designate specialty.[19][44]

California Labor Code Section4062.2: Panel Selection Procedures for Represented Workers [3]

Section 4062.2 applies exclusively to represented workers (those with attorney representation). The statute provides a two-stage process:

Stage 1: Agreed Evaluator Attempt (10-20 Days)

If parties cannot agree on an Agreed Medical Evaluator within 10 days of the initial request, with a possible extension of up to 20 additional days by agreement, either party may proceed to Stage 2.

Stage 2: QME Panel Selection (striking process)

The requesting party submits a QME panel request to the Administrative Director

The Administrative Director issues a three-member panel of QMEs in the requested specialty

Within 10 days of panel issuance, each party may "strike" (reject) one QME name

The remaining QME serves as the evaluator and must conduct the evaluation and issue a report within 30 days

Critically, Section4062.2(c) provides that "[i]f a party fails to exercise the right to strike a name from the panel within three working days of gaining the right to do so, the other party may select any physician who remains on the panel to serve as the medical evaluator."[3][65]

California Labor Code Section4062.2(d): Appointment Responsibility [3]

Section 4062.2(d) assigns the responsibility for scheduling the QME appointment to the represented employee or the employee's attorney. The statute provides: "The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment

within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements."

This provision has significant strategic implications: an applicant's failure to schedule promptly may result in the employer scheduling at an inconvenient location or time, or the employer obtaining scheduling advantage by controlling the appointment logistics.[3][58]

California Labor Code Section4063: Consultations and Follow-Up Evaluations [34]

Labor Code Section4063 permits a QME to request consultation from other physicians when the QME believes additional medical expertise is necessary. The QME's ability to consult specialists is particularly important in multi-system injuries or complex neurological or psychological conditions. The costs of consultation are typically borne by the claims administrator.[44]

California Labor Code Section4062.3: Information and Communication with Evaluators [34][46]

Labor Code Section4062.3 establishes strict protocols for submitting information and medical records to QMEs and AMEs. The statute distinguishes between "information" (substantive medical records and documents) and "communication" (scheduling, administrative matters):

Information (substantive medical records, diagnostic reports, prior medical-legal evaluations) must be served on the opposing party 20 days before submission to the evaluator

The opposing party has 10 days to object to the information

If no objection is timely filed, the information may be submitted to the evaluator

Communication (scheduling, availability) may be submitted to the evaluator concurrently with notice to the opposing party

Critically, QMEs and AMEs may refuse to review or may not bill for review of medical records that lack proper Section4062.3 declarations stating the number of pages and confirming compliance with the statute.[31][34][46]

California Labor Code Section4628: Physician's Responsibility for Medical-Legal Reports [28]

Labor Code Section4628 establishes that only the physician who personally conducts the evaluation may prepare the medical-legal report. The statute prohibits delegation of substantive report preparation to non-physician staff. The physician must personally sign the report under penalty of perjury and attest to having personally performed all non-clerical work.[25][28]

California Labor Code Section4663: Apportionment of Permanent Disability [10]

Labor Code Section4663 imposes mandatory apportionment analysis on QME and AME reports addressing permanent disability. The statute provides:

Apportionment of permanent disability shall be based on causation

A physician must determine what approximate percentage of permanent disability was caused by the industrial injury and what percentage was caused by other factors (pre-existing conditions, prior injuries, natural progression of disease)

In order for a physician's report to be complete on the issue of permanent disability, it must include an apportionment determination

A report that does not include an apportionment determination may be returned to the physician for correction

The apportionment requirement applies regardless of whether the evaluator believes apportionment is medically appropriate; failure to address apportionment renders the report incomplete.[10][29]

B. Regulatory Framework

California Code of Regulations Title 8 (Division of Workers' Compensation Regulations)

8 Cal. Code Regs. Section1: Definitions [9]

Section 1 defines key terms applicable to QME/AME practice, including:

"Qualified Medical Evaluator (QME)": a physician licensed by the appropriate licensing body for the state of California and appointed by the Administrative Director pursuant to Labor Code Section139.2

"Agreed Medical Evaluator (AME)": a physician selected by mutual agreement between the claims administrator and a represented employee

"Agreed Panel QME": a QME selected from a panel through agreement rather than striking (applies only to panels issued prior to January 1, 2013)

"Comprehensive Medical-Legal Evaluation": a medical evaluation performed pursuant to Labor Code SectionSection4060-4062 meeting the requirements of 8 Cal. Code Regs. Section9793(c)

"Physician's office": a bona fide office facility identified by street address and containing usual and customary equipment for evaluation

8 Cal. Code Regs. Section30: QME Panel Request Procedures [2][2][2][2]

Section 30 establishes detailed procedures for requesting QME panels, differentiating between unrepresented and represented cases:

For Unrepresented Cases:

The request must be submitted on QME Form 105 (Request for Qualified Medical Evaluator Panel-Unrepresented Employee)

For Section4060 disputes (compensability), the requesting party must attach the claims administrator's notice that the claim was denied or a request for compensability evaluation

For Section4061/Section4062 disputes (permanent disability/future care), if the claims administrator is requesting, it must attach a written objection identifying the primary treating physician, the date of the report being objected to, and the description of the medical determination requiring evaluation

If the form is incomplete, it is returned with explanation of deficiencies

The Medical Director may delay panel issuance pending receipt of additional required information

For Represented Cases (effective October 1, 2015):

All panel requests must be submitted electronically through the DWC website (www.dwc.ca.gov)

The requesting party must identify all required elements including the specialty designation and the disputed issue

The requesting party must print and serve a paper copy of the online request, the panel list, and supporting documentation on the opposing party with proof of service within one working day of generating the QME panel list

Failure to provide proper service may result in panel invalidation, as established in recent case law[20]

Each party has 10 days from service of the panel to strike one QME name

8 Cal. Code Regs. Section36: Service of Comprehensive Medical-Legal Evaluation Reports [22]

Section 36 establishes reporting requirements and service procedures:

For Represented Workers:

The QME/AME must serve the comprehensive medical-legal report on the injured worker, the worker's attorney, and the claims administrator using QME Form 122 (AME or QME Declaration of Service of Medical-Legal Report)

Service must be effected by mail, overnight delivery, or personal service

For Unrepresented Workers with Permanent Disability or Apportionment Findings:

The QME must serve the report with a separator sheet and document cover sheet

The QME must serve on the unrepresented worker and the claims administrator

The QME must simultaneously serve on the local DWC Evaluation Unit

8 Cal. Code Regs. Section38: Medical Evaluation Time Frames and Extensions [39]

Section 38 establishes mandatory deadlines:

Initial comprehensive medical-legal evaluation reports must be completed within 30 days after the QME/AME has examined the employee or commenced the evaluation procedure

Extensions of up to 30 days may be granted if the evaluator has not received test results or consulting physician reports necessary to address all disputed issues

Extensions of up to 15 days may be granted for "good cause" (medical emergencies, death in family, natural disasters)

All extension requests must be submitted using QME Form 112 at least 5 days before the deadline

If a report is late without extension approval, either party may request a replacement panel

For supplemental reports, the deadline is 60 days from the date of written request, with possible 30-day extension by mutual agreement.[39]

8 Cal. Code Regs. Section139.2: Qualified Medical Evaluator Appointment and Discipline [1]

Labor Code Section139.2 (implemented through Title 8 regulations) establishes qualifications, appointment procedures, and discipline standards for QMEs:

Qualifications for Appointment:

Must be licensed to practice in California (MD, DO, DC, psychologist, acupuncturist, dentist, optometrist, podiatrist)

For MDs/DOs: must be board certified in a specialty recognized by the Administrative Director, have completed an accredited residency program, or have been an active QME as of June 30, 2000

For chiropractors: must be certified in California workers' compensation evaluation by an approved provider

All physicians must complete 16 hours of training in disability evaluation report writing before appointment

All physicians must pass a competency examination administered by the Administrative Director

Reappointment Requirements:

Must comply with all applicable regulations and evaluation guidelines

Must complete at least 12 hours of continuing education in impairment evaluation or workers' compensation evaluation within the previous 24 months

Must not have been suspended, terminated, placed on probation, or disciplined by the Administrative Director during the previous term

Must timely pay fees required by the Administrative Director

Must not have had professional license suspended or revoked

8 Cal. Code Regs. Section9793: Comprehensive Medical-Legal Evaluation Standards [9]

Section 9793 establishes detailed standards for QME/AME report content, including:

The report must address all disputed medical-legal issues raised by the requesting party or party initiating the dispute

The report must include causation analysis (whether the condition resulted from the industrial injury)

The report must include apportionment determination (Labor Code Section4663) when permanent disability findings are made

The report must include impairment rating using the AMA Guides to the Evaluation of Permanent Impairment (5th Edition)

The report must include functional restrictions and work limitations

The report must include opinion regarding future medical care needs

For psychiatric injuries, the report must include percentage of causation determination (Labor Code Section4660.1)

The report must set forth the reasoning for all conclusions, not merely conclusory statements

8 Cal. Code Regs. Section10682: Physicians' Reports as Evidence [26]

Section 10682 (formerly Section10606) establishes evidentiary standards for medical reports in WCAB proceedings:

Medical reports should include: date of examination, history of injury, patient complaints, listing of all information reviewed, patient medical history, findings on examination, diagnosis, opinion regarding extent and duration of disability and work limitations, cause of disability, treatment indicated (past, present, and future), opinion regarding permanent disability and whether stationary, apportionment of disability, and reasons for the opinion

All medical-legal reports must comply with Labor Code Section4628 (physician responsibility)

Failure to comply with these requirements will not render a report inadmissible but will be considered in weighing the evidence

C. Key Case Law

Board of Immigration Appeals Precedent (Note: This is Workers' Compensation, Not Immigration Law)

The phrase "Board of Immigration Appeals" in the system prompt instructions does not apply to this workers' compensation legal analysis. Instead, the relevant binding appellate authority consists of California appellate courts and the Workers' Compensation Appeals Board (WCAB).

California Supreme Court Decisions

Brodie v. WCAB, 40 Cal.4th 1313 (2007) [29]

In Brodie, the California Supreme Court established the foundational standard for apportionment analysis under Labor Code Section4663. The court held that:

Apportionment must be based on causation of disability (not causation of injury)

Multiple causes frequently interact to cause permanent disability

Apportionment can be made to pre-existing pathology, prior injuries, and natural progression of disease

Physicians must provide an opinion on what percentage of the permanent disability is attributable to the industrial injury and what percentage is attributable to other factors

Apportionment is a legal requirement that physicians must address; failure to apportion renders a report incomplete

The Brodie standard requires that physicians apply correct legal principles when opining on apportionment. A medical opinion that refuses to accept correct legal principles does not constitute substantial medical evidence.[29]

Escobedo v. Marshalls, 70 Cal. Comp. Cases 604 (WCAB 2005) [48]

In Escobedo, the WCAB en banc decision established the sequential analysis for substantial medical evidence on apportionment issues. The court held that:

To be substantial evidence on apportionment percentages, a medical opinion must be framed in reasonable medical probability

The opinion must not be speculative; it must be based on pertinent facts and adequate examination and history

The opinion must set forth reasoning in support of conclusions

The physician must disclose familiarity with concepts of apportionment, describe the exact nature of apportionable disability in detail, and set forth the basis for the opinion

The Escobedo standard remains the controlling precedent for assessing QME/AME apportionment analysis.[29][48]

California Court of Appeal Decisions

DPR Construction v. WCAB (McClanahan), 111 Cal.App.5th 1136 (2025) [40][40]

In this 2025 decision (published June 11, 2025), the Third District Court of Appeal clarified standards for credibility findings and strict enforcement of discovery closure rules under Labor Code Section5502. The court held:

Labor Code Section5313 does not require detailed explanations of credibility findings beyond ultimate facts and evidence relied upon

Discovery closure rules under LC Section5502 are strictly enforced; violations are not subject to harmless error analysis

Failure to comply with mandatory settlement conference (MSC) discovery closure requirements requires remand for redetermination, even if the improperly admitted evidence might not have been sole basis for decision

When a QME report is admitted in violation of discovery rules, the procedural violation may require exclusion of the report or remand for reconsideration

This decision is significant because it imposes strict enforcement of procedural requirements for admitting QME/AME reports and establishes that procedural violations cannot be excused as harmless error.[40][40]

Lopez v. Rockstar Staffing, Inc., 2023 Cal.Wrk.Comp.P.D. LEXIS 199 (2023) [20]

In Lopez, the WCAB held that a QME panel was invalid for failure to comply with California Code of Regulations Section30(b)(1)(C), which requires that the party requesting a QME panel online must "print and serve a paper copy of the online request, the panel list, and a copy of any supporting documentation that was submitted online, upon the opposing party with a proof of service, within 1 (one) working day after generating the QME panel list."

The defendant requested a QME panel on January 9, 2023, and one was issued the same day. However, the defendant did not serve the panel until January 13, 2023, and failed to include the documentation submitted online. The WCAB rescinded the WCJ's decision, finding the panel invalid for failure to strictly comply with the timing and documentation requirements. This decision imposes strict procedural compliance on panel request service.[20][65]

Gamez v. Full Steam Staffing, 2018 Cal.Wrk.Comp.P.D. LEXIS 282 (2018) [65]

In Gamez, the WCAB held that when an applicant fails to timely strike a QME from a panel and the defendant also fails to formally notify the applicant that it is striking that same doctor and selecting another, the applicant retains the right to schedule an appointment with the doctor he has selected, making that doctor the operative QME. The decision clarifies that failure to strike does not automatically result in loss of control; rather, the party that timely struck may select from remaining physicians, but this selection must be affirmatively communicated.[65]

Scribner v. Rosewood Miramar Hotel, 2025 Cal.Wrk.Comp.P.D. LEXIS 13 (2025) [65]

In this recent 2025 decision, the WCAB clarified the consequence of untimely striking. The defendant timely struck one QME, but the applicant failed to strike by the deadline. The defendant then selected a different QME and sought to establish that selection as binding. The WCAB held that because the applicant's strike was untimely, the defendant had the right to select any remaining physician as the QME. However, the court emphasized that this right must be exercised proactively by notification; mere selection without communication does not establish the chosen QME if the applicant subsequently schedules with another doctor on the panel.[65]

Workers' Compensation Appeals Board Decisions

Maxham v. Cal. Dept of Corr. & Rehab., 82 CCC 136 (WCAB 2017, en banc) [49]

In Maxham, the WCAB en banc decision established standards for advocacy letters submitted to QMEs. The court held:

Advocacy letters to QMEs must not include inflammatory language, improper legal theories, or attempts to persuade the QME to deviate from applicable legal standards

Applicant's counsel may identify specific factual issues and ask the QME to consider particular evidence, but cannot argue that the QME should adopt specific conclusions or methodologies contrary to applicable law

Objectionable advocacy letters may provide grounds for excluding the QME report if the objecting party timely objects and the advocate's letter is submitted despite the objection

The QME retains independent obligation to apply correct legal standards regardless of advocacy letters

The Maxham standard permits defense counsel to challenge advocacy letters that exceed appropriate bounds and potentially exclude reports based on claimed bias induced by improper advocacy.[49]

Power v. WCAB, 51 CCC 114 (Court of Appeal 1986) [24]

In Power, the court established the principle that AME findings are presumptively entitled to controlling weight. The court stated:

> We begin by presuming that the agreed medical evaluator has been chosen by the parties because of his expertise and neutrality. Therefore, his opinion should ordinarily be followed unless there is good reason to find that opinion unpersuasive.

This principle establishes that AME reports carry heightened evidentiary weight compared to QME reports or treating physician reports, as both parties have voluntarily selected the evaluator.[24]

Willette v. Au Electric Corp, 69 CCC 1298 (WCAB 2004, appeals board en banc) [24]

In Willette, the WCAB established that QME reports do not automatically trump treating physician reports when the two conflict. The court held:

> When faced with differing medical opinions from the Panel QME, the treating physician, and the utilization review physician on the issue of whether prescribed treatment is reasonably required to cure or relieve the effects of the employee's injury, the WCJ or Appeals Board need not rely on the opinion of a particular physician.

This principle prevents QME reports from being given automatic precedence over PTP reports and requires fact-specific analysis of which report is more persuasive and better supported by substantial medical evidence.[24]

Part IV: Current Legal Landscape

Recent Developments (Last 90 Days and Current as of March 1, 2026)

Significant WCAB Decisions (2025-2026)

Daniel Linstad v. City of Richmond, ADJ20141060 (WCAB 2025) [21]

In this October 2025 decision, the WCAB addressed the proper application of the AMA Guides when a physician attempts to use analogy to rate permanent impairment. The defendant's IME (not QME) opined to a rating for low back injury by analogy to a hernia injury with concomitant loss of lifting capacity. The WCAB affirmed the WCJ's reliance on the AME's more detailed analysis, holding that even when an evaluator is an AME (as opposed to QME), the opinion must still meet substantial medical evidence standards. The decision emphasizes that both QMEs and AMEs must demonstrate how and why medical evidence supports the rating, staying within the "four corners" of the AMA Guides unless proper rebuttal analysis is provided under the Almaraz/Guzman framework.[21][75]

Edwar Vanegas Gerena, ADJ14789657 (WCAB 2025) [42]

In this July 2025 decision, the WCAB addressed the intersection of QME findings and vocational evidence in determining permanent and total disability. The court held that even when QME and AME reports apportion disability to non-industrial factors, the WCJ may consider vocational evidence regarding the applicant's amenability to rehabilitation. However, the court emphasized that the medical apportionment determination must still be considered; the vocational expert cannot simply disregard apportionment percentages.[42]

Lacadia Hartman v. VITAS Healthcare Corporation, ADJ20774534 (WCAB 2025) [54]

In this October 2025 decision, the WCAB addressed improper service of settlement documents and failure to disclose utilization review authorization prior to settlement. The applicant agreed to a Compromise and Release without knowledge that the insurance company had received UR authorization for shoulder surgery. The court held that settlement agreements can be set aside when parties lack material information and emphasizes the importance of full disclosure of all medical determinations and authorizations before settlement. This decision underscores the risk that QME/AME reports or medical decisions may be rendered moot by premature settlement.[54]

Oscar Villalobos, ADJ2913113 (WCAB 2025) [51]

In this 2025 decision, the WCAB addressed the consequences when an AME report is found to lack substantial medical evidence. The WCJ determined that the AME's reports did not constitute substantial medical evidence, and therefore suspended proceedings for failure to submit to reexamination. The WCAB reversed, holding that deficient medical reports should not automatically result in suspension of proceedings; rather, the appropriate remedy is to continue the case and allow development of the record through supplemental evaluations or expert testimony. The decision clarifies that procedural consequences must account for due process and full evidentiary record development.[51]

Jeanette Atilano, ADJ12300876 (WCAB 2023) [77]

In this 2023 decision (still controlling), the WCAB addressed the admissibility of QME reports when a worker objects to the evaluator based on cultural, language, or procedural fairness grounds. The court held that when a QME report lacks substantial medical evidence (the physician failed to adequately assess conditions due to procedural defects), the report may be excluded and an alternative evaluation obtained. The decision emphasizes that QME neutrality is achieved through substantive, fair evaluation processes, not merely through panel randomization.[77]

Federal Register Notices and Regulatory Updates

As of March 1, 2026, there are no pending Federal Register notices directly affecting California QME/AME procedures. However, practitioners should monitor the following sources for potential updates:

Federal Register notices related to federal worker classification changes (affecting whether workers are covered by federal OSHA or state workers' compensation)

Updates to Medicare Secondary Payer (MSP) rules affecting Medicare Set-Aside calculations for workers' compensation settlements (relevant when QME/AME reports establish ongoing medical needs)

USCIS/EOIR Policy Updates (Not Applicable)

This analysis is workers' compensation law; USCIS and EOIR are immigration agencies and do not regulate California workers' compensation procedures.

AILA Practice Advisories (Not Applicable)

AILA (American Immigration Lawyers Association) advisories do not apply to workers' compensation matters outside immigration law context.

Ninth Circuit Precedent (Controlling in Northern California)

The Ninth Circuit Court of Appeals does not have direct jurisdiction over workers' compensation matters, as these are state law issues. However, the Ninth Circuit applies federal constitutional principles to workers' compensation proceedings when constitutional issues arise (e.g., due process, equal protection challenges to state workers' compensation laws). Federal habeas corpus authority is limited in workers' compensation contexts except in cases involving fundamental constitutional violations.

District Court Injunctions Affecting Northern California

No current district court injunctions affecting California QME/AME procedures have been identified as of March 1, 2026. Practitioners should monitor Northern District of California (NDCal) and Central District of California (CDCal) dockets for potential challenges to:

Apportionment statutes under equal protection grounds

QME panel selection procedures under due process challenges

Restrictions on AME selection under equal protection or due process claims

Ninth Circuit and Fifth Circuit Circuit Splits

This is not applicable to workers' compensation AME/QME law, as workers' compensation is exclusively state-regulated. However, practitioners should be aware that federal benefits (Social Security Disability, Federal Employee Workers' Compensation) use different evaluator standards that may influence state law interpretation in some contexts.

California State Law Interactions

State Criminal Law Impact on Workers' Compensation Eligibility

While this report focuses on AME/QME procedures, practitioners should be aware that California state criminal law modifications may affect workers' compensation claims:

Penal Code Section1473.7 (Conviction Modification for Immigration Consequences): Though primarily an immigration statute, criminal conviction modifications under PC 1473.7 may affect workers' compensation eligibility if a conviction was the basis for claim denial or benefit reduction

Penal Code Section1203.43 (Post-Conviction Relief): Allows relief from conviction consequences; may affect workers' compensation claims if conviction-based disqualification is involved

California's Workers' Compensation Exclusive Remedy Doctrine

California recognizes workers' compensation as the exclusive remedy for workplace injuries (with limited exceptions for third-party liability). This doctrine affects QME/AME practice because employers receive immunity from civil suit in exchange for providing workers' compensation benefits.[62]

Part V: Definitions and Distinctions Between AMEs and QMEs

A. Qualified Medical Evaluator (QME) Definition and Role

A Qualified Medical Evaluator (QME) is a state-certified physician, dentist, psychologist, acupuncturist, chiropractor, optometrist, or podiatrist appointed by the California Division of Workers' Compensation (DWC) to provide neutral, independent medical-legal evaluations in workers' compensation disputes.[1][9][12] QMEs are selected through mandatory state panel procedures when the injured worker and claims administrator cannot agree on an evaluator, or when representation status precludes AME selection (unrepresented workers).[1][6][12] The QME's role is to evaluate the injured worker, review all relevant medical records, and issue an objective medical-legal opinion addressing the disputed medical-legal issues-

including causation, permanent disability rating, need for future medical care, work restrictions, and apportionment of disability to non-industrial factors.[8][11]

QMEs function as neutral experts appointed by the state rather than selected by either party. To qualify as a QME, a physician must pass a rigorous competency examination administered by the DWC at least twice annually, complete 16 hours of instruction in disability evaluation report writing covering the AMA Guides to the Evaluation of Permanent Impairment (5th Edition), anti-bias training, California workers' compensation law, and apportionment principles, and meet ongoing continuing education requirements (12 hours minimum every 24 months in impairment evaluation or workers' compensation-specific medical-legal evaluation).[1][11][79] QMEs are appointed by the DWC for two-year terms and must comply with all DWC regulations and evaluation guidelines, including mandatory report submission timelines (30 days), content standards (substantial medical evidence, reasoning disclosed, apportionment addressed), and service requirements (proper declaration of service to all parties).[1][11]

B. Agreed Medical Evaluator (AME) Definition and Role

An Agreed Medical Evaluator (AME) is a physician (or other licensed healthcare provider) selected by mutual agreement between an injured worker's attorney and the claims administrator or employer to conduct the comprehensive medical-legal evaluation without using the state's random QME panel selection process.[9][15][28][63] AMEs are available exclusively to represented workers under California Labor Code Section4062.2(a); unrepresented workers cannot use AMEs and must proceed with QME panels.[9][19][33][63] An AME does not need to be DWC-certified as a QME; the only requirement is that both parties consent to the physician's selection.[63] Many physicians who serve as AMEs are also certified QMEs, but this is not mandatory.[63]

The AME's role is identical to the QME's role: to evaluate the injured worker, review relevant medical records, and issue an objective medical-legal opinion on disputed medical-legal issues. The critical distinction is the selection process (mutual agreement vs. state panel) and, consequently, the evidentiary weight typically accorded to AME findings. Because both parties have voluntarily selected the AME, courts presume both parties trust the evaluator's expertise and neutrality, and thus AME findings are often characterized as "highly persuasive" and may be binding on both parties if both sides previously agreed to accept the AME's determination.[24][33][63]

C. Key Distinctions: AME vs. QME

| Characteristic | QME | AME |

|---|---|---|

| Availability | All workers (represented and unrepresented) | Represented workers only (requires attorney) |

| Selection Process | State-issued panel; parties strike one each | Mutual agreement between parties |

| Certification Requirement | Must be DWC-certified QME; pass exam, 16-hour training, continuing education | No DWC certification required; no state exam |

| Specialty Designation | Limited to state-recognized QME specialties | No limitation; parties may agree on any licensed physician |

| Geographic Limitation | Panel members selected based on worker's zip code | No geographic limitation; parties may select from anywhere |

| Timeline | Minimum 130+ days (panel request, 10-day striking, 90-day scheduling, 30-day report) | Typically 10-20 days to reach agreement; then 30-day report deadline |

| Cost | State-set fee schedule; cannot negotiate | Parties may negotiate fees; often higher than QME fees |

| Evidentiary Weight | Substantial evidence; weighed against PTP and other evidence; non-binding | "Highly persuasive"; often binding on both parties due to mutual selection; may supersede conflicting PTP reports |

| Appeal/Challenge Rights | Party may seek supplemental evaluation, request new panel, file petition challenging report; report subject to standard of review | Limited appeal rights due to mutual agreement; both sides bound by agreement to accept findings |

| Bias Challenge | May challenge on grounds of improper selection, conflict of interest, or non-compliance with regulations | May not challenge based on bias (both sides agreed); may only challenge if fraud or fundamental procedural defect |

| Confidentiality | Public record subject to WCAB and court review | May be subject to confidentiality agreement between parties |

D. Practical Implications of the AME vs. QME Distinction

For Represented Workers:

Represented workers must make a strategic decision early in the case regarding AME versus QME. If there is reasonable likelihood of AME agreement with the claims administrator (based on prior cooperation, straightforward dispute, strong evidentiary record), pursuing AME selection offers significant advantages: faster resolution (10-20 days to agreement vs. 130+ days for QME), specialist selection without geographic limitation, and highly persuasive findings that both parties have already committed to accept.[24][33] Conversely, if the claims administrator is hostile, uncooperative, or has previously selected unfavorable evaluators, QME panel selection may provide better neutral ground and statutory protections against bias.[1][6]

For Unrepresented Workers:

Unrepresented workers have no choice regarding AME; they must proceed with QME panels.[19][44] However, unrepresented workers retain critical strategic control over the specialty designation (within 10 days of receiving the request form) and the striking decision (selecting one of three panel QMEs). Missing these 10-day windows results in loss of control to the claims administrator.[6][19]

Strategic Timing Considerations:

The choice between AME and QME has implications for case timeline and settlement posture. AME selection accelerates toward settlement within 6-8 weeks (20 days to agreement + 30 days for report + 14 days for review = ~64 days). QME selection extends timeline to 4-5 months minimum, during which other discovery, treating physician reports, and medical treatment continue. This timing difference affects:

Whether temporary disability (TTD) benefits remain payable during the evaluation period

Opportunity for worker to continue treatment and demonstrate improvement before evaluation

Accumulation of additional medical records and evidence supporting worker's position

Worker's financial ability to withstand extended litigation timeline

Part VI: Procedural Framework for QME Selection and Management

A. Timeline and Deadlines for QME Panel Request and Selection

Step 1: Initiation of Dispute (Day 0 to Day 10)

Represented Workers:

Either the injured worker's attorney or the claims administrator may initiate a medical dispute under Labor Code Section4060 (compensability), Section4061 (permanent disability/future care), or Section4062 (other medical-legal issues) by sending a written request to the other party requesting agreement on a medical evaluator.[3][6][20]

Day 0: First party sends written request for medical evaluation, proposing one or more specific physicians (Agreed Medical Evaluator candidates)

Day 10: Deadline for second party to agree on an evaluator; if agreement not reached, parties may agree to extend period up to 20 additional days

Unrepresented Workers:

The injured worker or claims administrator submits QME Form 105 directly to the DWC Medical Unit. The unrepresented worker has 10 days from receiving the request form (sent by certified mail or personal delivery by claims administrator) to submit the form.[19][44]

Day 0: Claims administrator provides QME Form 105 to unrepresented worker by certified mail or personal delivery

Day 10: Deadline for unrepresented worker to submit completed form to DWC Medical Unit and request panel; if worker misses deadline, claims administrator may request panel and designate specialty

Step 2: QME Panel Request (Day 10-20 for Represented; Day 10-30 for Unrepresented)

Represented Workers:

If parties cannot agree on an AME within 10 days (or extended period up to 20 days), either party submits a panel request electronically through the DWC website (www.dwc.ca.gov) using the online request form.[2][2][2]

The requesting party must identify:

The medical specialty of the evaluator

The disputed medical-legal issue (e.g., whether injury is work-related, permanent disability rating, causation of specific symptoms)

Relevant Labor Code section(s) (Section4060, Section4061, or Section4062)

Any supporting documentation (denial letters, medical records, prior reports)

The requesting party must then print and serve a paper copy of the online request, the panel list (once generated), and all supporting documentation on the opposing party with proof of service within one working day of generating the panel list.[2][2][2] Failure to comply with this service requirement may result in panel invalidation, as established in Lopez v. Rockstar Staffing, Inc.[20][65]

Unrepresented Workers:

The unrepresented worker submits QME Form 105 to the DWC Medical Unit by mail or in person. The form must identify:

The medical specialty requested (as of right for the worker; if claims administrator is requesting, the claims administrator may object to the specialty within 10 days)

The disputed issue and relevant Labor Code section

Supporting documentation (denial letter for Section4060 disputes; objection letter for Section4061/Section4062 disputes)

The DWC Medical Unit issues a panel within 20 working days of receiving a complete form.[19][17]

Step 3: QME Panel Issuance and Service (Day 20-25)

The DWC Medical Unit generates a three-member panel of QMEs in the designated specialty, selected at random from physicians with offices in the geographic area (typically defined by zip code) requested or appropriate to the case.[2][15][2]

The panel is served on all parties (injured worker, injured worker's attorney if represented, claims administrator, and employer).[2]

Step 4: QME Striking Period (Day 25-40 for Represented; Day 20-35 for Unrepresented)

Within 10 days of service of the panel, each party may "strike" (reject) one QME name, leaving one physician to serve as the evaluator.[3][6][19]

Critical Procedural Rules:

Only the party that receives the panel within the designated 10-day window has the right to strike

Failure to strike by the deadline means the other party may select any remaining physician as the QME[65]

Each party gets only one strike; a party cannot strike two physicians

A timely strike must be communicated in writing to the other party and to the DWC Medical Unit[2][3][65]

Striking must occur "within three working days of gaining the right to do so"; if the first party strikes on Day 25, the second party gains the right on Day 26 and must strike by Day 29[3]

Strategic Considerations in Striking:

In striking a QME, each party typically assesses:

The QME's prior decisions and reputation (whether known to favor applicant or defendant positions)

The QME's qualifications and experience with the specific injury type (detailed CV should be reviewed)

Geographic proximity (some parties prefer local evaluators; others want distance to avoid repeat relationships)

Conflict of interest (whether the QME has financial relationships, prior employment, or associations with counsel or parties)

Recent case law indicates that the WCAB will not issue a new panel merely because a party subjectively dislikes all three QMEs or suspects bias without objective evidence.[17]

Step 5: QME Selection and Appointment Scheduling (Day 40-140)

Once striking is complete, the remaining QME is the designated evaluator. The parties have 90 days from the date of the panel request to schedule and complete the evaluation appointment.[2][19][39][58]

For Represented Workers:

Labor Code Section4062.2(d) assigns initial responsibility to the injured worker's attorney to arrange the appointment and notify the employer within 10 days after the QME is selected.[3] If the attorney fails to notify the employer within 10 days, the employer may arrange the appointment and notify all parties.[3][58]

For Unrepresented Workers:

Labor Code Section4062.1 assigns initial responsibility to the injured worker to select the QME and arrange the appointment within 10 days of receiving the panel.[19] If the worker fails to do so, the claims administrator may select from the remaining physicians and arrange the appointment.[19]

Geographic Location of Evaluation:

Both parties must agree on the location of the evaluation within reasonable geographic proximity to the worker's residence.[2][58] If parties cannot agree, the DWC Medical Unit may designate location based on standard practice (typically near worker's residence, employer's location of injury, or worker's attorney's office for represented cases).[2][58] Remote (video) evaluations are now permitted under California Code of Regulations Section46.3.[58]

Step 6: QME Evaluation and Report Deadline (Day 140-170)

The QME must examine the injured worker and issue the comprehensive medical-legal report within 30 calendar days from the date of commencement of the examination.[39]

Extensions Permitted Under Section38:

Up to 30 days additional extension if the QME has not received necessary test results or consulting physician reports needed to address all disputed issues (requested at least 5 days before deadline)[39]

Up to 15 days additional extension for "good cause" (medical emergency, death in family, natural disaster)[39]

If no extension is requested or approved and the report is late, either party may request a replacement panel at no cost to the late-filing QME.[17][39]

Report Submission:

The QME serves the report on all parties (injured worker, attorney if represented, claims administrator/employer) using QME Form 122 (Declaration of Service) with proof of service.[22][52]

Step 7: Post-Report Objection and Supplemental Evaluation Period (Day 170-240)

Once the initial report is served, parties have 30 days to decide whether to accept the findings or request supplemental evaluation or objections.[17][56]

If a party disputes the report's findings or believes additional information is necessary, the party may request a supplemental evaluation from the same QME (preferred) or, if the QME is unavailable, request a new panel.[17][39]

Supplemental evaluation requests must be made within specific timeframes and with proper supporting documentation (new medical records, specific questions addressing deficiencies in initial report).[39]

B. Procedural Framework for Represented Workers: AME vs. QME Strategy

Option 1: Pursue AME Agreement (Fastest Timeline, 10-50 Days to Report)

Procedural Steps:

Initial Written Proposal (Day 0): Injured worker's attorney sends written request to claims administrator proposing one or more specific physicians as potential AMEs. The proposal should identify the physicians' credentials, workers' compensation experience, relevant subspecialties, and availability for expedited evaluation.

Negotiation Period (Days 0-10): Claims administrator responds with agreement or counter-proposal. If neither side proposes additional options, the 10-day period is used for good-faith negotiation.

Extension Option (Days 10-20): If near agreement but not yet final, parties may extend period up to additional 20 days by mutual agreement.[3]

Mutual Written Agreement (Day 10-30): Once parties agree on a specific physician, they execute a written agreement (not required by statute but recommended) identifying the AME, the specific disputed issues to be evaluated, the location and timeframe for evaluation, and (optionally) any agreement regarding report findings or fee structure.

Notice to AME and Medical Records Transmission (Days 30-35): Both parties notify the agreed-upon physician of selection and transmit all relevant medical records according to Labor Code Section4062.3 protocols (with proper declarations, 20-day notice to opposing party, objection window).

AME Evaluation (Days 35-50): The AME evaluates the injured worker. The timeline is more flexible than QME (no statutory 30-day deadline applies specifically to AMEs, though standard practice follows QME timeline of 30 days).

Report Service (Days 50-60): The AME issues and serves the comprehensive medical-legal report with proper declaration of service.

Risk Assessment for AME Strategy:

Low Risk: Claims administrator has demonstrated cooperation on previous cases, medial record documentation is complete, no urgent appeals pending

Medium Risk: Relationship with claims administrator is neutral; past experience suggests moderate cooperation; case involves complex medical issues requiring specialist expertise

High Risk: Claims administrator has been hostile, uncooperative, or has previously selected evaluators unfavorable to applicant; urgency requires immediate panel request rather than AME negotiation delay

Option 2: Request QME Panel (Longer Timeline, 130-170 Days to Report)

Procedural Steps:

Attempt AME Agreement (Days 0-10): Unless relationship with claims administrator is clearly adversarial, initial attempt to agree on AME is prudent strategic move. Even if AME agreement fails, this demonstrates good faith.

QME Panel Request (Days 10-15): If AME agreement not reached, submit panel request electronically with proper specialty designation and supporting documentation. Ensure proper service on claims administrator with proof of service within one working day.

QME Panel Service (Days 15-20): DWC Medical Unit generates and serves three-member panel.

Striking Preparation (Days 20-25): Obtain detailed information on all three QMEs, including prior decisions, known positions on apportionment, experience with worker's specific injury type, and any conflict of interest concerns. Prepare striking strategy identifying preferred QME and two acceptable alternatives.

Striking Decision (Days 25-40): Strike one unfavorable QME if present; work with claims administrator if possible to agree on top choice. Document striking rationale.

Appointment Scheduling (Days 40-130): Arrange evaluation appointment and manage medical records transmission with proper Labor Code Section4062.3 compliance.

QME Evaluation and Report (Days 130-170): QME examines worker and issues report.

Risk Assessment for QME Strategy:

Lower Risk: Claims administrator is uncooperative or has bad-faith history; worker requires evaluation by specialist not available as AME; case timeline permits extended discovery

Medium Risk: Both AME negotiation and QME panel are viable; case complexity suggests benefit of neutral evaluation process

Higher Risk: Urgent appeal deadlines approach; timeline does not permit 130+ day QME process; case settlement is imminent

Option 3: Parallel Strategy (Both Processes Simultaneously)

When Appropriate:

High-value claim where cost of dual evaluations is justified ($2,000-$4,000+ in evaluator fees)

Significant likelihood of appeal; dual expert opinions strengthen record

Claims administrator and applicant's counsel have cooperative but uncertain relationship

Complex multi-body-part injuries requiring comprehensive evaluations

Procedural Framework:

Initiate AME Negotiation (Day 0): Send detailed AME proposal with physician credentials and references, demonstrating serious good-faith interest in agreement.

Simultaneously Prepare QME Panel Request (Days 0-10): Begin gathering specialty information, reviewing potential QMEs, obtaining prior decision compilations, and preparing striking strategy.

Conditional QME Request (Days 10-15): If AME agreement not finalized, submit QME panel request as backup. Communicate to claims administrator that QME panel is being requested as contingency but remains open to AME agreement if negotiation continues.

Proceed with Preferred Process (Days 15-50): If AME agreement is reached, cancel QME panel request or coordinate to use QME panel physician as AME. If AME agreement fails, proceed with QME striking and scheduling.

Risk Assessment:

Medium-to-High Risk: Duplication of effort and cost if both processes proceed simultaneously; potential appearance of non-cooperation if QME request is made while AME negotiation is ongoing; conflicting findings if both reports are issued

Part VII: Medical Records Submission and Information Provision to Evaluators

A. Labor Code Section4062.3 Compliance Framework

Labor Code Section4062.3 establishes strict protocols for submitting medical records and information to QMEs and AMEs. Failure to comply with these requirements may result in:

QME/AME refusal to review improperly-submitted records

Denial of payment for record review services

Incomplete evaluations (if necessary records are excluded due to procedural defects)

Challenge to report's admissibility or weight due to incomplete record relied upon

Key Distinction: "Information" vs. "Communication"[34][46]

Labor Code Section4062.3 distinguishes between:

"Information" (substantive medical records, diagnostic studies, prior medical-legal reports, medical summaries prepared by parties) - must be served on opposing party 20 days before submission to QME/AME, with 10-day objection window

"Communication" (scheduling, administrative matters, routine inquiries about evaluator availability) - may be submitted concurrently with notice to opposing party (no advance notice required)

Procedural Requirements for Information Submission Under Section4062.3(b):

Identify all information to be provided (list by document title, date, and source)

Serve written identification of information on opposing party by mail, email, or personal delivery

Include statement that opposing party may object within 10 days

If opposing party objects timely, do not submit objected-to information unless resolved by agreement or court order

If no objection within 10 days, information may be submitted to evaluator

All information submitted must include proper Section4062.3 declaration stating the exact number of pages and certifying compliance with service requirements[31]

Practical Implementation:

When preparing medical records package for QME/AME submission:

Organize Records Chronologically: Arrange all medical records, diagnostic studies, imaging reports, and prior evaluations in chronological order.

Create Index/Cover Sheet: Prepare document identifying each record by source, date, type (e.g., "Dr. Smith medical report dated 3/15/2025, pages 1-5"), and page numbers.

Prepare Declaration: Draft declaration (separate document, not part of records package) stating:

Number of total pages being submitted

List of documents by title and date

Attestation that declaration complies with Section4062.3 requirements

Signature under penalty of perjury

Serve 20 Days in Advance: Send index and declaration to opposing party (certified mail recommended) at least 20 days before submitting to evaluator.

Allow Objection Period: Wait 10 days for any objections. If opposing party objects to specific documents, remove those documents or file motion to compel submission.

Submit to Evaluator: After 10-day objection period closes, submit complete records package with original Section4062.3 declaration attached.

Common Deficiencies Leading to Payment Denial or Exclusion:[31]

Improper page count (declaration states 200 pages but package contains 250)

Missing declaration entirely

Incomplete service (records submitted directly to evaluator without prior notice to opposing party)

Untimely submission (fewer than 20 days' advance notice to opposing party)

Vague documentation identification (e.g., "medical records" without dates or sources)

QMEs and AMEs may decline to bill for review of records lacking proper Section4062.3 declarations, as the billing code (MLPRR - Medical-Legal Record Review, typically $3 per page) requires that records be "received by" the evaluator with proper documentation.[31]

B. Advocacy Letters and Written Submissions to QMEs/AMEs

Parties may submit written advocacy letters or issue submissions to QMEs/AMEs identifying specific disputed issues, providing factual context, and requesting the evaluator to address particular questions. However, these submissions are subject to the Maxham standard established in Maxham v. Cal. Dept of Corr. & Rehab., 82 CCC 136 (WCAB 2017, en banc).[49]

Permissible Advocacy Letter Content:

Specific identification of disputed medical-legal issues (e.g., "Applicant disputes whether his low back injury is compensable; causation is the disputed issue")

Factual statements relevant to the dispute (e.g., "Applicant reported back pain immediately following the July 15, 2025 lifting incident at work")

Requests for evaluator to address specific questions (e.g., "Please specifically address whether the radiographic findings support the diagnosis of herniated disc")

References to relevant medical literature or guidelines (e.g., "AMA Guides 5th Edition Chapter 12 addresses spinal impairment rating")

Identification of factual inconsistencies in records (e.g., "Medical note dated 6/1 describes severe pain; medical note dated 6/5 reports minimal pain; please reconcile")

Impermissible Advocacy Letter Content (Maxham Standard):[49]

Inflammatory language attacking the other party's position or credibility

Statements that the evaluator "must" reach a specific conclusion (preordaining opinion)

Arguments that the evaluator should deviate from applicable legal standards (e.g., "the apportionment requirement of Labor Code Section4663 should not apply in this case")

Requests to use specific rating methodologies not authorized by AMA Guides (e.g., "rate this condition using analogy to a more favorable diagnosis")

Character attacks on applicant or defendant

Demands that the evaluator reject treating physician opinions without medical basis

Procedural arguments about WCAB or court precedent (evaluator's role is medical assessment, not legal interpretation)

Defense Counsel Strategy Regarding Objectionable Advocacy Letters:[49]

Under Maxham and subsequent case law, if applicant's counsel submits an objectionable advocacy letter:

Timely Object: Defense counsel sends written objection to applicant's counsel and to evaluator within 5-10 days, identifying specific impermissible content and requesting that objectionable portions not be considered.

Motion to Exclude: If applicant's counsel resubmits objectionable material after defense counsel's objection, defense counsel may file motion with WCAB seeking to exclude the resulting report due to claimed bias or improper influence.

Supplemental Explanation: Evaluator, if questioned, may be required to explain in supplemental report whether advocacy letter influenced opinions.

Defense Advocacy Letter: Defense counsel may submit counter-advocacy letter addressing evaluator directly about impermissible content and requesting evaluator to apply correct legal standards.

Best Practice: Issue Submissions Rather Than Advocacy Letters

To minimize risk of Maxham objections, experienced practitioners often reframe advocacy communications as "issue submissions" or "statements of disputed issues" that identify questions for the evaluator to address without attempting to persuade the evaluator toward a particular outcome. Example:

> Statement of Disputed Issues for QME Dr. Smith > > The parties agree that the following issues require comprehensive medical-legal evaluation: > > 1. Causation of lumbar spine injury: Was Applicant's lumbar spine injury caused by the July 15, 2025 work incident, or by pre-existing degenerative disc disease? > > 2. Apportionment of permanent disability: If permanent disability results from the lumbar spine injury, what percentage of that disability is attributable to (a) the work injury, (b) pre-existing degenerative changes? > > 3. Future medical care: Will Applicant require ongoing medical care for the lumbar spine, and if so, what types and frequency of care? > > The enclosed medical records are submitted for review in addressing these issues. Applicant requests that Dr. Smith address each issue with specific reference to objective medical findings and applicable diagnostic standards.

This framing identifies issues without crossing into advocacy or impermissible persuasion.

Part VIII: QME/AME Report Requirements and Evidentiary Standards

A. Mandatory Content Requirements Under California Law

California law establishes detailed mandatory content requirements for QME and AME reports. Failure to include required elements may render a report incomplete and subject to rejection or supplemental report requests.

Labor Code Section4628 Requirements: Physician Responsibility

Labor Code Section4628 establishes that:

Only the physician who personally signs the report may have prepared it

Delegation of substantive report preparation to non-physician staff violates the statute

The physician must personally perform all non-clerical work (clinical assessment, analysis, opinion formation)

The physician must sign the report under penalty of perjury attesting personal performance[25][28]

The statute exists to prevent "ghost-written" reports where physician's signature is applied to reports prepared by clerical staff or consultants without physician review.

California Code of Regulations Section9793 Requirements: Comprehensive Medical-Legal Evaluation Standards

Title 8, California Code of Regulations Section 9793 establishes comprehensive standards for QME/AME report content. Required sections include:

[1. Identification Information]

Injured worker's name, claim number, date of injury

Date of QME/AME evaluation

Evaluator name, medical license number, specialty

Evaluator's office address and contact information

[2. Records Reviewed]

Complete list of medical records, diagnostic studies, prior evaluations reviewed

Including dates and sources of each document

Statement of any records requested but not received

Declaration under penalty of perjury that records reviewed comply with Labor Code Section4062.3

[3. History of Injury and Medical Treatment]

Mechanism of injury: detailed description of how injury occurred, including activities, tools, equipment involved

Relevant prior medical history: prior injuries, pre-existing conditions, prior workers' compensation claims affecting the same body part

Treatment chronology: all medical providers seen, dates of treatment, diagnoses, procedures, medications

[4. Current Medical History and Symptoms]

Applicant's description of current symptoms, pain location and character, functional limitations

Relationship of current symptoms to date of injury

Statements regarding impact on activities of daily living, work activities, personal relationships

[5. Physical Examination Findings]

Vital signs if relevant

Inspection of affected area (visible deformity, scarring, atrophy, swelling)

Range of motion testing with specific measurements and comparison to normal

Orthopedic testing (if applicable): specific tests performed (McMurray, Lachman, Romberg, straight-leg raise, etc.) with results

Neurological examination: motor strength, sensory testing, reflexes, coordination

Provocative testing: if relevant to condition (e.g., Spurling test for cervical radiculopathy)

Special studies: if any imaging reviewed, interpretation of MRI, CT, X-ray findings

[6. Diagnosis and Clinical Assessment]

Primary work-related diagnosis with supporting medical evidence

Secondary diagnoses or conditions identified

Statement of concordance or discordance with prior diagnoses

Reconciliation of any inconsistencies in prior medical records

[7. Causation Analysis]

Whether applicant's condition was caused by the work injury (industrial injury is the cause)

Whether applicant's condition was aggravated or accelerated by the work injury (pre-existing condition made worse)

Medical reasoning supporting causation conclusion: specific mechanism of injury, biomechanics, exposure, temporal relationship between incident and symptom onset

Distinction between causation of injury and causation of disability (critical under Labor Code Section4663 apportionment standard)

Apportionment Determination (Labor Code Section4663)

Mandatory in all reports addressing permanent disability

Specific percentage attribution: e.g., "60% of applicant's permanent disability is caused by the industrial injury; 40% is caused by pre-existing degenerative disc disease"

Medical reasoning supporting percentages: how pre-existing conditions contributed, what evidence (imaging, medical records, examination) supports attribution

Identification of non-industrial contributing factors: age-related degeneration, prior injuries, natural progression of disease

Important: apportionment CANNOT be based on age, gender, or immutable characteristics; must be based on specific pathology or clinical findings

[9. Maximum Medical Improvement (MMI) Status

Whether applicant has reached maximum medical improvement (condition is stable, not likely to improve significantly with further treatment)

If not at MMI, what additional treatment or time period would likely result in MMI

Clinical indicators supporting MMI or non-MMI conclusion

[10. Impairment Rating (AMA Guides 5th Edition)

Whole Person Impairment (WPI) percentage using AMA Guides 5th Edition

Specific chapter and section of AMA Guides applied

Measurements supporting rating: range of motion, sensory loss, functional limitations

If pain component included, specific statement that pain does not exceed 3% WPI

Explanation of how medical findings translate to impairment rating

If using "Almaraz/Guzman" rebuttal methodology, explicit explanation of why strict AMA Guides application does not adequately reflect impairment and how alternative method is better supported by medical evidence

[11. Work Restrictions and Limitations

Specific restrictions on work activities: no lifting over 10 pounds, no climbing, no prolonged standing, etc.

Duration of restrictions: temporary or permanent

Description of types of work applicant is able to perform given restrictions (sedentary, light duty, modified, regular)

Whether applicant can return to regular occupation or requires modified/different work

[12. Future Medical Care Recommendations

Whether applicant requires ongoing medical treatment

Specific types of care: physical therapy, pain management, medication management, surgery, etc.

Frequency and duration of recommended care

Whether care is temporary or permanent/life-long

Consultation recommendations: whether applicant should see additional specialists

[13. Declaration and Signature

Declaration under penalty of perjury that report is truthful

Physician's signature, printed name, license number

Date of signature

Attestation that physician personally performed all non-clerical work

California Code of Regulations Section10682 (Evidence Standards for Medical Reports)

Title 8, California Code of Regulations Section 10682 identifies additional requirements for reports to be admissible as evidence and to receive evidentiary weight:

Report must comply with all Section9793 requirements

Report must comply with Labor Code Section4628 (physician responsibility)

Report must identify the cause of disability with specificity

Report must explain the physician's reasoning, not merely state conclusions

Reports failing to comply with these standards are not rendered inadmissible but are considered in weighing the evidence; deficiencies reduce weight and credibility

B. "Substantial Medical Evidence" Standard

QME and AME opinions are tested against the "substantial medical evidence" standard established in [Richardson v. Perales, 402 U.S. 389 (1971) and refined in Escobedo v. Marshalls, 70 Cal. Comp. Cases 604 (WCAB 2005).[48]

Substantial Medical Evidence Requires:[16][48]

Opinion framed in terms of reasonable medical probability (more likely than not; >50% likelihood), not possibility or speculation

Opinion based on accurate history and examination of the injured worker

Opinion supported by specific medical reasoning: physician must explain HOW and WHY the medical evidence supports the opinion

Opinion must address pertinent facts: physician cannot ignore inconsistencies or relevant prior medical history

Opinion must not be based on inadequate examination (cursory evaluation insufficient to address complex issues)

Opinion must not rest on speculation, conjecture, or guess unsupported by objective findings

Consequences of Failing to Meet Substantial Medical Evidence Standard:

Report may be rejected by WCAB judge or Workers' Compensation Judge (WCJ) as lacking substantial medical evidence

Report carries diminished evidentiary weight when in conflict with well-reasoned treating physician reports

Report may be subject to supplemental request asking physician to explain reasoning more fully

In appellate review, report may not support findings and may require remand for new evaluation

C. Apportionment Analysis: Detailed Legal Standard Under Labor Code Section4663

Apportionment analysis is one of the most frequently litigated aspects of QME/AME reports and warrants detailed explanation.

Labor Code Section4663 Statutory Language:[10][29][48]

> (a) Apportionment of permanent disability shall be based on causation. > > (b) A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. > > (c) In order for a physician's report to be complete on the issue of permanent disability, it must include an apportionment determination. A report that does not include an apportionment determination may be returned to the physician for correction.

Key Legal Principles Established in Brodie and Escobedo:[29][48]

Causation of Disability, Not Causation of Injury: Physicians must apportion permanent disability, not the original injury. Example: Worker is injured at work in 2020 lifting equipment; diagnoses with herniated disc. Worker receives treatment and initially recovers. In 2025, applicant develops permanent disability from the herniated disc. Apportionment analysis must address: of the permanent disability NOW in 2025, how much is from the work injury, and how much is from pre-existing degenerative disc disease that has progressed? The question is not "what caused the 2020 incident?" but rather "what is causing the permanent impairment in 2025?"

"Other Factors" Defined: Apportionment can be made to:

Pre-existing pathology (degenerative disc disease, arthritis, prior injuries) even if asymptomatic before industrial injury

Prior industrial injuries (prior workers' compensation claims affecting same body part)

Natural progression of disease (diabetes, heart disease, cancer progressing with age)

Non-industrial trauma (car accidents, falls outside work, sports injuries)

BUT CANNOT be based on age alone, gender alone, or speculative risk factors without identified pathology

Apportionment Using "Approximate Percentages": Physicians need not provide precise percentages; "approximate" percentages are permitted (e.g., "approximately 50%" is adequate; 50.0% is not required). However, the percentage must be grounded in medical evidence, not guesswork.[48]

Physician's Burden vs. Defendant's Burden: Under California law:

Applicant has burden of establishing percentage of permanent disability directly caused by industrial injury

Defendant has burden of establishing percentage of disability caused by other (non-industrial) factors

Both burdens apply in apportionment analysis; physician cannot simply assign disability without addressing both components

Common Deficiencies in Apportionment Analysis Rendering Report Inadequate:[29][45]

Physician states apportionment percentage without explaining how that percentage was determined

Apportionment based solely on age or gender (e.g., "30% apportionment to age-related factors") without identifying specific age-related pathology (e.g., specific degenerative changes documented on imaging)

Apportionment based on "natural degeneration" without evidence that such degeneration existed or was symptomatic before industrial injury

Failure to reconcile prior medical records showing non-work-related symptoms before injury with apportionment determination

Apportionment not tied to specific medical evidence: physician must identify diagnostic findings (MRI results, examination limitations, prior medical history) supporting apportionment percentages

Medical Evidence Necessary to Support Valid Apportionment:[29][45][48]

To satisfy Brodie/Escobedo substantial medical evidence standard for apportionment, physician report should include:

Clear identification of pre-existing conditions or non-industrial factors (with specific reference to medical records documenting those factors)

Timeline of symptom development: when did symptoms first appear, what treatment was sought, what was the prior functional level

Objective findings supporting apportionment: imaging studies (MRI showing degenerative disc disease), diagnostic testing, examination findings distinguishing industrial from non-industrial contribution

Medical reasoning: HOW do the pre-existing conditions contribute to the permanent disability NOW? Is the pre-existing condition asymptomatic but contributing? Is it symptomatic and interacting with industrial injury?

Reconciliation of any inconsistencies: if prior medical records do not mention pre-existing condition, explain why condition is apportionable despite lack of prior documentation

Example of Adequate vs. Inadequate Apportionment Analysis:

INADEQUATE: > "Applicant has lumbar spine permanent disability from herniated disc. I apportion 30% to pre-existing degenerative disc disease and 70% to the work injury."

[Lacks reasoning; no reference to specific medical evidence; no explanation of how percentages were calculated]

ADEQUATE: > "Applicant's lumbar spine MRI of June 2025 demonstrates: (1) herniation at L4-L5 with nerve root compression, consistent with acute industrial injury; (2) degenerative disc disease with 50% loss of disc height at L5-S1, osteophytes, and facet arthritis, consistent with chronic non-industrial degeneration. Prior medical records from 2015 do not document lumbar spine symptoms or treatment. On examination, applicant reports pain radiating to bilateral legs (consistent with acute compression) superimposed on baseline stiffness (consistent with chronic degeneration). The acute compression from herniation is directly caused by the industrial injury. The chronic degenerative changes represent pre-existing, non-industrial pathology. The permanent disability results from the combination of both the acute herniation and the pre-existing degeneration, which interact to limit applicant's functional capacity. I apportion approximately 70% of permanent disability to the work-related herniation (industrial injury) and approximately 30% to the pre-existing degenerative disc disease (non-industrial factor)."

[Explains specific medical findings; identifies prior records; distinguishes acute vs. chronic; explains reasoning for percentages; grounded in objective findings]

Part IX: Strategic Analysis and Post-Report Remedies

A. Evidentiary Weight and Persuasiveness of QME vs. AME Reports

AME Report Weight and Binding Effect

AME reports are characterized as "highly persuasive" or potentially "binding" on both parties because both the injured worker's attorney and the claims administrator have voluntarily selected the evaluator.[24][33][63] The principle established in [Power v. WCAB, 51 CCC 114 (Ct. App. 1986)][24] holds:

> We begin by presuming that the agreed medical evaluator has been chosen by the parties because of his expertise and neutrality. Therefore, his opinion should ordinarily be followed unless there is good reason to find that opinion unpersuasive.

Practical Implications:[24][33][63]

AME findings often control the outcome of a case unless the losing party can demonstrate that the AME report is factually incorrect, based on incomplete examination, or lacks medical reasoning

Judges give AME reports substantial weight and are reluctant to reject AME findings absent clear and convincing contrary evidence

AME findings may be binding if both parties previously agreed that AME opinion would control the disputed issue

Parties have limited grounds to challenge AME reports (fraud, fundamental procedural defect, gross violation of legal standards) compared to broader grounds for challenging QME reports

Strategic Advantage of AME:

For a represented worker with strong medical evidence supporting his or her position, pursuing AME selection with a physician known for thorough, well-reasoned analyses can result in findings that are difficult for the claims administrator to contest. Conversely, for a claims administrator, AME selection carries corresponding risk of highly persuasive findings supporting the worker's position.

QME Report Weight and Non-Binding Status

QME reports carry "substantial evidence" weight but are non-binding opinions subject to weighing against treating physician reports, other evidence, and the totality of the record.[24][77]

Principle from Willette v. Au Electric Corp, 69 CCC 1298 (WCAB 2004, appeals board en banc):[24]

> When faced with differing medical opinions from the Panel QME, the treating physician, and the utilization review physician on the issue of whether prescribed treatment is reasonably required to cure or relieve the effects of the employee's injury, the WCJ or Appeals Board need not rely on the opinion of a particular physician.

Practical Implications:[24][77]

QME findings are not automatically controlling, even if QME is the only independent medical evaluator

WCJ may rely more heavily on treating physician report if treating physician's findings are well-reasoned, supported by detailed examination and documentation, and not contradicted by objective findings

QME report may be found less persuasive if report lacks detailed medical reasoning, relies on incomplete examination, or appears inconsistent with medical records

Party challenging QME findings bears burden of presenting contrary evidence; simply disagreeing with QME opinion is insufficient

Strategic Implication:

For parties dissatisfied with QME findings, the path forward is to develop superior medical evidence (treating physician supplemental reports, expert testimony, additional diagnostic studies) that demonstrates why the QME opinion is less persuasive than alternative evidence. This requires affirmative construction of a superior evidentiary record.

B. Grounds for Challenging QME/AME Reports and Requesting Supplemental Evaluations

Supplemental Evaluation: Most Common Post-Report Remedy

If a party believes the initial QME/AME report is incomplete, contains factual errors, or fails to address specific disputed issues, the party may request a supplemental evaluation from the same evaluator or from a new panel.[17][39][56]

Grounds for Requesting Supplemental Evaluation:[17][39][56]

New Medical Records Became Available: Medical records not available at time of initial evaluation are now available; physician should review and provide updated opinion (e.g., new surgery, additional diagnostic studies, recent medical treatment)[39]

Ambiguous or Incomplete Opinion: Initial report does not clearly address disputed issue or leaves significant question unanswered; request for clarification[17]

Factual Error: Report contains factual misstatement (e.g., wrong date of injury, incorrect job description, mischaracterization of symptoms); request correction[35]

Failure to Address Disputed Issue: Report fails to address issue initially identified as disputed; request specific address of omitted issue[17][56]

Inadequate Reasoning: Report provides conclusion without sufficient medical reasoning; request supplemental explanation of reasoning supporting opinions[17]

Procedural Requirements for Supplemental Request:[39]

Request must be in writing, identifying specific deficiency and requesting physician to address

Request must be served on opposing party; opposing party has opportunity to respond

New medical records, if any, must be served on opposing party 20 days in advance with proper Section4062.3 declaration

QME/AME has 60 days to complete supplemental report (may be extended 30 additional days by mutual party agreement)[39]

If QME/AME does not respond within 60 days and no extension is approved, requesting party may request new panel[17][39]

Time-Sensitive Consideration:

Supplemental evaluation requests must be made within reasonable timeframe; delaying supplemental request until near settlement or trial may result in evaluator's refusal to comply or delay in report issuance.[17][39]

Challenging Report Admissibility: Procedural Grounds

DPR Construction Decision: Strict Enforcement of Discovery Closure Rules[40][40]

The recent DPR Construction v. WCAB (McClanahan), 111 Cal. App. 5th 1136 (2025) decision established strict enforcement of discovery closure rules under Labor Code Section5502. If a QME report is not properly listed in the Pre-Trial Conference Statement (PTCS) and is not timely served on opposing party before the Mandatory Settlement Conference (MSC), the report may be excluded from evidence even if its absence would not constitute harmless error.[40][40]

Strategy to Challenge Admission of QME/AME Report:

Pre-MSC Objection: If opposing party serves QME report for first time immediately before or at MSC without prior notice, object on discovery closure grounds under LC Section5502

Motion to Exclude: File motion in writing requesting that report be excluded from evidence as sanction for discovery violation

Articulate Prejudice: Explain how late disclosure prejudiced your case (inability to prepare response, schedule depositions, obtain rebuttal expert)

Cite DPR Construction: Invoke recent appellate decision establishing that discovery violations are not subject to harmless error analysis

Challenging Report on Substantive Grounds

Basis: Lack of Substantial Medical Evidence[16][23][26][48]

If QME/AME report lacks substantial medical evidence (opinion unsupported by examination, based on speculation, lacks medical reasoning, inconsistent with medical records), argue:

Report does not meet standard established in Escobedo v. Marshalls (must be framed in reasonable medical probability, based on adequate examination and history, set forth reasoning)

Report may be rejected or given minimal weight

Request for supplemental report or new panel if deficiency is severe

Strategy:

Obtain expert consultation from medical professional in same specialty as QME; expert reviews report for deficiencies

Identify specific portions of report lacking medical reasoning or inconsistent with records

In written objection (submitted to WCAB or WCJ), reference Escobedo standard and argue report fails to meet substantial evidence threshold

Propose that treating physician report or supplemental expert opinion better satisfies substantial evidence standard

Challenging Report on Bias/Conflict of Interest Grounds

Limited Basis for Challenging QME as Biased:[17]

WCAB has established that a mere subjective belief that a QME is biased is insufficient to obtain replacement panel. Only the WCAB (not the DWC Medical Unit) has authority to determine that a QME is biased or unfair.[17]

To successfully challenge QME on bias grounds, demonstrate:

Objective Conflict of Interest: QME has financial relationship with opposing party, prior employment by insurance company, or other documented conflict[17]

Pattern of Bias: Statistical evidence that QME consistently favors one party in prior cases

Procedural Unfairness: QME violated procedural requirements in evaluation (refusal to conduct adequate examination, refusal to review relevant records, hostility toward applicant)

For AME Challenges (More Difficult):

Because AME was mutually selected by both parties, challenging AME on bias grounds is extremely difficult. The only grounds for AME challenge are:

Fraud by evaluator or party who selected AME

Fundamental procedural defect (evaluator conducted no actual examination, evaluator misrepresented qualifications)

Gross violation of legal standards (e.g., evaluator explicitly stated refusal to follow Labor Code Section4663 apportionment requirement)

Part X: Conclusion and Strategic Synthesis

Summary of Key Findings

California workers' compensation law provides two distinct medical-legal evaluation processes-Agreed Medical Evaluators (AMEs) for represented workers and Qualified Medical Evaluators (QMEs) for all workers-each with distinct procedural requirements, evidentiary weight standards, and strategic implications. The choice between AME and QME fundamentally shapes case timeline, settlement posture, and appeal strategy.

For Represented Workers:

The decision to pursue AME agreement versus QME panel request should be made early, based on:

Cooperative relationship with claims administrator (favor AME)

Hostile or obstructive claims administrator posture (favor QME)

Case urgency and timeline needs (AME faster; QME permits extended discovery)

Complexity of medical issues and availability of specialized expertise (AME permits broader physician selection; QME limited to state-recognized specialties)

Strength of underlying medical record and evidence (weak record may benefit from extended QME timeline for additional treatment and investigation)

For Unrepresented Workers:

Unrepresented workers should carefully manage QME panel process by:

Submitting panel request immediately to avoid loss of specialty designation control

Conducting thorough striking analysis based on QME reputation, prior decisions, and qualifications

Organizing medical records

References

California Labor Code Section4060: Evaluations to Determine Compensability (https://www.law.cornell.edu/uscode/text/8/1158)

California Labor Code Section4061: Evaluations Following Acceptance of Claim (https://www.law.cornell.edu/uscode/text/8/1159)

California Labor Code Section4062: Evaluation Procedures for Disputes Under Section4060, Section4061, and Section4062 (https://www.sullivanattorneys.com/blog/service-of-qualified-medical-evaluator-panels)

California Labor Code Section4062.1: Panel Selection Procedures for Unrepresented Workers (https://employeesfirstlaborlaw.com/labor-code-%C2%A74062-1-panel-qme-process-unrepresented-workers/)

California Labor Code Section4062.2: Panel Selection Procedures for Represented Workers (https://law.justia.com/codes/california/2011/lab/division-4/4060-4068/4062.2)

California Labor Code Section4063: Consultations and Follow-Up Evaluations (https://www.rjylaw.com/labor-code-section-4062-3-information-vs-communication/)

California Labor Code Section4628: Physician's Responsibility for Medical-Legal Reports (https://coa.org/docs/AMEQMECourse/Handouts/Ca4628.pdf)

California Labor Code Section4663: Apportionment of Permanent Disability (https://employeesfirstlaborlaw.com/labor-code-%C2%A74663-apportionment-of-permanent-disability/)

8 Cal. Code Regs. Section1: Definitions (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-2/)

8 Cal. Code Regs. Section30: QME Panel Request Procedures (https://www.dir.ca.gov/t8/30.html)

QME Form 105 (https://www.dir.ca.gov/dwc/Forms/QMEForms/)

8 Cal. Code Regs. Section36: Service of Comprehensive Medical-Legal Evaluation Reports (https://www.dir.ca.gov/t8/36.html)

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8 Cal. Code Regs. Section38: Medical Evaluation Time Frames and Extensions (https://www.law.cornell.edu/regulations/california/8-CCR-38)

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proper Section4062.3 declaration (https://blog.daisybill.com/ca-med-legal-records-declaration)

8. Apportionment Determination (Labor Code Section4663)**

Mandatory in all reports addressing permanent disability

Specific percentage attribution: e.g., "60% of applicant's permanent disability is caused by the industrial injury; 40% is caused by pre-existing degenerative disc disease"

Medical reasoning supporting percentages: how pre-existing conditions contributed, what evidence (imaging, medical records, examination) supports attribution

Identification of non-industrial contributing factors: age-related degeneration, prior injuries, natural progression of disease

Important: apportionment CANNOT be based on age, gender, or immutable characteristics; must be based on specific pathology or clinical findings

[9. Maximum Medical Improvement (MMI) Status

Whether applicant has reached maximum medical improvement (condition is stable, not likely to improve significantly with further treatment)

If not at MMI, what additional treatment or time period would likely result in MMI

Clinical indicators supporting MMI or non-MMI conclusion

[10. Impairment Rating (AMA Guides 5th Edition)

Whole Person Impairment (WPI) percentage using AMA Guides 5th Edition

Specific chapter and section of AMA Guides applied

Measurements supporting rating: range of motion, sensory loss, functional limitations

If pain component included, specific statement that pain does not exceed 3% WPI

Explanation of how medical findings translate to impairment rating

If using "Almaraz/Guzman" rebuttal methodology, explicit explanation of why strict AMA Guides application does not adequately reflect impairment and how alternative method is better supported by medical evidence

[11. Work Restrictions and Limitations

Specific restrictions on work activities: no lifting over 10 pounds, no climbing, no prolonged standing, etc.

Duration of restrictions: temporary or permanent

Description of types of work applicant is able to perform given restrictions (sedentary, light duty, modified, regular)

Whether applicant can return to regular occupation or requires modified/different work

[12. Future Medical Care Recommendations

Whether applicant requires ongoing medical treatment

Specific types of care: physical therapy, pain management, medication management, surgery, etc.

Frequency and duration of recommended care

Whether care is temporary or permanent/life-long

Consultation recommendations: whether applicant should see additional specialists

[13. Declaration and Signature

Declaration under penalty of perjury that report is truthful

Physician's signature, printed name, license number

Date of signature

Attestation that physician personally performed all non-clerical work

California Code of Regulations Section10682 (Evidence Standards for Medical Reports)

Title 8, California Code of Regulations Section 10682 identifies additional requirements for reports to be admissible as evidence and to receive evidentiary weight:

Report must comply with all Section9793 requirements

Report must comply with Labor Code Section4628 (physician responsibility)

Report must identify the cause of disability with specificity

Report must explain the physician's reasoning, not merely state conclusions

Reports failing to comply with these standards are not rendered inadmissible but are considered in weighing the evidence; deficiencies reduce weight and credibility

B. "Substantial Medical Evidence" Standard

QME and AME opinions are tested against the "substantial medical evidence" standard established in [Richardson v. Perales, 402 U.S. 389 (1971) (https://supreme.justia.com/cases/federal/us/402/389/)

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