Memorandum of Understanding

Carve-Out/Alternative Dispute Resolution Joint Labor Management Committee
City and County of San Francisco (CCSF)

And

_____ MD

For Inclusion into The

Carve-Out/Alternative Dispute Resolution
Independent Medical Evaluator Medical-Legal List

The City & County of San Francisco has entered into a Workers' Compensation "Carve-Out"/Alternative Dispute Resolution Program (hereinafter the ADR Program) that has been authorized by the State Division of Workers' Compensation under Labor Code section 3201.7. The participating unions are the San Francisco Firefighters Local 798 and the San Francisco Police Officers Association.

In this program, medical-legal disputes will be resolved by Independent Medical Evaluators (IMEs) who have been approved by a Joint Labor Management Committee consisting of members of the City and participating unions. **This replaces the state-required Qualified Medical Evaluator process.**

You have been selected by the Joint Committee to serve as an IME – Medical Legal Evaluator to resolve medical-legal disputes. This Memorandum of Understanding (MOU) establishes the agreement between the physician and the Joint Committee. Your continued participation will be dependent on your ability to deliver prompt, efficient evaluations, and reports.

I. PURPOSE

This Memorandum of Understanding describes the Parties' agreement on the objectives, policies, and terms for delivering medical legal opinions. Participation by Provider-Members is voluntary. It represents the mutual commitment of these medical providers and the Joint Committee to the timely and expeditious delivery of medical legal reports to the parties of claim consistent with the approved ADR Program.

II. SCOPE of AGREEMENT

The City requests that participating physicians provide evaluation services promptly, and within the following time frames consistent with the physician's ability to do so.

Dr. _____ agrees to:

A. Examine the employee (if in-person evaluation required) within thirty (30) days of request **and** delivery of applicable medical records. If this is not possible, the physician should be communicating with the parties on when an appointment can be expected. If delayed, a replacement provider may be selected.

B. Deliver a complete medical/legal report that fully addresses all issues in dispute within sixty (60) days from date of evaluation, or delivery of medical records if no in-person evaluation. If additional time or consultation is required, the IME may request additional time by contacting the Member Advocate/Ombudsperson. (Contact information will be provided*).* **Please note that the CCSF accepts service of reports electronically per DWC Regulation Section 36.7.**

C. Clearly specify an employee's ability to return to full or modified duty with applicable restrictions as early as possible.

D. Receive and review medical records in electronic format (CD, encrypted email, physical memory device, etc.)

III. TERMS OF THIS AGREEMENT

A. This MOU will remain in effect by consent unless either party exercises its option to terminate. Physicians may choose to withdraw from agreement at any time. Removal from the list by the Joint Committee can occur at any time for failing to meet the expectations outlined in this agreement.

B. Fees and Reimbursements
Providers will be timely reimbursed for services rendered in accordance with the CCSF Medical-Legal Fee schedule with the AME -94 modifier. Reports will be reviewed for to ensure that the M/L codes are appropriately applied based on the complexity factors.

C. A provider's signature on Attachment A of this document confirms that the provider agrees to the provisions in this agreement incorporating all attachments and appendices.

Attachment A

CCSF IME Medical-Legal List Memorandum of Understanding (MOU) Signature Page

On signing of this MOU, the signatory attests to the following:

"I have read and understand the purpose, scope, terms and accountabilities of this Memorandum of Understanding. I have reviewed and do accept the expectations and policies described in its Attachments."

PLEASE COMPLETE LEGIBLY, SCAN into .pdf and **RETURN** within 15 days by email to Helene Paz at Helene.paz@sfgov.org. Or you may fax it back to (415) 701-5884.

Date: _____

Medical Provider's Name: _____

Title: _____

Individual Practitioner's signature*:*

X _____

Group Affiliation Name (if applicable):

_____

Attachment B

Physician Credentials

PROVIDER NAME, Degree(s): _____

If Applicable: **Group Practice/Healthcare Organization/Facility NAME and summary information:**

Tax ID Number :		
NPI Number :		
Phone Number:		**Cell (if applicable):**
Record Acceptance Email Address:		
Website URL:		
Practice Locations **Primary:** **Secondary:**		

Office Manager name and contact number:

* Providers/IME Members agree to notify the CCSF Workers Compensation Division within 10 days of knowledge of:

- Changes to your contact information, including office address, telephone, fax, and email.
- Changes to your California Medical License status, including the imposition of sanctions or probation by any medical licensing body.
- Any criminal indictments or charges filed against you. Suspension from participation in the workers' compensation system issued by the Administrative Director of the California Division of Workers' Compensation pursuant to Labor Code section 139.21 et. seq.