After last weeks update, I was reminded that not all recipients were aware that upon Carl's retirement a bit more than a year ago, I founded SC Advocates and the California Workers' Compensation Services Association as a means to continue to serve the workers' compensation community.

Many of you have subscribed and renewed the annual subscription to CWCSA's on-call consulting service. If others are interested, I encourage those of you who have not yet done so, to visit the websites - www.scadvocates.com and www.ca-wcsa.org to find out how we can be of service to you in a very affordable way.

Now for an update on last week's medical-legal fee schedule meeting:

The initial two hours were a rehash and catch-up from meetings held in December. These discussions were prompted by presentation of three proposals. One from a large payor group, the other two from provider-side representatives.

The employer proposal did not get a lot of traction as it seemed to abandon earlier "consensus" and "walked back" on issues that many attendees thought were already on their way to resolution.

While one of the two provider proposals seemed to raise more questions than it answered, the other was different. Simply put, it attempted to revise the current "ML" coding system in order to implement the Legislative Audit Committee's recommendation that the MLFS conversion factor be raised by 30%. Based on work already "completed" by the MLFS workgroup, the proposal did not seem to fit with the entire group's previous expectations. Surprisingly enough however, the 30% increase itself was never challenged. The issues raised by this third proposal concerned coding and ground rules. This was to be expected because similar to the treating fee schedule (OMFS) and the current MLFS, how a fee schedule is administered - the ground rules for use, billing and payment - often has more to do with frictional and total costs than the simple math used to calculate the fee.

After a break, the group got down to some consensus-building based upon a fee schedule structure established by the group at the end of the December meeting. This discussion was framed upon previously agreed services fundamental to the dispute resolution process. The goal became reaching some level of consensus about the fee schedule's rate for each of the listed activities.

Keep in mind that the group did not tackle any modifiers (ie. those that might raise reimbursement for complex cases, geography or hard to find specialties), final definitions or any of the other critical ground rules that will operationalize the new fee schedule. This means there remain many, many questions yet to be answered. Nevertheless, the following basics seemed to have traction:

- Flat Rate for all evaluations = $2000
- Pages of medical records included in the above = 200
- Per page reimbursement for all pages over 200 = $3/page

- Follow up evaluations flat rate = $1325
- Pages of medical records included = 200
- Per page reimbursement for all pages over 200 = $3/page
    - Special note: There was absolutely no consensus regarding the timeframe in which follow ups take place. The current nine months is likely to change to "some longer time frame." This is a great example of the critical ground rules that must be considered as equally important as the dollar amounts involved.

- Supplementals = $650
- Pages of medical records included = 50
- Per page reimbursement for all pages over 50 = $3/page

- Depositions = $425/hr

- Missed appointment (for 'any' reason) = $500
    - Note: Records submitted timely would need to be reviewed and a written synopsis sent to the parties even though the review would not be considered "evidence' at that point. The review and synopsis would be paid at $3 per page after the initial 200 pages - same as if the injured worker had showed up. The missed appointment fee and record review would be invoiced and paid together.
    - A subsequent face-to-face eval would be billed at $2000 but the records, having already been reviewed and paid would not be reimbursed a second time. It was gently pointed out under this circumstance, the record review would also need to be integrated into the resulting report because the previously submitted review could not stand alone. It remains to be seen whether any additional reimbursement will be allowed for this "additional report prep time."

- Subrosa = $325/hr - presumably to include the written narrative and attestation under penalty of perjury as to the time spent in review.

The final discussion of the day started to address "Extraordinary and Highly Complex Cases."

The concept is to identify conditions present in complex or extraordinary cases in an objective, binary (yes/no) manner. The specific criteria would be established in advance during the appointment phone call or shortly thereafter. A list of such criteria were discussed. The initial proposal contemplated a threshold of 6 or more to qualify the case as complex. Once defined as "complex" the evaluator (QME or AME) would

not be bound by the fee schedule. Instead, the evaluator would submit a written proposal as a Labor Code Section 5307.11 contract. The employer/insurer could accept the proposal or the two parties could modify it. It was proposed if the employer rejects the proposal, it could request another panel (choose another evaluator) or set a hearing with a WCAB judge to determine the issue. Involving the WCAB was not immediately popular. A court decision may take a long time and one of the two parties will "lose" and believing it is being forced into being short changed by the decision. Appeals would be counterproductive, but required by due process. Dropping the WCAB path and absent another viable option, this idea has enough merit to warrant further discussion.

The following were among the complexity criteria proposed:

1. A history of multiple injuries (3 or more)
2. Multiple DOI (3 or more)
3. 2 or more CT periods?
4. 2005 or earlier Date of injury
5. Complex issues of apportionment due to multiple employers (3 or more).
6. Multiple body parts involved (3 or more).
7. Multiple surgeries (3 or more).
8. Multiple Specialists involved (3 or more).
9. Specific requests from parties requiring extensive time to address.
10. Presence of both physical and psychiatric components.
11. Widely divergent opinions.
12. Review of depositions and other legal documents.
13. Petition to reopen a claim for new and further.
14. Rebuttal of a presumption statute.
15. Dispute of findings with treater of QME/AME

Despite its potential... "The devil is in the details."

It is critical to keep in mind that any general nodding of heads at these meetings may not ultimately mean total agreement. One must remain skeptical that any party to this process will simply accept this "consensus" as the final word. Payors and providers alike realize all bets are off until the entire fee schedule, including all necessary ground rules, is completed.

<u>The next Fee Schedule Stakeholder meeting is scheduled for January 31</u>. If readers have any <u>constructive</u> comments or ideas regarding modifiers, the level of increase that mental health and internal medicine cases should be awarded, opinions concerning any of the "consensus" items discussed above or issues that appear to be forgotten, please email or call with your comments to the contact information below.

I look forward to hearing from you

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