California Society of Industrial Medicine and Surgery

CSIMS

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Physician Reporting in the California Workers' Compensation System

A Position Paper

Presented to

The California Division of Workers' Compensation

The Commission on Health and Safety and Workers' Compensation

And

The RAND Corporation

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Executive Summary

The California Society of Industrial Medicine and Surgery (CSIMS) respectfully submits this white paper and its accompanying data and documentation to the Division of Workers' Compensation (DWC), the Commission on Health and Safety and Workers' Compensation (CHSWC) and to the RAND Corporation (RAND) for use in the development of the current study and pending recommendations described as "…whether changes should be made in the various reports required from primary treating physicians and in the fee schedule for medical-legal expenses…"[1]

CSIMS agrees with the Division and CHSWC that physician reporting is the most vital link between the employer's obligation to provide benefits and the injured worker's medical/physical condition throughout the life of a claim and, under many circumstances, into the future.

To be of value, each communication must provide "substantial medical evidence" in its own right, so that injured workers, claims administrators, other physicians, lawyers and the court system are adequately informed. To that end, each report must facilitate and adapt to the required level of detail necessary to communicate clearly the injured workers' condition and present the required medical evidence in a manner that answers any question concerning the injured worker's present condition and addresses any disputed medical facts that may exist at the time.

By definition, a medical-legal report must meet the standard for substantial medical evidence. This means it cannot represent surmise, speculation, conjecture or guess. The evaluator must incorporate correct legal theory and clearly explain the "how and why" for each conclusion using the "reasonable medical probability" standard for all conclusions, while reporting an adequate medical history, exam and a thorough review of the relevant medical records.

This definition and applicable components cannot be supported by any checkbox or form report. By its very nature, the PR-4 cannot provide a physician the opportunity to meet the standard of substantial medical evidence. The PR-4 report is completely inadequate to resolve a claim properly except in the most simple and routine cases. That is, single injury claims when no impairment, co-morbidities or multiple employers are involved and neither the worker nor the employer is disputing any medical issues.

[1] *Overview of RAND Study on WC-Required Reports and Medical-Legal Evaluations* - Barbara Wynn, RAND Project Contact, July 2014

Synthesis of the information presented by each report must remain with the authoring physician and not be allowed to become an amalgam of information gathered from various, disparate sources and then analyzed and interpreted by a third party.

Our paper provides analysis and recommendations that we believe will improve physician reporting with the intention of enhancing overall quality, accuracy, timeliness and the usefulness of each and every medical-legal report[2].

Our recommendations can be summarized as follows:

1) We strongly suggest that the current review of written reports by RAND be an actual collaboration between the very people who hands-on, must daily produce, review and make decisions based upon the content of these reports. If any of these users are omitted from the process, the result will not be an improvement and may likely result in unforeseen consequences that confound the original purpose of the review and revision effort.

2) The current medical-legal reporting system has stood the test of time and, in the most part, continues to work well. High quality, accurate reports, authored by well trained and competent evaluators, are the backbone of substantial medical evidence. Automated systems cannot deliver the "how and why" necessary to provide well-reasoned evidence. Moreover, we provide data that show medical-legal report costs are not going up. On the contrary, they are level or trending down[3]. Data also show that California's current hourly reimbursement rates are substantially lower than those found throughout the United States[4] for reasonably comparable work. However, we do not dwell on costs in order to justify raising rates. Instead, data in the form of actual reports are provided to point out that the current medical-legal fee schedule system, when used properly, produces medically and legally sound evidence[5]. It is the legally acceptable way to produce the substantial medical evidence required to resolve disputes. Any recommendation for raising reimbursement will be based on the value of the work involved.

[2] Analysis of the various treating physician reports is not within the scope of this white paper. CSIMS believes their content and purpose are markedly different than that of medical-legal reports and deserve their own, separate analysis.
[3] CHSWC Annual Report - 2014
[4] Babitsky, Donovan, Mangraviti - SEAK, Inc., *Survey of Expert Witness Fees* ©2014 SEAK, Inc.
[5] See Section III of this Position Paper for examples of quality reports that meet this standard and could not be rendered as evidence using a "check box" system of any kind.

3) We also provide insight into several improvements to the present system (not just the fee schedule itself), recognizing that there are elements of the medical-legal reporting system that have eroded for lack of physician education, quality control and ongoing corrective action.

CSIMS has earned a longstanding reputation within California's workers' compensation community and with the Division for reasoned analysis and effective solutions for systemic problems as they are identified. It is in this spirit that we submit this CSIMS position paper, entitled "Physician Reporting in the California Workers' Compensation System."

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I. The Regulation of Medical-Legal Fees in California: History and Suggestions for Change

CSIMS had an instrumental role in the genesis of the current MLFS, presenting a template to the workers' compensation community that was enhanced and refined through the administrative process. Continuing its input, CSIMS now seeks to assist the efforts of the RAND Corp. with an overview of current workers' compensation medical-legal report billing.

After providing a historical overview of Medical-Legal fees in California workers' compensation, a review of the current system is provided, along with possible suggestions for a comprehensive overhaul of the medical-legal fee structure. CSIMS believes that review of the medical-legal fee structure is a worthy goal, and one that should have three primary objectives: ensuring simplicity and predictability of a fee schedule, cost containment and, importantly, improvement in the quality of medical-legal reporting. As medical-legal reports typically reflect the final stage of medical input into a workers' compensation case, the standards for production of a report worthy of being considered as *substantial medical evidence* are quite high. This is demonstrated by the lengthy requirements for medical reporting set forth in Labor Code Section 4628 and in 8 *California Code Regulations* Section 10606. A medical-legal fee schedule should both reflect these requirements as well as encourage adherence to them.

A. Evolution of Medical-Legal Fee Regulation

Prior to 1984, there was very little regulation of medical-legal fees in California workers' compensation cases. Comprehensive medical-legal reports filed in workers' compensation cases merely had to be accompanied by a copy of the billing for the services on a form prescribed by the Administrative Director that had to include the physician's specialty, if any, and separately itemize the charges for all of the following:

1. A review of medical records;
2. Compiling of the patient's medical history and performing a medical examination of the patient;
3. Report preparation, including necessary research; and
4. The total charge.

There was no regulation of the price of any of these charges and, beginning around 1982, concerns arose as to the need for some regulation to control medical-legal costs while encouraging an adequate pool of skilled physicians to prepare medical-legal reports.[6]

[6]The following discussion of the history of the evolution of the Medical-Legal Fee Schedule draws heavily from the language of *Ameri-Medical Corp. v. Workers' Comp. Appeals Bd.*, (1996) 42 Cal. App. 4th 1260, 1275-1279.

Predictability Sought

In March 1983, the Temporary Advisory Committee on Medical-Legal Expenses (Committee),[7] appointed pursuant to Chapter 1150 of the Statutes of 1981 (Assembly Bill No. 682 (Young)), made written recommendations to the Legislature regarding the workers' compensation system. The Committee was concerned with "[t]he continued availability of competent physicians to evaluate physical impairment resulting from industrial injury," "[t]he absence of uniform, valid and acceptable standards to determine unreasonable or excessive charges," "[t]he appropriate use of industrial medical-legal services," "[t]he quality of industrial medical-legal reports," and the "[p]rompt payment of reasonable fees for industrial medical-legal services." (Rep. of Temporary Advisory Com. on Medical-Legal Expenses, Mar. 1983, Assem. Bill No. 2196 (McAlister) (1983-1984 Reg. Sess.) p. 2.)

In reported findings, the Committee stated, in relevant part, that its recommendations were "designed to establish standardized criteria for the evaluation of medical-legal expenses on a consistent basis. Committee believes that its proposal will provide a basis for the payor [sic] of industrial medical-legal services to make a timely determination of whether the charges are appropriate and therefore subject to timely payment, yet not be unduly restrictive thus allowing the physician providing the services to be fully compensated for the reasonable value of those services." (Rep. of Temporary Advisory Com. on Medical-Legal Expenses, Mar. 1983, Assem. Bill No. 2196, ch. 596, supra, at p. 6.) The Committee also recommended the development of fee ranges by medical specialty and the establishment of the 80th percentile, which is "that dollar value at or below which 80 per cent of all physician charges fall," as criteria of reasonableness of the fee. (Id. at p. 8.) A fee at or below the 80th percentile, according to the Committee, would be deemed rebuttably reasonable. (Ibid.) However, "[w]e provide for some flexibility in that the payor [sic] can rebut charges which fall at or below the 80th percentile or the physician can provide information to support charges higher than the 80th percentile. The point is that our recommendations are benchmarks not absolutes. They must be viewed with some degree of elasticity." (Id. at p. 9.) The 80th percentile benchmark was the result of negotiations initiated by the California Society of Industrial Medicine and Surgery (CSIMS) and the California Workers' Compensation Institute (CWCI) and adopted by the Committee.

During the 1983-1984 Regular Legislative Session, the Committee's recommendations were incorporated into Assembly Bill No. 2196, which added article 2.5 (medical-legal expenses), consisting of Sections 4620-4627, to the Labor Code. (See Rep. of Temporary Advisory Com. on Medical-Legal Expenses, Mar. 1983, Assem. Bill No. 2196, supra.) The new statutory scheme "prescribe[d] fee guidelines for independent medical examiners based on data collected from physicians in the particular medical specialty regarding the fee charged for the

[7]DWC Administrative Director Ralph Roy Ramirez chaired the Committee which was composed of 42 representatives of medical providers, insurers, self-insured and legally-uninsured employers, applicants' and defense attorneys and other workers' compensation industry stakeholders. It conducted seven public meetings between March 11, 1982, and February 25, 1983.

type of report requested." (Cal. Workers' Compensation Practice (Cont.Ed.Bar Supp. 1984) § 7.17, p. 25.) The bill required the publication of "a schedule based on the range of medical-legal fees that specified medical specialists actually charged during the previous 12 months," made "it a rebuttable presumption that all medical-legal fees are appropriate if they fall under the 80th percentile of the ranges[,]"[8] and "[urged] the Governor to implement a suggestion by the Temporary Advisory Committee on Medical-Legal Expenses that the division [of Workers' Compensation] study the incidence of physician 'shopping' and overutilization of industrial medical-legal services and to make appropriate recommendations." (Analysis of Assem. Bill No. 2196 (Jan. 17, 1984) p. 2 (McAlister) (1983-1984 Reg. Sess.).) A legislative analysis determined "the bill probably would not result in additional costs to local public agencies because, if anything, the new schedule would reduce costs associated with medical-legal fees in two ways. First, it would reduce costs to the extent that it reduced fees that currently exceed the 80th percentile in cases where there is no justification for the payment of higher fees. Second, it would reduce litigation before the Workers' Compensation Appeals Board over the appropriateness of fees that are currently charged. Such disputes are currently handled on a case-by-case basis. . .." (Analysis of Assem. Bill No. 2196 (McAlister), supra, p. 3.)

Percentile for Presumptively Reasonable Fees Adjusted

While the other newly added Labor Code sections addressed issues of payment and reimbursement, Section 4624 established a market-survey-based method of setting rates under which the Administrative Director of the Division of Industrial Accidents annually polled and then published "the range of fees for initial comprehensive industrial medical-legal reports charged by . . . physicians." (former § 4624, subd. (a).) This statute provided for rebuttably presumed reasonable rates set at the 80th percentile of this range. (former § 4624, subd. (c)). In 1990, the Legislature repealed original Section 4624 and adopted a substantially similar statute. This new statute lowered the rebuttably presumed reasonable rates to the 73rd percentile of the fee range, and made the rate rebuttably presumed reasonable "notwithstanding any other section of this article." (§ 4624, subds. (a), (c)).

Fee Schedule Revised For More Precision

Medical-legal fees, however, continued to rise and the Legislature attempted to address this concern with the 1993 passage of Senate Bill No. 31, (Ch. 4, Stats. 1993 (Johnston)). (See also *American Psychometric Consultants, Inc. v. Workers' Comp. Appeals Bd.*, 36 Cal. App. 4th 1626 at p. 1641.) The bill required the administrative director to adopt and revise a medical-fee schedule that would be "prima facie evidence of the reasonableness of fees charged for medical-legal expenses" rather than merely publish a range of fees charged by independent physicians. The bill also prohibited medical providers "from charging more than the fees allowed by the medical-legal fee schedule except upon showing that the higher fee is reasonable and justified by extraordinary circumstances." (Sen. Floor Analysis, Unfinished

[8]The presumed-reasonable charges were specified according to their relevant medical specialty: Orthopedics; Internal Medicine and Cardiology; Neurology; Psychiatry; and All Others.

Business for Sen. Bill No. 31, supra, p. 2.) To this end, the bill amended Sections 4620-4622 and 4625, repealed Section 4624, and added Section 5307.6, which established the fee schedule. (See Legis. Counsel's Dig., Sen. Bill No. 31 (1993-1994 Reg. Sess.) ch. 4 and DWC rule 9795 (Cal. Code Regs., tit. 8, § 9795).) The bill was subsequently amended by provisions in Assembly Bill No. 110 which required the administrative director, among other items, "to set medical-legal fees based on the relative difficulty of the work and time expended in contact with the patient and in preparing the report." (Sen. Rules Com. Conference Rep. on Assem. Bill No. 110 (1993-1994 Reg. Sess.) pp. 6-8; Prop. Conference Rep. No. 2, Assem. Bill No. 110, as amended May 5, 1993 (Peace and Brulte) (1993-1994 Reg. Sess.).)

Assembly Bill Nos. 110 and 2196 and Senate Bill No. 31 sought to lower costs associated with medical-legal fees by placing limits on the amount medical providers could charge, and to reduce litigation by creating presumptively reasonable rates. This was accomplished by enacting Labor Code provisions, and concurrent regulations, that set and controlled the level and range of fees. The established fees were developed to "provide remuneration to physicians performing medical-legal evaluations at a level equivalent to that provided to physicians for **reasonably comparable work** and which additionally recognizes the relative complexity of various types of evaluations, the amount of time spent by the physician in direct contact with the patient, and the need to prepare a written report" (§ 5307.6, subd. (a)) [emp. added].

These parameters for determining reimbursement for medical-legal evaluations remain sound and in force.

The genesis of the current Medical-Legal Fee Schedule (MLFS) found in Rule 9795 was the passage of AB 110 in 1993. The schedule was first promulgated by the Administrative Director, effective August 3, 1993. It was subsequently revised and updated in 1994, 1999, 2006 and 2013 either to increase remuneration or to adjust complexity factors in light of statutory changes.

B. The Current Schedule – an overview

One might invoke the old saying: "If it isn't broken, don't fix it," and be right from the perspective that the current schedule structure has stood the test of time. However, improvement is always possible and may be necessary.

The current schedule structure represents a firm working foundation from which to improve. Carefully crafted and constructive improvements will assuage those who might attempt to persuade otherwise.

A good place to start this discussion is the 2014 calendar year review conducted by the Commission on Health and Safety and Workers' Compensation (CHSWC)[9]. CSIMS applauds CHSWC's recognition that *"...it will be important to remember that the quality of medical-legal reports has an impact on the cost of the system and the timeliness of benefit delivery which may very well overshadow the direct cost of medical-legal costs."* (Annual Report, p. 65).

CSIMS makes special note of the rising cost of medical-legal evaluations in the last few years and the commentary by *CHSWC* that *"...complexity of impairment rating under the AMA* Guides*, new rules for apportionment, and the criteria for medical treatment decisions under the Medical Treatment Utilization Schedule are among the reasons..."* (Annual Report, page 76). Offsetting the increased cost of individual reports is the observation by CHSWC that there has been a significant decline in the number medical-legal evaluations per claim since 2005 (Annual Report, p. 67).

While the cost driver for increased average report fees is not precisely known, a significant factor seems to have been the costs for psychiatric reports. Those costs are plainly now headed for significant reduction in light of the enactment of Labor Code Section 4660.1 which utilizes new criteria that markedly decrease the number of compensable consequence psychiatric injuries.

It is important to note that the 2014 CHSWC fee schedule study does not account for inflationary pressures. For example, on page 76 of the Annual Report, the average cost of an evaluation in 1990 is given as $986, compared to $1,994 in 2011. However, with an annualized inflation rate of 2.67% across those years, the adjusted cost of a 1990 report is $1,713.80. The cost increase then quantitatively has been less than $14 per year. It is for this reason that a truer measure of medical-legal costs will recognize the overall percentage costs related to medical-legal reports. Here, in terms of total medical costs, it is encouraging that medical-legal costs as a percentage of the total of all claim costs, have actually dropped significantly, from a high of 4.9% to 3.3% in 2011, the lowest percentage since 2003 (Annual Report, p. 75).

C. **Improvements to the current schedule**

CSIMS has identified some fundamental aspects of the current schedule that are not performing at optimal levels:

1) QME competency and resulting lack of quality reporting.

    a) The lack of proficiency and experience results in highly variable record review time, which in turn, results in unpredictable billed charges for comparable work.

[9] This report is hereinafter referred to as the "Annual Report." It can be found at http://www.dir.ca.gov/chswc/Reports/2014/CHSWC_AnnualReport2014.pdf

b) QMEs have incomplete or non-existent feedback about the accuracy and quality of their reports.
c) Although depositions can provide a type of feedback, this is costly and time-consuming.

2) The dearth of QMEs entering the system.
   a) There is a net loss of evaluators because the graying QME pool is not being replenished by younger talent.
   b) Expertise in report quality is suffering.
   c) Greater dependence on others to help with reports.
   d) Too few individuals performing a disproportionate number of evaluations.
3) The QME and AME process is overly time consuming
   a) Injured workers are timed out of TTD benefits.
   b) Potential loss of TTD benefits due to delays often force premature and less-than-optimal settlements.
   c) Delayed settlements because of the number of required evaluations in complicated cases.
4) Diagnostic test results are delayed, inadequate and/or testing facilities will not perform the tests.
   a) Necessary tests requested by QMEs and AMEs (Labor Code Section 4620) are unnecessarily and improperly subjected to the utilization review process to decide medical necessity when that is not the standard (8CCR Section 9794 (a)(1)).
   b) The current Medicare-based, RBRVS fee schedule has driven down reimbursement for vital diagnostic tests, resulting in the best testing centers refusing to provide them.
   c) Fewer participating testing centers results in highly discounted and potentially sub-standard testing facilities becoming the only ones available due to the forced use of ancillary networks by carriers.
5) Fee Schedule complexity factors can be misused by evaluators and payors alike.
   a) Reimbursement disputes that heretofore were few or almost non-existent are now frequent.
   b) The overhead cost for all evaluators has increased unnecessarily.
6) Records are delayed or missing in delivery.
   a) Causes further delays and higher costs when supplemental reports are required.
7) The process used to choose QME panels is not random.
   a) Too few evaluators obtain an inordinate proportion of the panel positions.
   b) New QMEs find it difficult to enter the marketplace.

CSIMS recognizes that most of the issues identified above are not endemic to the fee schedule itself, but to the system that has grown up around it. In some instances, the problem is exacerbated by the system.

Regardless, these exist to a lesser or greater degree throughout the system. CSIMS believes that the MLFS will become more efficient with proper attention being paid in these areas. We also believe that if left unaddressed, these issues will continue to plague the system regardless of how the MLFS may change in the future.

In this section, CSIMS will respond to the following:

- What is the problem?
- What are plausible solutions?
- How do the injured worker and employer benefit from the solution?

How can the DWC measure the effectiveness of the solution?

1) QME competency and resulting lack of quality reporting.
   a) Solutions
      i) Increase required training for new QMEs. For example, raise the biennial continuing education requirement from 12 to 18 hours for new QMEs. Keep the CE increase in place for the initial 6 years (3 recertification cycles) and require that a minimum of 50% of the hours be in advanced reporting writing curriculum.
      ii) Require all QMEs be recertified every 6 years (every three renewal cycles).
   b) Benefits
      i) Learning is accelerated. Injured workers and employers benefit from more accurate reports and settlements.
      ii) Fewer depositions save money.
      iii) Accurate settlements save employers money.
   c) Measurements
      i) DEU ratings
      ii) Med-legal cost data
      iii) Settlement data
2) The dearth of QMEs entering the system.
   a) Solutions
      i) Raise reimbursement. Make evaluations a more attractive part of a medical practice.
      ii) Changes to the QME certification test should be made, with greater emphasis on actual reporting of issues as opposed to compliance with deadlines for submission of various letters and forms. The QME certification test should be refocused upon the development of substantial medical evidence. While some emphasis must be placed upon the administrative and regulatory details of the reporting system, it is our experience based on feedback from those having taken the test, that the emphasis on rules overshadows report content. That is, those aspects of medical-

legal reports that matter most to the injured worker, the Disability Evaluation Unit, Claims Adjusters, attorneys and the Appeals Board, must receive greater emphasis.

iii) CSIMS would welcome the opportunity to explore how the test might be better integrated with the 12 Hour Report Writing curriculum pursuant to 8 CCR, Section 11.5

iv) Provide each candidate with a post-test subject matter profile for those who do not pass. For example, provide a numeric comparison of the number of questions offered by the test covering each major topic and the number that the candidate answered correctly.

v) Establish a report peer review system that can, using a written review and critique, provide guidance for new QMEs during their initial two or three years or first 20 reports, whichever comes first.

vi) Provide more evaluation opportunities.

b) Benefits

i) Candidates who must re-test have a focus for future study, developing additional expertise in their weakest competencies.

ii) More QMEs in the pool increases access and trend towards shorter wait times.

iii) Expertise and experience grow faster.

iv) The "graying factor" has less of an effect.

c) Measurements

i) Profile the size of the QME pool geographically (geocode), specialty, age and the number of evaluations performed.

3) The QME and AME process is overly time-consuming for injured workers.

a) Solution

i) Build up the pool of QMEs. More QMEs shorten the wait times for evaluations

ii) Reinstate fully paid consultations. (New Regulation 31.7 and revised Regulation 32 are not working.)

(1) Establish a series of codes (and reimbursement) within the MLFS to be used exclusively for describing and billing consultations delivered in the medical-legal setting.

b) Benefits

i) Fewer injured workers are timed out of TTD benefits.

ii) Fewer premature settlements due to impending loss of benefits.

iii) Fewer delays in settlement because consultations are accomplished much quicker and potentially at lower expense than QME evaluations.

c) Measurement

i) Profile time from application to settlement and settlement amount(s).

ii) Profile the number of QME evaluations needed (discrete QMEs involved plus re-evaluations, supplementals and depositions.

4) Diagnostic tests results are delayed, inadequate and/or testing facilities will not perform the tests.
    a) Solution
        i) Raise reimbursement for diagnostic tests when ordered by a QME or AME
        ii) No prior authorization needed if request is based on a test or tests previously performed and the request meets the standard for valid requests pursuant to 8 CCR 9794(a)(1).
        iii) Similar to consultants, the medical-legal testing center does not need to be part of the MPN or a network required by the carrier for treatment.
    b) Benefit
        i) Tests available more rapidly; less delays in final conclusions.
        ii) Tests will likely be of a higher quality. Better data make better medical evidence.
        iii) Frictional costs go down for employers and providers.
    c) Measurement
        i) Profile the costs vs. the time to settlement.
        ii) Survey employers and providers about access and cost after one year.

5) Complexity factors can be misused by evaluators and payors alike.
    a) Solution
        i) Replace some of the existing MLFS complexity factors with more appropriate objective criteria.
    b) Benefit
        i) Fewer reimbursement disputes.
        ii) Lower frictional costs.
    c) Measurement
        i) Monitor and profile the nature of reimbursement disputes in the med-legal setting.
        ii) Profile and compare report costs before and after.
6) Records are delayed or missing in delivery.
    a) Solution
        i) Raise reimbursement for supplementals required because records were verifiably not sent by the claims administrator.
        ii) Increase complexity when/if records are verifiably incomplete or untimely delivered.
        iii) Adopt penalties for willful failures to send medical records to the evaluator in a timely manner.
    b) Benefit
        i) Payors are properly incentivized to deliver records timely.
        ii) The number and cost of supplemental reports made necessary by delivery of late or additional records is reduced

c) Measurement
   i) Count supplementals – Profile lower costs
   ii) Length of time a claim remains open after a dispute is lodged.

7) Despite the restriction in the number of offices each QME can maintain, the panel selection process is not random.
   a) Solution
      i) Modify the Division's panel selection software to count each QME's name only once per panel search regardless of the number of office addresses that may come up for that QME.
   b) Benefit
      i) The number of offices becomes less relevant and less likely to skew the chance of selection.
      ii) Lower barrier to entry for newer QMEs.
   c) Measurement
      i) Profile the number of times each QME is placed on a panel.
      ii) Profile the number of times each QME is actually chosen.
      iii) Report the ratio of panel appearances to the number of times chosen.

D. Is there an adequate alternative to the current MLFS?

Is there a feasible alternative fee schedule structure?

In the past, efforts were made to place greater reliance on the opinions of the treating physician and, for a while, there was even a *presumption of correctness* applied to those reports[10]. The efforts proved misguided and foundered due to the complexity demands inherent in medical-legal reports. Additionally, it rapidly became apparent that there were inherent conflicts of interest when treating physicians evaluated the permanent disability and impairment of their own patients. Many PTPs viewed themselves as patient advocates, thereby distancing their opinions from objectivity. For other physicians, the reverse was the case. The demise of the now defunct Labor Code Section 4062.2 treating physician presumption speaks well to the failure of the well-intentioned concept.

Of late, there has been increasing reliance in assuring treating physician reporting via Forms PR-2, PR-3 and PR-4. Is it advisable to consider a similar checkbox style of reporting for medical-legal reporting? We believe that the guiding principles of workers' compensation case law negate the idea. The central requirement for any medical-legal report in the State of California is that it meet the requirement of being worthy of consideration as Substantial Medical Evidence. A recent case (*Blackledge*[11]) noted:

[10] See *Minniear v. Mt. San Antonio Community College District*, (1996) 61 *Cal. Comp. Cases* 1055.
[11] *Blackledge v. Bank of America*, (2010) 75 *Cal. Comp. Cases* 613.

The physician's report should include a summary list of the impairments and impairment ratings by percentage, together with a calculation of the final WPI, and a statement of the rationale underlying the WPI opinion.

Medical reports and opinions are not substantial evidence…if they are based …on incorrect legal theories…an expert's opinion which assumes an incorrect legal theory cannot constitute substantial medical evidence…a physician's opinion regarding WPI must set forth the physician's opinion reasoning, not merely his or her conclusions….an opinion that fails to disclose its underlying basis and gives a bare legal conclusion does not constitute substantial evidence.

…the chief value of an expert's testimony rests upon the material from which his or her opinion is fashioned and the reasoning by which he or she progresses from the material to the conclusion, and it does not lie in the mere expression of the conclusion; thus the opinion of an expert is no better than the reasons upon which it is based.

Many other cases establish the foundation and provide the framework for proper medical-legal reporting. Those include *Escobedo v. Marshalls*[12], *Yeager*[13] (a.k.a., *Gatten*), and *Benson*[14] amongst a long list. Clearly, a check box form cannot accommodate the database required for production of Substantial Medical Evidence.

By definition (Labor Code §4068, 8CCR §10606, *Place v. WCAB,* (1970) 35 CCC 525), a medical-legal report must meet the standard for substantial medical evidence. This means it cannot represent surmise, speculation, conjecture or guess. The evaluator must incorporate correct legal theory and clearly explain the "how and why" for each conclusion (*Milpitas Unified v. WCAB (Guzman III),* (2010) 75 CCC 837; (6th DCA) (S. Ct. denied writ.)) using the "reasonable medical probability" standard for all conclusions (*Escobedo v. Marshall)* while reporting an adequate medical history or exam and thorough review of the relevant medical records.

This definition and applicable required components cannot be supported by any checkbox or form report. By its very nature, the PR-4 cannot provide a physician with an adequate opportunity to meet the standard of substantial medical evidence. No checkbox report is able to resolve a claim properly except in the most simple and routine cases. That is, single injury claims when no impairment, co-morbidities or multiple employers are involved and neither the worker nor the employer is disputing any medical issues.

The CSIMS members who collaborated to create this position paper spent countless hours developing and debating alternatives to the current system but were unable to come up with any alternative method that was superior to the existing MLFS. Each alternative method we

[12] *Escobedo v. Marshalls*, (2005) 70 *Cal. Comp. Cases* 604.
[13] *Yeager v. WCAB (Gatten)*, (2006) 71 *Cal. Comp. Cases* 1687, 145 *Cal. App. 4th* 922.
[14] *Benson v. Workers' Comp. Appeals Bd.*, (2009) 170 *Cal. App. 4th* 1535.

considered had some, if not many, adverse side effects that did not improve the quality of medical-legal reports or the skills of those who perform the evaluations and write the reports.

CSIMS members have in-the-trenches medical experience and insights that can evaluate the true practicality of alternative reporting methods and processes. Their experience can make a dramatic difference in the implementation of any changes promoted to improve how medical reports of all types communicate vital information to those that need it most…the injured worker and employer.

II. Summary and conclusions

Given the length of time the current complexity based billing system has existed, a review of the efficacy of that system is understandably a subject of interest at present.

Calls for fee schedule reform are often times a muted code for cutting reimbursement rates. Such would be a shortsighted maneuver in light of the data already supplied which shows an absence of true cost acceleration evaluated by multiple measures. Whether done as an inflationary comparison to evaluations from more than twenty years ago or as a measure of percentage cost against overall costs, there simply isn't a cost spiral present.

Whether measured as a percentage cost as against all costs in the workers' compensation system or viewed through the lens of inflation, the cost for medical-legal reporting has not exhibited any significant increase over two decades' time. Indeed, given that the data reviewed from 2011 could not take into account the effect of Labor Code 4660.1, there is reason to be optimistic that medical-legal fees may actually be headed downward even absent any regulatory or statutory action.

While cost is a legitimate point of inquiry, it is possible to miss the forest for the trees if cost becomes the *sine qua non* of an inquiry. The fundamental purpose of the medical-legal evaluation process must drive the inquiry. At their core, medical-legal reports represent substantial medical evidence that can be used to facilitate claims handling and claims resolution. An inquiry into improving the medical-legal reporting system must then evaluate how well the present or any changes to the current medical-legal fee structure better enables that core purpose of orderly claims handling and claims resolution based on substantial medical evidence.

By definition, a medical-legal report must meet the standard for substantial medical evidence. This means it cannot represent surmise, speculation, conjecture or guess. The evaluator must incorporate correct legal theory and clearly explain the "how and why" for each conclusion using the "reasonable medical probability" standard for conclusions while reporting an adequate medical history or exam and thorough review of the relevant medical records.
This definition and applicable components cannot be supported by any checkbox or form report. By its very nature, the PR-4 cannot provide a physician the opportunity to meet the standard of substantial medical evidence. The PR-4 report is completely inadequate to

resolve a claim properly except in the most simple and routine cases. That is, single injury claims when no impairment, co-morbidities or multiple employers are involved and neither the worker nor the employer is disputing any medical issues.

With respect to this requirement, CSIMS believes the current fee schedule is arguably, in fact, empirically per CHSWC data and more than two decades of case law, doing the job more than adequately.

Rather than identifying significant issues with the fee schedule itself, this paper briefly explores a number of issues that have grown up around the fee schedule and have negatively impacted its purpose. This led to the conclusion that flaws to the medical-legal system exist more in relationship to training of QMEs and systemic issues than to any putative billing irregularities.

The current complexity based medical-legal fee schedule has been cost effective and is likely to remain so with the solutions and improvements CSIMS suggests in Section II B, together with integration of better defined and more objective complexity factors. Changes to the schedule should only be made if significant improvement in accountability or efficiency can be demonstrated in advance of implementation.

Recommendations generated by the pending RAND study have the potential to reach into and change virtually every facet of communication between treating and evaluating physicians, the injured worker, the employer and the Workers' Compensation Appeals Board. Implementation of numerous Labor Code provisions will likely be affected including Labor Code §§ 4061.5, 4068, 4610, 4610.5, 4628, 4658.7, 4662, 4663, 4664 and 4050 among others.

In pursuit of simplification, refinements, "administrative efficiency" and useful modifications of reports, there is a significant probability of missing many critical aspects of how the system actually works "on the ground." It is not enough to consider these as inevitable "unintended consequences" when we are presently at a juncture where such adverse consequences could be avoided entirely.

While CSIMS cannot speak for all stakeholders, we believe it is within bounds to state that there are no stakeholders who will not be affected by the RAND recommendations resulting from this study.

Therefore, we must once again emphasize our interest in remaining a resource to RAND. Our members, with decades of experience writing and billing for treatment and medical-legal reports, offer to discuss not just those ideas we considered and rejected, but any other concepts and ideas that are under consideration.

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