December 9, 2020

Hon. George Parisotto
Administrative Director
Division of Workers Compensation
1515 Clay Street, 17th floor
Oakland, CA 94612

Director Parisotto,

The history of revisions to the Medical-Legal Fee Schedule is rich with concepts, issues and ensuing discussions between the Division and stakeholders of all stripes. Unfortunately, the sheer number of those concepts, issues, discussions has caused a near-catastrophic paralysis that threatens the viability of an efficient process by which injured workers can obtain a fair and impartial medical evaluation when disputed medical issues are raised.

The Division is not without input from the regulated public on a vast number of macro and nuanced problems surrounding the medical-legal process and the proposed Medical-Legal Fee Schedule (MLFS). The relatively recent report by State Auditor, Elaine Howell provided an excellent analysis and sound recommendations addressing many.

Thus, in addition to the annotated review of the current proposed language for 8CCR §§ 9793,9794 and 9795, I will elaborate upon only two. One the Audit addressed directly and one I believe was missed.

The first involves the absurd length of time the MLFS has gone with no adjustment to reimbursement rates. This length of inattention is the major cause of current friction and was a major factor giving birth to the Division's QME inquisition that devastated careers and did irreparable damage to the working relationship between the Division and corps of evaluators.

I refer specifically to the Auditor's recommendation that the reimbursement rate for medical-legal evaluations (8CCR § 9795) include an annual cost-of-living adjustment. I understand the Division believes it may not have authority to include an adjustment factor into the regulation. I beg to differ. Labor Code § 5307.6 (a) requires "adoption **and revision**" (emph. added) of the MLFS. As to the frequency of such revisions, the same section requires adoptions and revisions take place "at the same time he or she adopts and revised the medical fee schedule pursuant to Section 5307.1." Revisions of the OMFS take place on a routine and regular basis - several times each year -unencumbered by the Administrative Procedures Act. The MLFS "enjoys" the same privilege verified within the "Notice of Proposed Rulemaking" wherein we read the following notice:

> AN IMPORTANT PROCEDURAL NOTE ABOUT THIS RULEMAKING:
>
> **The Medical-Legal Fee Schedule "establish(es) or fix(es) rates, prices, or tariffs" within the meaning of Government Code section 11340.9(g) and is therefore not subject to Chapter 3.5 of the Administrative Procedure Act (commencing at Government Code section 11340) relating to administrative regulations and rulemaking.**

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Thus, a cost-of-living adjustment could be implemented as often as each revision of the OMFS without delay or debate. Taking these facts together, we see absolutely no reason the Administrative Director is prevented from including an appropriately indexed annual cost of living adjustment (COLA) within the MLFS.

On the contrary it appears the Administrative Director has little choice but to eliminate a very important deficit and cause of great friction in operating the MLFS by complying with the Auditor's stipulation and the unambiguous language of Labor Code §5307.6.

The second issue is one I believe the Auditor missed, but not due to a less-than-thorough audit. Rather, I do not believe even most participants in this system understand it. I refer to the role that Maximus Inc. plays in reimbursement dispute resolution through the Independent Bill Review (IBR) process.

I learned of the depth of the relationship between the Division and Maximus during the later throws of the QME inquisition period. While I have no issue with that relationship per se, it was clarified in firsthand conversation, that Division Medical Unit staff educates and trains Maximus and its Independent Bill Reviewers (my terminology) how to interpret the MLFS to settle eligible reimbursement disputes.

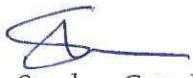
I raise this issue because the current fee schedule is not likely to eliminate the overall level of friction experienced by the current MLFS. At best, the proposal will swap current ambiguities with new ones. The level of friction is not likely to abate. Rather it will shift record review to the most egregious area of contention besides others including friction regarding reimbursable versus un-reimbursable Supplemental reports, the exact meaning of "available" as it is applied to delivery of medical records, issues surrounding reimbursement of "missed appointments," the use of certified interpreters and other newly minted issues better articulated by others in the community.

All this begs the question how will the Division train Maximus to discern reimbursement issues that the Division itself will ensconce in the system? How will that training be presented without prejudice?

I urge all training of Maximus staff after the adoption of an updated MLFS be accomplished by a small team of industry participants working with Division staff. The Division's Medical Unit staff must be joined by billing experts from both the provider and payor community plus one or two members from the corps of evaluators.

Thank you for your attention to these and the myriad of issues the community will bring to the Division based on the current proposal.

Cordially,



Stephen Cattolica

CWCSA

Enclosure – Annotated version of the proposed "Text of Regulations"

Title 8. Industrial Relations
Division 1. Department of Industrial Relations
Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director - Administrative Rules
Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

§ 9793. Definitions.

As used in this article:

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

(b) “Contested claim” means any of the following:

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

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

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

(4) Where the claims administrator has accepted liability for a claim and a disputed medical fact exists.

(c) “Comprehensive medical-legal evaluation” means an evaluation, which includes an examination of an employee, and which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section ~~10606~~ 10682 and (B) is either:

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

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

(d) “Claims Administrator” means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-

administered self-insured employer, a group self-insurer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority.

(e) “Disputed medical fact” means an issue in dispute, including an objection under Section 4062 of the Labor Code to a medical determination made by a treating physician concerning: (1) the employee's medical condition, (2) the cause of the employee's medical condition, (3) For injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30, 2013, treatment for the employee's medical condition; (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition; or (5) the employee's medical eligibility for rehabilitation services.

(f) “Explanation of review” means the document described in Labor Code sections 4603.3(a) and 4622 that is provided to a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician when the claims administrator has objected to the cost of a medical-legal expense.

(g) “Follow-up medical-legal evaluation” means an evaluation which includes an examination of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section ~~10606~~ 10682, (B) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician within ~~nine~~ twelve (12) months following the evaluator's examination of the employee in a comprehensive medical-legal evaluation and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive medical-legal evaluation.

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

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

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

Commented [SC1]: There is no data to support 18 months nor support for any change from the existing nine-month timeframe. The longer time between evaluations, the less familiarity with the former evaluation will exist. This change appears to be nothing more than an attempt to placate payor concerns about costs. While costs are an important consideration, they should not outweigh the conditions under which a follow-up evaluation takes place. **What is the DWC’s factual basis and data indicating any change to this time frame is required?**

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

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

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

Commented [SC3]: A medical-legal evaluation as defined in subparagraph 9793(c) cannot be served as service is defined. However, the "narrative report" can be served on the Parties.

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

(j) "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.

(k) "Primary treating physician" is the treating physician primarily responsible for managing the care of the injured worker in accordance with subdivision (a) of Section 9785.

(*l*) "Reports and documents required by the administrative director" means an itemized billing, a copy of the medical-legal evaluation report, any correspondence received by the physician from the parties to the action, and any verification required under Section 9795(c). "Correspondence received by the physician from the parties to the action," does NOT include any medical records.

Commented [SC4]: Notwithstanding recent pronouncements and assurances the definition of "correspondence" does not include any medical records, a direct reference clarifies this "fact." A generally accepted definition of "correspondence" carries no weight or affect when one party seeks to obfuscate the med-legal evaluation process.

(m) "Supplemental medical-legal evaluation" means an evaluation which (A) does not involve an examination of the patient, (B) is based on the physician's review of records, test results or other medically relevant information which was not available to the physician pursuant to Labor Code Section 4062.3(b) & (e) at the time of the initial examination, or a request for factual correction pursuant to Labor Code section 4061(d), (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section ~~10606~~ 10682 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

Commented [SC5]: Reference to LC Section 4062.3 (c) & (e) and other applicable code references will clear up any ambiguity or confusion in connection with use of the word "available." Use of this reference will also reinforce the mandatory exchange of records between the parties before submission to the evaluator thus better substantiating what records (pages) are to be billed.

(n) "Record Review" means the review by a physician of documents received by the physician pursuant to Labor Code Section 4062.3(b) & (e) in connection with a medical-legal evaluation or request for a Supplemental evaluation report. The documents may consist of medical records, legal transcripts, medical test results, and or other relevant documents. For purposes of record review, a page is defined as one side of an 8 ½ by 11 single-sided document, chart or paper, whether presented in physical or electronic form. Multiple condensed pages or documents displayed on a single page shall be charged as separate pages. Any documents sent to the physician for record review must be accompanied by a declaration under penalty of perjury that the provider of the documents has complied with the provisions of Labor Code section 4062.3 before providing the documents to the physician. The declaration must also contain an attestation as to the total page count of the documents provided. A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider.

Authority: Sections 133, 4622, 4627, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4061, 4061.5, 4062, 4610.5, 4620, 4621, 4622, 4625, 4628, 4650, 5307.6 and 5402, Labor Code.

§ 9794. Reimbursement of Medical-Legal Expenses.

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

(1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the ~~o~~ Official ~~m~~ Medical ~~f~~ Fee ~~s~~ Schedule adopted pursuant to Labor Code Section 5307.1. No other charges shall be billed or reimbursed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report. In no event shall the claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report. Additionally, the claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the claims administrator, if adequate medical information is already in the medical record provided to the physician. Obtaining "prior authorization" as described is not subject to the Utilization Review process pursuant to Labor Code Section 4610 and 8CCR Section 9792.6, et seq.

(2) As a medical legal expense, the cost of services described in subparagraph (a)(1) are not subject to contracted discounts otherwise attributable to those same services when provided in conjunction with the Utilization Review process pursuant to Labor Code Section 4610.

Commented [SC6]: "received" is triggering event. Documents sent, but not received are irrelevant

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Commented [SC7]: Reference to LC Section 4062.3 (c) & (e) and other applicable code references will clear up any ambiguity or confusion in connection with use of the word "available." Use of this reference will also reinforce the mandatory exchange of records between the parties before submission to the evaluator thus better substantiating what records (pages) are to be billed.

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Commented [SC9]: It is incumbent on the DWC to require both the biller and payor to abide by the OMFS when required.

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Commented [SC10]: The DWC has ample experience with complaints and the ensuing issues caused by claims administrators that insist the QME or AME submit an RFA for the purpose of obtaining authorization for tests as described. The med-legal evaluators and those testing services involved with providing tests in the Med-Legal context must not be burdened with attempting to navigate the treating physician authorization process. An alternate can be put into regulation – even one that mirrors the

Commented [SC11]: Medical-Legal expenses are not subject to discounts provided in a treatment setting.

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

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

(c) A claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the evaluator or other provider of the objection within sixty days after receipt of the itemized bill, reports and documents required by the administrative director using an Explanation of Review pursuant to Labor Code Section 4603.3. Any notice of objection must also include or be accompanied by all of the following:

(1) An Explanation of Review shall indicate the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or other provider shall not be altered. If the objection is based on appropriate coding of a procedure, the Explanation of Review shall include both the code reported by the provider and the code believed reasonable by the claims administrator, and shall include the claim's administrator's factual basis used to determine why its code more accurately reflects the service provided.

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

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

(4) A statement pursuant to Labor Code section 4622(b)(1) that the physician or provider(s) of services as described in paragraph (a)(1) may seek a second review by the claims administrator of the reduction of billing of the medical-legal expense. The statement shall also state the request for second review by the physician or provider(s) of services as described in paragraph (a)(1) and completion of the second review process of the medical-legal expense under California Code of Regulations, title 8, section 9792.5.5.

(5) A statement that the request for second review by the physician and completion of the second review process of the medical-legal expense by the claims administrator is a prerequisite to seeking independent bill review provided in Labor Code section 4603.6.

(6) A statement that if the provider does not seek a second review and the only issue in dispute is the amount of payment, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any additional payment.

(d) If the provider disputes the amount of payment made by the claims administrator on a bill for medical-legal expenses following the receipt of an explanation of review issued

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Commented [SC12]: Med-legal expenses for testing may not be eligible for the SBR and IBR the same a treatment setting. Yet, they are also not eligible for SBR & IBR in a med-legal setting. This language clarifies that eligibility for the med-legal SBR and IBR processes.

under subdivision (c), the provider must request the claims administrator to conduct a second review of the bill. The second bill review request must be made according to the provisions of California Code of Regulations, title 8, section 9792.5.5.

(e) If after completion of the second review process under Labor Code section 4622(b)(1) the physician still contests the amount paid for the medical-legal expense, the physician shall only contest the amount to be paid by requesting independent bill review as provided in Labor Code section 4603.6.

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

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(f) If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid pursuant to the fee schedule set forth in section 9795, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which shall also contain the following statements:

(1) The physician or provider(s) of services as described in paragraph (a)(1) may object to the denial of the medical-legal expense issued under this subdivision by notifying the claims administrator in writing of their objection within ninety (90) days of the service of the explanation of review; and

(2) If the physician or provider(s) of services as described in paragraph (a)(1) does not file a written objection with the claims administrator challenging the denial of the medical-legal expense issued under this subdivision, neither the employer nor the employee shall be liable for the amount of the expense that was denied.

(g) If the claims administrator receives a written objection to the denial of the medical-legal expense under subdivision (d) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a petition to review of the denial of medical-legal expense and a declaration of readiness to proceed pursuant to section 10228 et. seq.

(h) All reports and documents required by the administrative director shall be included in or attached to the medical-legal report when it is filed and served on the parties pursuant to Section ~~10608~~ 10610 or served on the parties pursuant to Section 4061 or 4062 of the Labor Code.

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

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(j) A physician or provider(s) of services as described in paragraph (a)(1) may not charge, nor be paid, any fees for services in violation of Sections 139.3 and 139.32 of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;

~~(i)~~ (k) Claims administrator shall retain, for five years, the following information for each comprehensive medical evaluation for which the claims administrator is billed:

(1) name and specialty of medical evaluator;

(2) name of the employee evaluated;

(3) date of examination;

(4) the amount billed for the evaluation;

(5) the date of the bill;

(6) the amount paid for the evaluation, including any penalties and interest;

(7) the date payment was made.

This information may be stored in paper or electronic form and shall be made available to the administrative director upon request. This information shall also be made available, upon request, to any party to a case, where the requested information pertains to an evaluation obtained in the case.

Authority: Sections 133, 4622, 4627, 5307.3 and 5307.6, Labor Code.
Reference: Sections 139.3, 139.32, 4620, 4621, 4622, 4625, 4626, 4628 and 5307.6, Labor Code.

§ 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

(a) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

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

(b) The fee for each evaluation is calculated by multiplying the relative value by $~~12.50~~16.25, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of any medical records in preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is

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expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

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CODE	~~*B.R.*~~*RV*	*PROCEDURE DESCRIPTION*
ML~~1~~200	31 ($503.75)	*Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation*. Includes instances where the injured worker does not show up for the evaluation, the interpreter does not show up for the evaluation or when required, the interpreter cannot provide proof of certification which makes it impossible to go forward with the exam, the injured worker leaves the evaluation before the completion of the evaluation, the injured worker is more than 30 minutes late for the appointment and the QME is unable to continue with the scheduled QME appointment, or in the case where the appointment has been canceled within six business days of the scheduled appointment date. If the physician produces a record review report within 30 days of the date of the missed appointment the physician shall be reimbursed at the rate of $3.00 per page for any records reviewed in excess of 200 pages. When billing for a record review report under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report. Any pages reviewed for this record review report will be excluded from the page count for reimbursement when the face-to-face or supplemental evaluation takes place. If fees for failed appointments and for late cancellations are incurred through the fault or neglect of the injured worker or his/her representative, the employer may seek to credit those charges against the injured worker's award. ~~This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.~~

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CODE	*RV*	*PROCEDURE DESCRIPTION*
ML~~1~~201	124~~5~~ ($2,015)	*Comprehensive Medical-Legal Evaluation*. Includes all comprehensive medical-legal evaluations that do not qualify as follow-up or supplemental medical-legal evaluations. The fee includes review of 200 pages of records. Review of records in excess of 200 pages shall be reimbursed at the rate of $3.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report. ~~*Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour.~~
CODE	*RV*	*PROCEDURE DESCRIPTION*

Commented [SC13]: The evaluator cannot be put at risk with respect to the number of pages. They have no control over what they receive. Therefore**, Parties submitting records should be required to submit the affidavit of the contents of the records under penalty of perjury. That affidavit should be considered part of the record and can be used to substantiate the pages billed.**

The evaluator must be given a means to indicate a number of pages if different than the affidavits indicate.

ML~~1~~202	81~~50~~ ($1,316.25)	*Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation by a physician which occurs within twelve (12) months of the date on which a prior comprehensive medical-legal evaluation was performed by the same physician. The fee includes review of 200 pages of records that were not reviewed as part of the initial comprehensive medical-legal evaluation or as part of any intervening supplemental medical-legal evaluations. Review of records in excess of 200 pages shall be reimbursed at the rate of $3.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report. ~~*Basic Comprehensive Medical-Legal Evaluation*. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.~~
CODE	*RV*	*PROCEDURE DESCRIPTION*

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Commented [SC15]: The evaluator cannot be put at risk with respect to the number of pages. They have no control over what they receive. Therefore**, Parties submitting records should be required to submit the affidavit of the contents of the records under penalty of perjury. That affidavit should be considered part of the record and can be used to substantiate the pages billed.**

The evaluator must be given a means to indicate a number of pages if different than the affidavits indicate.

Deleted: Review of records in excess of 200 pages shall be reimbursed at the rate of $3.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report. ¶

ML~~1~~203	40~~75~~ ($650)	*Fees for Supplemental Medical-Legal Evaluations*. The fee includes services for writing a report after receiving a request for a supplemental report from a party to the action or receiving records that were not received pursuant to Labor Code Section 4062.3 (c) and (e), at the time of the initial or follow-up comprehensive medical-legal evaluation. Fees will not be allowed under this section for supplemental reports: (1) following the physician's review of information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report; or (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation, or a prior supplemental medical-legal evaluation. Failure to issue a supplemental report upon request because of an inability to bill for the report under this code would constitute grounds for discipline by the Administrative Director or his or her designee. The fee includes review of 50 pages of records. Review of records in excess of 50 pages that were received as part of the request for the supplemental report shall be reimbursed at the rate of $3.00 per page. When billing under this code, the physician shall include in the report a verification under penalty of perjury of the total number of pages of records reviewed by the physician as part of the supplemental medical-legal evaluation and preparation of the report. ~~*Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below.~~

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		~~In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon;~~
		~~(1) Two or more hours of face-to-face time by the physician with the injured worker;~~
		~~(2) Two or more hours of record review by the physician;~~
		~~(3) Two or more hours of medical research by the physician;~~
		~~(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;~~
		~~(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;~~
		~~(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;~~

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		~~(7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.~~
		~~(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.~~
		~~(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.~~

CODE	*RV*	*PROCEDURE DESCRIPTION*
ML~~1~~2004	7~~5~~ ($455/hr)	*Fees for Medical-Legal Testimony.* The physician shall be reimbursed at the rate of RV 7, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of two hours for a deposition. If a deposition is canceled fewer than eight (8) calendar days before the scheduled deposition date, the physician shall be paid a minimum of one hour for the scheduled deposition. ~~*Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances*. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:~~
		~~(1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon.~~
		~~(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;~~

		~~(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.~~
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML~~1~~2205	5 ($325/hr)	*Fees for Review of Sub Rosa Recordings.* The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for time spent reviewing sub rosa recordings. The physician shall include in his or her report verification under penalty of perjury of time spent reviewing sub rosa recordings. The fee for reviewing sub rosa recordings may be allowed in addition to any fee for any single report written by the physician as a result of the review of the sub rosa recordings. If the sub rosa recordings are received by a physician prior to the issuance of a pending report related to a medical-legal evaluation, the physician may not also bill a supplemental report fee in connection with the review of the sub rosa material. ~~Fees for medical-legal testimony. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of one hour for a scheduled deposition.~~

Commented [SC16]: This is stipulation is an overreach and over simplification of compliance with its requirement. What is the evaluator to do if the sub rose is received such that the time required to review and write/rewrite the report delays service of the report past 30 days?

CODE	*B.R.~~V~~*	*PROCEDURE DESCRIPTION*
ML~~1~~206	~~5~~ ($0)	*Unreimbursed Supplemental Medical-Legal Evaluations.* This code is designed for communication purposes only. It indicates and acknowledges that compensation is not owed for this report. This code shall be used for supplemental reports: (1) following the physician's review of information which was received pursuant to Labor Code Section 4062.3 (c) and (e) at the physician's office for review or was included in the document record provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical-legal report; (2) addressing an issue that was requested by a party to the action to be addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation, or a prior supplemental medical-legal evaluation; or (3) addressing an issue that should have been addressed in a prior comprehensive medical-legal evaluation, a prior follow-up medical-legal evaluation, or a prior supplemental medical-legal evaluation pursuant to the requirements for a medical-legal evaluation and or report as required by any provision of title eight, California Code of Regulations, sections 9793, 9794 and 9795. ~~Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.~~
CODE	*B.R.*	*PROCEDURE DESCRIPTION*

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Commented [SC17]: Based on what? Only if the cover letter is fully compliant with current law and not a legacy checkbox form letter.

ML-PRR	($3.00 per page)	*Record Review.* This billing code used to identify charges for review of records in excess of pages included in medical-legal numerical billing codes. Excess pages are billed at three dollars per page.

Commented [SC18]: See previous comment about use and weight of affidavit submitted when records are received.

(d) The services described by Procedure Codes ML-~~1~~201 through ML-~~1~~20~~6~~3 may be modified under the circumstances described in this subdivision. The modifiers shall not be applicable to per page charges for record review in any of the Procedure Codes ML-201 through ML-203. The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

-92 Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-93 Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML-~~1~~20~~2~~1 and ML-~~1~~20~~3~~2.

Commented [SC19]: "Conduct the examination" must include "tele-evals."

-94 Evaluation ~~and medical-legal testimony~~ performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.35. If modifier -93 is also applicable for an ML-~~1~~20~~2~~1 or ML-~~1~~20~~3~~2, then the value of the procedure is modified by multiplying the normal value by 1.45.

-95 Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

-96 Evaluation performed by a Psychiatrist or Psychologist when a psychiatric or psychological evaluation is the primary focus of the medical-legal evaluation. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 2. If modifier -93 is also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.10. If modifier -94 is also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.35. If modifier -93 and -94 are also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.45.

-97 Evaluation performed by a physician who is board certified in Toxicology when a Toxicology evaluation is the primary focus of the medical-legal evaluation. Where this

Commented [SC20]: Aren't all QMEs board certified (LC 139.2)? If not this stipulation will cause defense to choose non-board certified toxicologist QMEs which may compromise the clinical quality of the report and conclusions. **If the QME is a toxicologist, that's all that matters.**

modifier is applicable, the value of the procedure is modified by multiplying the normal value by 2.0. If modifier -93 is also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.1. If modifier -94 is also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.35. If modifier -93 and -94 are also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.45.

-98 Evaluation performed by a physician who is board certified in Medical Oncology when an Oncology evaluation is the primary focus of the medical-legal evaluation. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 2.0. If modifier -93 is also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.1. If modifier -94 is also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.35. If modifier -93 and -94 are also applicable for an ML-201 or ML-202, then the value of the procedure is modified by multiplying the normal value by 2.45.

(e) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable and shall be reimbursed in the same manner as set forth in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1.

(f) This section shall be effective as of April 1, 2021 and shall apply to the following: (1) medical-legal evaluation reports where the examination occurs, or is missed persuant to 8CCR Section 9795(c) on or after April 1, 2021; ~~the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments;~~ (2) medical-legal testimony provided on or after April 1, 2021; ~~the effective date of the 2006 amendments;~~ and (3) supplemental medical-legal reports that are requested on or after April 1, 2021 ~~the effective date of the 2006 amendments~~ regardless of the date of the original examination.

(g) Nothing in this regulation affects the operation of Labor Code section 5307.6.

(h) If a medical-legal evaluation is ordered by an administrative law judge or court of competent jurisdiction, the judge has the authority to apply the appropriate modifier to that medical-legal evaluation for purposes of billing.

Authority: Sections 133, 4627, 5307.3 and 5307.6, Labor Code.
Reference: Sections 139.2, 4061, 4061.5, 4062, 4610.5, 4620, 4621, 4622, 4625, 4626, 4628, 5307.6 and 5402, Labor Code.

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Commented [SC21]: What is the data and evidence that these evaluations are any less complex than mental health QME/AME

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Commented [SC22]: See comment under toxicology.

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Commented [SC23]: **To what "appropriate modifier" does this paragraph refer?**