8 CCR §§ 9794 - 9795

§ 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 Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1. 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.

(2) 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.

(3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.

(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 physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative director using an explanation of review. Any notice of objection shall 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 rationale as to 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 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 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 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.

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

(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 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 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 or served on the parties pursuant to Section 4061 or 4062 of the Labor Code.

(i) Physicians 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.

(j) A physician 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 administrators 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.

Note: Authority cited: 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.

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§ 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, 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 records, 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 expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service. If prior agreement of the parties is required under any provision of this regulation, the physician may not condition performance of the evaluation on receipt of prior agreement of the parties.

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

CODE	*B.R.*	*PROCEDURE DESCRIPTION*
ML100		*Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation*. This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML101	5	*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. No more than 3 hours may be billed for report preparation under this code.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML102	50	*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*
ML103	75	*Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below.
		In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed 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. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;
		(3) Two or more hours of medical research by the physician, using sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon this complexity factor. An evaluator who specifies this complexity factor must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;
		(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. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;
		(6) Addressing and providing an analysis of the issue of medical causation, ~~upon written request of the party or parties requesting the report~~ provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the

		evaluation;
		(7) Addressing the issue of apportionment, when items (A) and (B) below both apply: (A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injury~~ies~~ to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more ~~or more~~ dates of injury~~ies~~ 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.~~ (B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.
		(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*
ML104	5	*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 actually and necessarily incurred for the production of the medical-legal report and required for the evaluation, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. ~~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~~ The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be billed for report preparation.
		(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. The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be billed for report preparation;
		(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the start of the evaluation, that the evaluation involves extraordinary circumstances. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. When billing under this subdivision of the 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*
ML105	5	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.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML106	5	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. No more than three hours may be billed for report preparation under this code. No more than two hours may be billed for medical research under this code. In order to bill for medical research under this code, the physician must use sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon medical research in billing. An evaluator who bills for medical research under this code must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon.

(d) The services described by Procedure Codes ML101 through ML106 may be modified under the circumstances described in this subdivision. 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 102 and ML 103.

-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 1.25. If modifier -93 is also applicable for an ML-102 or ML-103, then the value of the procedure is modified by multiplying the normal value by 1.35.

-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.

(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 apply to medical-legal evaluation reports where the examination occurs on or after 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 the effective date of the 2006 amendments; and (3) supplemental medical legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.