



## California Workers' Compensation Institute

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December 15, 2020

VIA E-MAIL – [DWCRules@dir.ca.gov](mailto:DWCRules@dir.ca.gov)

Maureen Gray, Regulations Coordinator  
Department of Industrial Relations  
P.O. Box 420603  
San Francisco, CA 94142

### **Re: Proposed Amendments to Medical-Legal Fee Schedule Regulations**

Dear Ms. Gray:

These comments on proposed amendments to the Medical-Legal Fee Schedule regulations are presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 83% of California's workers' compensation premium, and self-insured employers with \$65B of annual payroll (30% of the state's total annual self-insured payroll).

Insurer members of the Institute include AIG, Alaska National Insurance Company, Allianz Global Corporate and Specialty, AmTrust North America, AXA XL Insurance, Berkshire Hathaway, CHUBB, CNA, CompWest Insurance Company, Crum & Forster, EMPLOYERS, Everest National Insurance Company, GUARD Insurance Companies, The Hanover Insurance Company, The Hartford, ICW Group, Liberty Mutual Insurance, North American Casualty Company, Pacific Compensation Insurance Company, Preferred Employers Insurance, Republic Indemnity Company of America, Sentry Insurance, State Compensation Insurance Fund, Travelers, WCF National Insurance, Zenith Insurance, and Zürich North America.

Self-insured employer members include Albertsons/Safeway, BETA Healthcare Group, California Joint Powers Insurance Authority, California State University Risk Management Authority, Chevron Corporation, City and County of San Francisco, City of Los Angeles, City of Pasadena, City of Torrance, Contra Costa County Risk Management, Costco Wholesale, County of Los Angeles, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, East Bay Municipal Utility District, Foster Farms, Grimmway Farms, Kaiser Permanente, Marriott International, Inc., North Bay Schools Insurance Authority, Pacific Gas & Electric Company, Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Shasta-Trinity Schools Insurance Group, Southern California Edison, Special District Risk Management Authority, Sutter Health, University of California, and The Walt Disney Company.

Recommended revisions to the proposed regulations are indicated by underscore and ~~strikeout~~. Comments and discussion by the Institute are identified by *italicized text*.

## Priority Considerations

The California Workers' Compensation Institute is deeply concerned that the year-long process undertaken by the Division to obtain input and support from the entire community (including claims administrators, providers, and injured employees) has been compromised. The Institute wishes to share our profound concerns about the entire premise of the proposed Medical-Legal Fee Schedule regulations.

- During the extensive stakeholder meetings, it was understood that the Division wished to move away from a fee schedule based on complexity factors in favor of a flat fee system that would avoid the problematic features of the current system. The proposal for a flat fee system was quickly joined to a per page fee – but throughout the discussions, the per page fee was 100% premised upon the creation of a Records Organizer that would serve to eliminate duplicate records and ensure that a single, discrete set of chronologically sorted records would be presented to the provider. That process would benefit all participants, including medical-legal providers, claims administrators, and injured workers. A mandated Records Organizer concept is the *sine qua non* of a per page fee and thus the entire flat fee system.

The Division has the power to both implement and compel compliance with a Records Organizer system. Labor Code section 4627 provides the administrative director with authority to “*promulgate* such reasonable rules and regulations as may be necessary to interpret [Article 2.5, Medical-Legal Expenses] and *compel compliance* with its provisions.” If the Division nevertheless believes that it does not have the authority under section 4627 to mandate the orderly process of records submission, then the flat fee system should be postponed until legislation providing that authority can be put into place.

- According to the Initial Statement of Reasons, “The schedule based on a flat fee system should reduce frictional costs. The increase in amounts payable to Providers is expected to increase report quality and attract new physicians to the QME program.”

The attempt to eradicate disputes over the level of service and attendant fee by implementing a flat fee results in equating the most basic evaluations with the most complex, with the number of pages submitted for record review substituting as a proxy for complexity. Labor Code section 5307.6(a) requires that the fee schedule recognize the “relative complexity” of the particular evaluation. There is no way to ascertain the relevancy or complexity of each page that is sent to the evaluating physician (or more accurately, the pages actually reviewed by the physician after they have been sorted, collated, and summarized by support staff). Under the proposed regulations, a fax cover sheet submitted as part of subpoenaed records receives the same weight as an operative report or a hospital discharge summary.

- The proposed fee schedule fails to address even the most obvious points of friction in the new system. What happens when the parties do not comply with the 20-day requirement under Labor Code section 4062.3? Under most circumstances, and pursuant to Labor Code section 4062.3 and 8 CCR 35, objections may not be made to the submission of medical records; this may result in the submission of duplicate medical records and a \$3.00 per page request for reimbursement. Disputes will arise regarding the number of pages attested to and the number of pages received. A dispute about whether submission

of records is in violation of section 4062.3 is, under the en banc decision in *Suon*, within the purview of the WCJ to fashion a remedy. But the disputed payment issue remains in the Independent Bill Review process, with its strict timeframes. This two-track resolution will lead to inconsistent outcomes, when the payer has been required to provide payment under IBR but the WCJ later agrees with the payer's position.

- According to the ISOR, the goal of mitigating the frictional costs associated with determining the level of service for most medical-legal evaluations will be achieved under the flat fee structure. As detailed above, frictional costs associated with disagreements over complexity factors will likely be replaced by disputes over page counts and relevancy of content. Disputes concerning criteria for determining “extraordinary circumstances” under Labor Code section 5307.6(b) will continue; in the stakeholder meetings, the provider community expressed an intent to utilize this section as a way to capture increased reimbursement, and because the proposed fee schedule does not address the subject at all, the disputes will certainly increase.
- The proposed regulations preclude review (and reimbursement) of records submitted without an attestation. If a full and proper attestation is somehow separated from the submitted records, the provider will not review the records. Instead, in order to obtain reimbursement, the provider will wait – and then submit a supplemental report when the attestation is located. Because the page count of “included” records in a Supplemental Report (ML 203) is far below that in Comprehensive Evaluation (ML 201), this scenario lends itself to abusive practices because providers will realize reimbursement at a much lower threshold.
- According to the ISOR, the “increase in amounts payable to providers is expected to increase report quality.” Although aspirational, it is ill-advised to assume that increasing a provider's fee in any way guarantees a concomitant improvement in the quality of the medical report for which payment is sought. Instead, the quality of a medical report depends entirely on the provider's ability to submit a substantial evidence report which meets the threshold evidentiary requirement (*e.g.*, not based on facts no longer germane, on inadequate medical histories and examinations, on incorrect legal theories, or based on surmise, speculation, conjecture, or guess). The State Auditor's Report itself referenced the avoidable delays in claim resolution, delays in provision of employee benefits, and unnecessary litigation caused by inaccurate and incomplete medical reports. However, the remedy to improve the quality of these reports should not be predicated on increasing amounts to be paid but rather on continuous QME oversight and enforcement by the DWC and challenges to inaccurate or incomplete medical-legal reports at the WCAB. Moreover, while an increase in fees might retain some providers who consistently submit quality reports, increasing the fee amounts also results in the unintended consequence of retaining providers who *do not* submit quality reports. The proposed fee schedule might well attract physicians whose primary incentive is the amount to be paid rather than production of a quality medical report.

The proposed fee schedule has little chance of getting the Division out from under the criticism that is tied to the current system, and instead increases the likelihood of exacerbating the existing problems. The Institute urges the Division to instead institute a two-year interim measure such as an across-the-board increase in the reimbursement rate under existing 8 CCR §9795 that

addresses the concerns set forth in the State Auditor's Report. During the two-year pause, legislation can be drafted (even by the Division itself) to set the necessary foundation for the flat fee system – a foundation that ensures its success rather than its failure. A two-year pause would also provide ample opportunity for the Division to improve regulations governing the education, training, and reappointment of QMEs.

Having shared our strong misgivings about the current proposal, CWCI nevertheless wishes to provide assistance in the drafting of the proposed regulations, as outlined below. We only hope that these proposals can wait for the proper foundation to be built.

### **§ 9793: Definitions.**

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

(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 10682, (B) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician within nine months following the evaluator's examination of the employee prior to April 1, 2021, or eighteen (18) months following the evaluator's examination of the employee on or after April 1, 2021, in a comprehensive medical-legal evaluation, and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive medical-legal evaluation.

(l) "Reports and documents required by the administrative director" prior to April 1, 2021 means an itemized billing, a copy of the medical-legal evaluation report, and any verification required under Section 9795(c);, and on or after April 1, 2021 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).

(n) "Record Review" means the review on or after April 1, 2021, by a physician of documents sent to the physician in connection with a medical-legal evaluation or request for 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 an 8 ½ by 11 single-sided document, chart or paper, whether 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 entity providing 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. This declaration may be signed electronically with a digital signature. A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider.

**Discussion:**

*A longstanding concern has been the utilization of the medical-legal fee structure by treating physicians. A regulatory limitation is needed to curtail this practice in order to avoid disputes as to whether a treating physician's report is medical-legal in nature. Accordingly, the Institute suggests new language that provides clarity to treating physicians wishing to bill for their services under the Medical-Legal Fee Schedule when a medical-legal report was not requested.*

*The proposed regulations require a declaration of compliance with Labor Code section 4062.3 as well as attestation of the total page count of records being provided to the QME. In most instances, however, the claims administrator will not submit documents directly from the claims file but instead will request that their copy service make direct service of records to the evaluator. Under these circumstances, it will be necessary for the Division to clarify which entity (the claims administrator or the copy service) is charged with the obligation to submit the declaration. Of course, the copy service will not have engaged in the meet and confer requirements of section 4062.3. Accordingly, a solution could be to require the claims administrator to comply with section 4062.3, submit the appropriate declaration, and then have the copy service attest only to the page count of the records in question.*

*The Institute suggests that language be added to permit the signed declaration required under this subsection to be made electronically.*

*The Institute strongly recommends the addition of language in subsections (g), (l), and (n) to make clear that the amended definitions apply only to dates on or after the effective date of these rules.*

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

(b) The fee for each evaluation is calculated by multiplying the relative value by **\$12.50 for medical-legal evaluation procedures conducted prior to April 1, 2021, or \$16.25 for medical-legal evaluation procedures conducted on or after April 1, 2021**, 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. **For services conducted prior to April 1, 2021, t**The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the time 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.

**Discussion:**

*The Institute strongly recommends the addition of language in subsection (b) to make clear that the amended regulations apply only to dates on or after the effective date of these regulations. Inasmuch as the Division is moving to a flat fee payment structure, language describing payment based on complexity and time must be limited to services prior to the effective date of the revised regulations.*

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

ML204	7 ( <del>\$455</del> <u>\$425</u> /hr)	<i>Fees for Medical-Legal Testimony.</i> The physician shall be reimbursed at the rate of RV 7, or <del>his or her</del> <u>their</u> 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, <u>including preparation and testimony time</u> . If a deposition is canceled fewer than eight (8) days before the scheduled deposition date, the physician shall be paid a minimum of one hour for the scheduled deposition.
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**Discussion:**

*During the stakeholder meetings, a figure of \$425 was suggested by attendees. Inasmuch as the current rate for deposition testimony is \$250, a 70% increase in the hourly rate should be sufficient to address the concerns in this instance. Since depositions rarely last longer than one hour, a two-hour minimum adequately addresses a reasonable time associated with preparation and testimony.*

ML206	(\$0)	<del>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 available in 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.</del>
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**Discussion:**

*The description contained in ML 203 already outlines certain aspects of a Supplemental Report that are not reimbursable. Creation of a separate code describing a non-payable service will cause confusion and the Institute suggests removing this language. While a supplemental report may be generated to address a deficiency in the associated comprehensive report, there is no requirement for the evaluating physician to submit a bill for zero fees associated with that*

*supplemental report. Although some providers may not be incentivized to submit a zero-fee billing, to the extent that such bills are generated they will represent new administrative costs for both the provider and for the claims administrator. If the intent of this code is for purposes of tracking these types of reports by the Division, inconsistency in the use of the code will result in unreliable statistics.*

(f) Amendments to Tthis section shall be effective as of April 1, 2021, and shall apply to the following: (1) medical-legal evaluation reports where the examination occurs on or after April 1, 2021; (2) medical-legal testimony provided on or after April 1, 2021; and (3) supplemental medical-legal reports that are requested on or after April 1, 2021 regardless of the date of the original examination. Amendments to this section related to the reimbursement for excess per page record review shall remain in effect only until April 1, 2023, and as of that date are repealed.

#### **Discussion:**

*Substantive changes made to section 9795 warrant clarification that amended language and rates do not apply to medical-legal services prior to April 1, 2021. Providers of medical-legal services, as well as claims administrators, independent bill reviewers providing IBR services, and WCAB judges, must rely on clearly defined dates for all proposed changes for these regulations.*

*The per-page records review charge is an integral component of these proposed regulations. During the stakeholder meetings held over several months, all participants recognized that a per-page charge could only be implemented if made in conjunction with a Records Organizer that would act as a clearinghouse and gateway. The Institute understands that the Division may believe that it does not have sufficient authority to regulate a new process such as this, and that formal legislation would have to be enacted. Because of the current health pandemic, it is not clear whether the legislature will have the time to take this up given other urgent priorities. Accordingly, the Institute urges the Division to include a “sunset” clause in these proposed regulations, in order that the per-page charge might be tested and withdrawn if it is indeed unworkable without the Records Organizer concept being implemented concurrently.*

*A concurrent voluntary pilot program utilizing a Records Organizer would provide the Division with the necessary information to incorporate into new mandatory regulations after the appropriate legislative authority is secured.*

(g) Nothing in this regulation affects the operation of Labor Code section 5307.6. The term “extraordinary circumstances” as set forth in Labor Code section 5703.6(b) shall be limited to evaluations performed in the fields of psychiatry/psychology, oncology, or toxicology, as performed by specialists with the corresponding Board Certification, and shall be reimbursed according to the modifiers set forth in this section.

#### **Discussion:**

*The stakeholder discussion participants were united behind a limitation to the statutory opportunity to circumvent the fee schedule. Following extensive discussion, there was general*

*agreement that “extraordinary circumstances” should be defined as evaluations for psychiatry, psychology, oncology, and toxicology. While the proposed modifiers of -96, -97, and -98 appropriately increase the reimbursement rate for these highly complex, specialized, and underrepresented fields, there needs to be a defined restriction in order to avoid abusive practices.*

*Alternatively, a change in the Definition section at the outset of these amendments could accomplish the same result.*

Thank you for the opportunity to comment, and please contact us if additional information would be helpful.

Sincerely,

Ellen Sims Langille, General Counsel  
Stacy L. Jones, Senior Research Associate

ESL:SLJ/pm

cc: George Parisotto, DWC Administrative Director  
Katrina Hagen, DIR Executive Director  
CWCi Claims Committee  
CWCi Medical Care Committee  
CWCi Legal Committee  
CWCi Regular Members  
CWCi Associate Members