



Medical-Legal Fee Schedule Tutorial

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Definitions

Abbreviations used in this presentation:

LC - the Labor Code

CCR - Title 8 California Code of Regulations

WCAB - Workers' Compensation Appeals Board

AD – Administrative Director



- “Claim”
 - means a claim for compensation as evidenced by either the filing of a claim form (DWC 1) pursuant to LC § 5401 or notice or knowledge of an injury under LC § 5400 or § 5402.
- “Contested Claim”
 - Liability is rejected.
 - Claim is presumed compensable. (LC § 5402)
 - Failure to respond to demand for payment or failure to send delay letter. (LC § 4650)
 - Disputed medical fact.



- "Comprehensive medical-legal evaluation"
 - an evaluation of an employee which
 - results in the preparation of a narrative medical report prepared and attested to in accordance with LC § 4628, any applicable procedures promulgated under LC § 139.2, and the requirements of CCR § 10606
 - And is either:
 - 1) performed by a Qualified Medical Evaluator pursuant to LC § 139.2 (h), (a panel QME) or
 - 2) performed by a QME, Agreed Medical Evaluator (AME), or the primary treating physician (PTP) for the purpose of proving or disproving a contested claim, and which meets the criteria found under the definition of "medical-legal expense".



- "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.



- “Disputed medical fact”
 - 1) the employee's medical condition
 - 2) the cause of the employee's medical condition
 - 3) 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
 - 5) the employee's medical eligibility for vocational rehabilitation services.



- "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 LC § 4628, any applicable procedures promulgated under LC § 139.2, and the requirements of CCR § 10606.
 - B. Is performed by a QME, AME, or PTP within **nine months** following the evaluator's examination of the employee in a comprehensive medical-legal evaluation.
 - C. Involves an evaluation of the same injury or injuries evaluated in the comprehensive medical- legal evaluation.



- "Medical-legal expense"
 - means any costs or expenses incurred by or on behalf of
 - any party or parties,
 - the AD
 - the WCAB
 - For any of the following:
 - X-rays
 - laboratory fees
 - other diagnostic tests
 - medical reports
 - medical records
 - medical testimony
 - interpreter's fees, as needed



- The expenses must be 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:
 - comprehensive medical-legal evaluation report
 - follow-up medical-legal evaluation report
 - supplemental medical-legal evaluation report
- In addition, all of the following five conditions need to exist:



- 1) The report is prepared by a physician, as defined by LC § 3209.3.
- 2) The report is obtained at the request of
 - a party or parties
 - the AD
 - the WCAB
 - 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.



- 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 evaluation 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 30 days. (LC §139.2 (j)(1)(A))



- "Medical-legal testimony"
 - means expert testimony provided by a physician at a deposition or WCAB hearing, regarding the medical opinion submitted by the physician.
- "Medical research"
 - is the investigation of medical issues.
 - It includes:
 - investigating and reading medical and scientific journals and texts.
 - It **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 DWC (including the *Physicians' Guide*)
 - other legal materials.



- "Primary treating physician" (PTP)
 - is the treating physician primarily responsible for managing the care of the injured worker in accordance with subdivision of CCR § 9785 (a).
- "Reports and documents required by the AD"
 - means an itemized billing
 - a copy of the medical-legal evaluation report
 - and any verification required under CCR § 9795(c).



- "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 at the time of the initial examination
 - C. results in the preparation of a narrative medical report prepared and attested to in accordance with LC § 4628, any applicable procedures promulgated under LC § 139.2 of the Labor Code, and the requirements of CCR § 10606
 - D. is performed by a QME, AME or PTP following the evaluator's completion of a comprehensive medical-legal evaluation.





Under Which Fee Schedule?



Official Medical Fee Schedule

- The following services are paid according to the Official Medical Fee Schedule (OMFS).
 - Diagnostic tests including X-rays and Laboratory services.
 - These services are not payable unless the subjective complaints and physical findings warranting the test are included in the medical-legal evaluation report.
 - Absent prior authorization, they are not payable if adequate medical information is already in the medical record provided to the physician.
 - Consultations by other physicians, including the PTP.



Medical-Legal Fee Schedule

- The following services are paid under the Medical-Legal (MLFS)
 - Comprehensive medical-legal evaluations
 - Follow-up medical-legal evaluations
 - Supplemental medical-legal evaluations
 - Medical-Legal testimony



What's Included in the Payment?

- The fee for each medical-legal evaluation procedure is all inclusive, and includes reimbursement for:
 - The history
 - The physical examination
 - Review of records
 - Preparation of a medical-legal report including
 - typing
 - transcription services
 - **Please note: the typing and transcription services are not separately reimbursable, they are already included in the payment for the evaluation.**
 - Overhead expenses.



How to Calculate Payment

- Relative Value (RV) is the number assigned to each level of Medical-Legal evaluation that indicates the relative amount of work required to perform the evaluation. There are seven ML levels.
- Conversion Factor (CF) is the amount of money paid per RV unit. It is currently \$12.50 for all levels of Medical-Legal evaluation.
- Modifiers are codes used to identify special circumstances.
 - Some modifiers effect the level of payment.
 - Some modifiers are just for identification purposes.



- Time Units are used for ML 101, 104, 105 and 106
 - A time unit is 15 minutes rounded off to the nearest quarter hour.
- The formula for payment w/o a Modifier:
 $RV \times CF \times \text{Time units (if applicable)} = \text{payment}$.
- With a modifier: $RV \times CF \times \text{Time units} \times \text{Modifier \%} = \text{payment}$



How is the Level of Payment Determined?

- The complexity of the evaluation is the dominant factor determining the appropriate level of service.
- The times to perform procedures are expected to vary due to clinical circumstances, and are therefore not the controlling factor in determining the appropriate level of service.





Complexity Factors

The following are the complexity factors used to determine the level of Medical-Legal Evaluation.



- 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 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, or if a bona fide issue of medical causation is discovered in the evaluation.
- 7) Addressing the issue of Apportionment under the following circumstances:
 - when determination of this issue requires the physician to evaluate three or more injuries or pathologies.
 - the claimant's employment by three or more employers.



Apportionment continued:

- 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)
- two or more or more injuries involving two or more body systems or body regions as delineated in the above mentioned Table of Contents.
- upon written request of the party or parties requesting the report
- if a bona fide issue of apportionment is discovered in the evaluation.



- 8) Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances
- 9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
- 10) Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.



ML 100 - By Report

- Missed appointment code.
- For communication only.
- Doesn't imply compensation is owed.
 - No set value. Payment, if any, determined on a case-by-case basis.
- Some claims administrators will pay for this code and some will not.
 - It's a good idea to communicate your expectations of payment, in writing, at the time the appointment notification is sent. Make sure to copy both the claims administrator and the injured worker.
 - **Please note: Lack of agreement to your payment preferences is not grounds for refusing to see the patient.**



ML 101 - RV 5 Per 15 Min. \$62.50/15 min or \$250/hr

- Follow-up ML evaluation.
- Occurs within **nine months** of initial ML evaluation.
- Involves a physical examination.
- The physician must verify, under penalty of perjury, the time spent by him or her on the following activities:
 - review of records
 - face-to-face time with the injured worker
 - preparation of the report (doesn't include clerical time)
- Time spent shall be tabulated in 15 minute increments.



ML 102 - RV 50 Per Evaluation \$625.00

- A basic medical evaluation which does not meet the criteria of any other medical-legal evaluation.
- Paid at a flat rate.
 - All expenses are included except for diagnostic testing.



ML 103 - RV 75 Per Eval. \$937.50

- A basic medical evaluation which involves three complexity factors.
- Paid at a flat rate.
 - All expenses are included except for diagnostic testing.



ML 104 - RV 5 Per 15 Min.
\$62.50/15 min or \$250/hr

- 4 or more complexity factors
 - 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.



- 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.
- 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:
 - a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code
 - 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
 - if applicable, any other activities.



ML 105 RV 5 Per 15 Min.
\$62.50/15 min or \$250/hr

- Fees for medical-legal testimony.
- The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including:
 - reasonable preparation
 - travel time
- The physician shall be paid a minimum of one hour for a scheduled deposition.



ML 106 RV 5 Per 15 Min.
\$62.50/15 min or \$250/hr

- Fees for supplemental medical-legal evaluations.
- Fees will not be allowed under this section for supplemental reports 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 the initial report
 - the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.



Medical - Legal Modifiers

- -92 primary treating physician.
- -93 interpreter needed.
 - Increases fee by 10%. Only applicable on ML 102 or 103
- -94 AME evaluation.
 - Increases fee by 25%
- -95 panel QME. No change in fee



Timeframes for Payment

- Medical-Legal expenses shall be paid within 60 days of receipt by the employer of the documents required by the AD (see Definitions) unless the claims administrator contests liability for the payment.
- If liability is being contested the claims administrator shall pay the uncontested portion within 60 days and provide a written objection to the physician.
- **Please note: Physicians may not charge or be paid for services in violation of LC § 139.3 or LC § 5307.6 (d).**



- Objection notices will contain all of the following:
 - 1) An explanation of the basis for the objection.
 - If the objection is based on coding, the original code will be provided along with the code the claims administrator feels is appropriate
 - The rationale for the different code must be provided.
 - If the entire medical-legal expense is being denied, the claims administrator shall provide the legal, medical or factual basis for the denial.



- 2) If additional information is necessary for payment, a clear description of the information needed is required.
- 3) The name, address and telephone number of the contact person dealing with the objection.
- 4) A statement that the physician may adjudicate the issue before the WCAB.
- 5) No form objections that do not identify the specific deficiencies of the report in question.



Examples

- Example 1: ML 102 w/o Modifier.

$RV \times CF = \text{payment}$

$RV = 50 \quad CF = \$12.50$

$50 \times \$12.50 = \625

- Example 2: ML 102 with Modifier 93

$RV \times CF \times \text{Modifier \%} = \text{payment}$

$RV = 50 \quad CF = \$12.50$

Modifier 93 = 10% (1.1)

$50 \times \$12.50 \times 1.1 = \687.50



- Example 3: ML 103 w/o Modifier

$RV \times CF = \text{payment}$

$RV = 75 \quad CF = \$12.50$

$75 \times \$12.50 = \937.50

- Example 4: ML 103 with two Modifiers 93 & 94

$RV \times CF \times \text{Modifier \%} = \text{payment}$

$RV = 75 \quad CF = \$12.50$

Modifier 93 = 10% Modifier 94 = 25%

Combined % = 35% (1.35)

$50 \times \$12.50 \times 1.35 = \$1,265.63$



- Example 5: ML 104 w/o Modifier
4 hour QME evaluation
RV x CF x Time units = payment
RV = 5 CF = \$12.50 Time = 4 hrs = 16 units
 $5 \times \$12.50 \times 16 = \$1,000$
- Example 6: ML 104 with Modifier 94
12 hour AME evaluation
RV x CF x Time units x Modifier % = payment
RV = 5 CF = \$12.50 Time = 12 hrs = 48 units
Modifier 94 = 25% (1.25)
 $5 \times \$12.50 \times 48 \times 1.25 = \$3,750$



Penalties and Interest

- Bills unreasonably unpaid within the 60-day time frame are subject to a 10% penalty.
- Interest on the unpaid portion of the bill is at 7% per annum retroactive to the date of the receipt of the bill and report by the employer.



- Example: An unreasonably unpaid ML 102 received 90 days ago.

ML 102 = \$625

Penalty @ 10% = \$62.50

Interest @ 7% = \$43.75/year

Divide the interest rate by 365 to get a daily rate.

$\$43.75/365 = \0.12 interest per day.

Multiply by 90 days.

$\$0.12 \times 90 = \10.80 interest

Total payment due: $\$625 + \$62.50 + \$10.80 = \698.30



Record Retention

- The physician shall keep billing records for three years.
 - These records shall be made available to the AD, by date of examination, upon request.
- The claims administrator will keep billing records for three years.
 - The information shall be made available to the AD upon request.
 - It shall also be made available to any party to the case where the requested information pertains to an evaluation obtained in the case.



- The following information must be kept by the claims administrator:
 - Name and specialty of medical evaluator
 - Name of employee evaluated
 - Date of examination
 - Amount billed for evaluation
 - Amount paid for evaluation, including any penalties and interest
 - Date payment was made



LC § 4628

- (a) Except as provided in subdivision (c), no person, other than the physician who signs the medical-legal report, except a nurse performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the nonclerical preparation of the report, including all of the following:
 - 1) Taking a complete history.
 - 2) Reviewing and summarizing prior medical records.
 - 3) Composing and drafting the conclusions of the report.



- (b) The report shall disclose the date when and location where the evaluation was performed;
- that the physician or physicians signing the report actually performed the evaluation;
- whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the AD pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6
- shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation.
 - If the report discloses that the evaluation performed or the time spent performing the evaluation was not in compliance with the guidelines established by the AD, the report shall explain, in detail, any variance and the reason or reasons therefor.



- (c) If the initial outline of a patient's history or excerpting of prior medical records is not done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.
- (d) No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.



- (e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.
- (f) Knowing failure to comply with the requirements of this section shall subject the physician to a civil penalty of up to one thousand dollars (\$1,000) for each violation to be assessed by a workers' compensation judge or the appeals board. All civil penalties collected under this section shall be deposited in the Workers' Compensation Administration Revolving Fund.



- (g) A physician who is assessed a civil penalty under this section may be terminated, suspended, or placed on probation as a qualified medical evaluator pursuant to subdivisions (k) and (l) of Section 139.2.
- (h) Knowing failure to comply with the requirements of this section shall subject the physician to contempt pursuant to the judicial powers vested in the appeals board.
- (i) Any person billing for medical-legal evaluations, diagnostic procedures, or diagnostic services performed by persons other than those employed by the reporting physician or physicians, or a medical corporation owned by the reporting physician or physicians shall specify the amount paid or to be paid to those persons for the evaluations, procedures, or services. This subdivision shall not apply to any procedure or service defined or valued pursuant to Section 5307.1.



- (j) The report shall contain a declaration by the physician signing the report, under penalty of perjury, stating: **"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."** The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county wherein it was signed.
- (k) The physician shall provide a curriculum vitae upon request by a party and include a statement concerning the percent of the physician's total practice time that is annually devoted to medical treatment.



Cal Code of Regs §10606

- The following elements must be included in a medical-legal report.
 - Date of examination
 - History of the injury
 - Injured medical history
 - Findings of the examination
 - A diagnosis
 - Cause of disability



- Treatment indicated
- Permanent disability findings, if any
- Nature, extent and duration of disability
- Apportionment
- An original signature of the physician
- Information received from parties reviewed or relied upon
- Percentage of causation due to actual events of employment (psychiatric injuries only)



For More Information

- Go to our web site at www.dir.ca.gov/dwc
- E-mail to dwc@dir.ca.gov

