| MEDICAL LEGAL FEE SCHEDULE | RULEMAKING COMMENTS  48 DAY COMMENT PERIOD | NAME OF PERSON/  AFFILIATION | RESPONSE | ACTION |
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| 9793(g)  9795(c) ML202 | Regarding Follow-up Medical-Legal Evaluation, commenter notes the following three issues:  Commenter opines that it’s improbable that a QME will have a significant recollection of records reviewed, even after as little as 3 months after the initial QME, let alone 18 months afterwards which will require as intensive a review as if the records had not been previously provided. He opines that this provides a free ride for insurers that cannot be bothered to sort out the records.  Commenter notes that the verbiage does not specifically state that QMEs can or cannot bill for records in excess of 200 pages when the records have all been previously reviewed. On many occasions, commenter has received thousands of pages of records from insurers, which he had previously reviewed submitted again for the Follow-up Medical-Legal Evaluation. This requires him to re-review everything in order to determine that they are not new records due to the insurers’ lack of conscientiousness about the process of providing medical records during follow-up evaluations.  Commenter also states he often receives correspondence from counsel submitted with previously reviewed records requesting that he perform a detailed and thorough re-review of previously submitted records.  Commenter states that one of the advantages of the revised Medical-Legal fee schedule is that there is less room for interpretation and dispute over billing. He opines that the need to include review of previously provided records as a freebee, and the requirement that “the physician shall include in the report a verification under penalty of perjury to the total number of pages of records reviewed by the physician as part of the medical-legal evaluation and preparation of the report” is unfair, onerous and a trap.  Commenter requests that the issue of medical record review charges for Follow-up Medical-Legal Evaluation be simplified so as to avoid issues of contention and confusion as well as exploitation of the QME physician to provide free work product. | Michael Tooke, MD, MPH, FRCSC, FAAOS  October 29, 2020  Written Comment | The AD disagrees with the comment. It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up for supplemental evaluation. This would yield the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule. A reading of the entirety of the description of an ML 202 makes clear that the intent was that billing for record review would be confined to records not previously reviewed as part of a prior evaluation or report.  Verification of pages of records reviewed is a tool added simply to provide for accountability. | None. |
| 9795(c) ML200 | Commenter states that it appears that the text of the proposed regulations for “missed appointment” (whether due to a no-show by applicant or by certified interpreter after waiting for 30 minutes) remains unchanged under the code ML200 at $503.75.  The only proposed change that commenter notes is that all records reviewed in association with the missed appointment can be billed under this code at $3.00 per page. He opines that this appears to have been changed from the last proposal where the first 200 pages could not be charged for and when reviewing over 2,000 pages the charge would drop to $2.00 per page. | Jim Plato  October 29,2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9795(c) ML201 | Commenter notes that the Comprehensive Medical-Legal evaluation remains unchanged at $2,015 (a flat fee). He opines, since there is no indication otherwise, that the review of records charge remains at no charge for the first 200 pages, $3 per page up to the first 2,000 pages and at $2 per page over 2,000 pages. | Jim Plato  October 29,2020  Written Comment | All record review is billed at $3.00 dollars per page. |  |
| 9795(c) ML202 | Commenter notes that the Follow-up Medical-Legal Evaluation is billed at $1,316.25 (a flat fee) is now defined as an evaluation that occurs within 18 months of the most recent previous evaluation (the previous proposal said 24 months). Review of records would be charged for as described under ML201. | Jim Plato  October 29,2020  Written Comment | The language is clear review of records for a follow-up evaluation is described in ML202. | None. |
| 9795(c) ML203 | Commenter notes that the Supplemental Medical-Legal Evaluation is billed at $650 (a flat fee) (as opposed to an hourly fee?) with record review charges being the same as described under ML201 and ML 202. | Jim Plato  October 29,2020  Written Comment | The language is clear review of records for a supplemental report is described in ML203. | None. |
| 9795(c) ML204 | Commenter notes that Medical-Legal Testimony (depositions) is billed at $455 per hour. Commenter sees no changes stated in the current proposal, and that as happens now, the first hour of preparation time and first hour of deposition time will be paid in full. After the first hour, the billing would go by the quarter hour, (i.e., $113.75 per quarter hour). | Jim Plato  October 29,2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9795(c) ML205 | Commenter notes that review of Sub Rosa videos does not appear to have been changed from the previous proposal and is billed at $325 per hour. | Jim Plato  October 29,2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(l) | Commenter notes that under this section QMEs would be required to send in with the report a copy of any correspondence, (i.e., assumed to be any letters of instruction), from a party to the case, (i.e., attorneys and/or insurance carrier claims adjuster). Although not specified in the proposal or in this CCR, this would appear be in addition to addressing any questions from the attorneys and/or insurance carrier claims adjuster that the QME must include in the report itself. | Jim Plato  October 29,2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”, and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | None. |
| 9793(n)  LC section 4602.3 | Commenter notes that under LC4602.3, any attorney (assume this also includes the claims adjuster…it is not really specified) who sends records for review must provide an attestation *under penalty of perjury* as to the number of pages included for review. If this new proposal is adopted and an attorney or claims adjuster were to send the QME records without a signed attestation, he would advise of this failure in the QME report and would not review the records. Commenter would inform the parties that he will only review such records upon receipt of a signed attestation and, if that if he has already submitted the report and he receives the attestation after-the-fact, he would then review the records and charge for same under the supplemental report charge ML203. If he receives an attestation but there is no page count included, he would send a brief written communication to the parties advising that he will not proceed with the record review until a page count under signed attestation is received, unless he receives in writing authorization that the insurance carrier will accept his own page count. (And all of this includes duplicate records, as there is nothing he can see in the new proposal that excludes duplicate records and, of course, it still takes time to discern duplicate from non-duplicate records.) Commenter requests that this situation be spelled out and clarified in the new fee schedule. | Jim Plato  October 29,2020  Written Comment | This requirement was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. | This section has been amended, please see update. |
| 9795(c) ML201  9795(d) | Commenter seeks clarification of the modifier for psychiatric exams (-96) regarding the calculation for ML 201, reimbursed at $2015 – would the psychiatric exam be reimbursed at $4030 with this modifier? | Stephen J. Heckman, Ph.D., QME  Licensed Clinical Psychologist  November 2, 2020  Written Comment | Yes. | None. |
| 9795(c) ML202 9795(c) ML203 | Commenter is an orthopedic surgeon who has been practicing for 25 years and have been performing QMEs for 5 years. Commenter welcomes the majority of proposed changes; however the following proposals do not take into account that even if medical records are duplicate, they are NEVER in chronological order. Plus, duplicate records are always interspersed among new records. Commenter must first summarize them, put them in chronological order, and then compare to those which have been provided for her previously issued reports. THIS IS MORE TIME-CONSUMING THAN REVIEWING THE INITIAL RECORDS. Commenter opines that she did not provide the records and should not be penalized for duplicate records. QMEs need to be paid for the time spent on ALL records provided, duplicate or not. At $3/page, estimating 130 pages/hour, the QME is paid $390/hr. to review records. The party that provides the records should be paying their staff (paid less than $390/hr.) to review the records and eliminate the duplicates. Commenter requests that we do not make her waste her time reviewing duplicate records for free.  Commenter notes that ML 202 that the fee included review of 200 pages of records that were not previously reviewed as part of the initial comprehensive medical-legal evaluation or as part of any intervening supplemental medical-legal evaluations.  Commenter notes that ML 203 states that 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. | Joanne Halbrecht, MD, Orthopedic Surgeon  November 4, 2020  Written Comment | The fee schedule as written does not proscribe billing for duplicate records. The fee schedule only proscribes billing for records previously reviewed or in some cases previously available to the QME. | None. |
| 9795(c) - various | Commenter is referencing the proposed medical-legal fee schedule for Internal and Cardiovascular QME evaluation.  Commenter opines that the flat fee for initial QME exam, follow-up exam and supplemental report may work for a simple injury involving a single body part, but does not cover the basic cost of an internal or cardiovascular comprehensive evaluation. Oftentimes there is a need to analyze in detail controversial physical and emotional factors involving multiple body parts, review multiple orthopedic and psychiatric evaluations, consider toxic/infectious/carcinogenic factors, and search medical literature, review depositions statements and personnel records.  Commenter makes the following recommendations:   * The fee for each evaluation should be more than doubled from the current (15 year old) relative value of $12.5 per unit of time to $30 per unit of time. * Keep all the current ML codes, including ML 104. The complexity of the evaluation is the major factor determining the appropriate level of service. * No show/late cancellation fee should be $800 to discourage misuse of QME time. | Roger Nacouzi MD  November 4, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(n)  9795 | Commenter asks how are medical records going to be transmitted to his office – via delivery or electronically?  Commenter questions if the letter of attestation sent with the records is mandated? Commenter opines that it should be incumbent on the scheduling party to send the letter of attestation to all parties, including the number of pages. Questions how to ensure that the number of pages attested to is accurate and what process is in place to ensure that there is an agreement on the number of pages in order to minimize billing disputes.  If a large amount of medical records is delivered to his office late, after the patient has been examined, but prior to the report being due, and he does not have time to review them to include in the report, commenter opines that for a supplement report, the records should be billable at $3 per page and not be covered by the exam fee of $2015.  Commenter seeks clarification as to what the procedure would be if he is asked to address specific questions but is unable to answer them due to lack of testing or medical records provided. Commenter recommends that the supplemental report should be billable separately once the information becomes available and not covered under the original report fee. | Duke Ahn  November 6, 2020  Written Comment | The delivery system is controlled by the party making the delivery. These regulations do not address delivery methods and is not the subject of this rule making.  The letter of attestation is intended to be mandatory. Disputes over page count are subject to current billing dispute resolution methods.  Title 8, California Code of regulations § 38(c) provides a mechanism for the physician to seek an extension of time to serve the report.  If a physician states in writing in the report valid reasons why an issue cannot be addressed in the report that explanation should reasonably allow the production of a reimbursable supplemental report. | This section has been amended, please see update. |
| General Comment | Although not in this current proposal, commenter has heard a “rumor” about a cap on fees. Commenter states that this would be a deal-killer on the doctor side and create a mass exodus from the system.  Commenter opines that the reality of the proposed system (billing records instead of time) is that there will be a cut in pay for the majority of “old ML 104 type” cases and for the majority of supplemental reports. However, there will be the occasional case where the payment will be significantly higher than under the old system, simply because of voluminous records and that hopefully this will offset losses on the many other cases – balance out. | Joshua Kirz, PhD  November 8, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n)  9795 | Commenter opines that this new proposal makes the pages of records attestations too complex and unwieldy. Please do not burden the attorney's with counting the pages. Half the time they don't even know. Lots of times CDs of records trickle in from a copy service. The attorneys are then supposed to send another letter attesting to pages with each CD? You're asking the impossible.  Commenter recommends letting the doctor attest to the number of pages. Under penalty of perjury, doctors are going to be accurate. Besides, if there is a significant discrepancy, the carrier will recognize it and can pursue disciplinary action. | Joshua Kirz, PhD  November 8, 2020  Written Comment | Strict compliance with Labor Code § 4062.3 should alleviate the problem of records being provided in multiple deliveries. Inaccurate page count by parties delivering records can be cross checked with page count performed by physician.  The regulations as written already require that the physician attest to the number of records reviewed under penalty of perjury.  The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. They should minimize disputes over page count. | This section has been amended, please see update. |
| 9793(m)  9795(c) ML206 | Commenter opines that this section, as written, is ripe for the Defense abusing the doctors anytime they disagree with one of our medical-legal opinions. They must document that the doctor did not discuss AT ALL a standard medical-legal issue (e.g., causation of injury, P&D, etc.).  Commenter recommends that this section be deleted. He opines that doctors are not going to omit a major topic in order to generate another bill. In the extraordinarily rare situation where this occurs it can be dealt with on a case by case basis such as requesting the doctor submit an unbilled supplemental report and if necessary disciplinary action by the Division. | Joshua Kirz, PhD  November 8, 2020  Written Comment | Noted. | This section has been deleted, see update. |
| Future Increases | Noting that there has been no increase in fees for the last 14 years, commenter opines that there should be a built in cost of living increase. | Joshua Kirz, PhD  November 8, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| General Comment | Commenter states that while not perfect, he applauds the efforts taken to produce this current proposed fee schedule. Commenter opines that it is an appropriate upgrade to the previous fee schedule and that any significant unintended consequences can be addressed later. | Anthony Fenison, MD  November 16, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| Future Increases | Commenter thanks the Division for their work on the Medical-Legal Fee Schedule. Recommends that an automatic cost of living adjustment be implemented for this fee schedule. | Leisure Yu  November 18, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| 9795(d) -96 | Commenter states that a 2.0 psychiatric/psychological modifier represents a pay cut on many of the complex and time-based evaluations. Recommends a 3.0 modifier which she opines is more reasonable. | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(g) | Commenter notes the proposed re-evaluation period is now 18 months. Opines that 9 to 12 months would be a more reasonable time period. | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment | The Administrative Director disagrees. Negotiations in and stakeholder meetings initially produced agreement on a 24 month time period for reevaluation reports. This agreement was later repudiated, which led to the 18 month time period being selected. The time period should allow for sufficient change in the medical condition or circumstances of the injured worker to justify resort to initial evaluation fee levels. | None. |
| 9795(c) | Commenter opines that time for record review can, at the discretion of the carrier, be reduced if doctors review reports that are not considered “relevant”. Recommends that the DWC require that a physician be paid for reviewing those records that are submitted for an evaluation. An evaluator cannot determine whether a report is relevant other than by reviewing it, and therefore must be paid for that time. | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment | The fee schedule provides for reimbursement at $3.00 per page for records reviewed by the physician. | None. |
| 9793(n)  9795(c) | Commenter states that the proposed changes would implement administrative hurdles before an evaluator can bill for their time in medical record review of more than 200 pages. Commenter opines that this should not be in the purview of the QME or AME, who should be reimbursed for reviewing the records (and number of pages of records) they were provided by the parties, who alone must be responsible for administrative tasks such as removing blank and duplicative pages and assuring an accurate page count. Further, the parties must be required to provide medical records to the evaluator 14 days in advance of evaluations. | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment | The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. This should minimize disputes over page count.  The prohibition on billing for records sent without an attestation should encourage parties to carefully select relevant records and send them to the physician in a timely manner. | This section has been amended, please see update. |
| 9794(h) | Commenter notes that the current proposal includes a requirement that the doctor must include with the service of their report, all documents he or she received from the parties. This creates an unacceptable new requirement that further burdens the evaluator with extra labor, printing, and postage costs, but perhaps more importantly creates an environmentally disastrous and appalling careless waste of paper | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”, and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | None. |
| 9795(c) ML203 | The current proposal allows the parties to deny payment of supplemental reports when they believe an issue “should have been” addressed in a prior comprehensive report. This proposal is far too arbitrary and could potentially allow the parties to demand supplemental report with no intention of paying for the evaluator’s time in the preparation of such. | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment |  | Language regarding unreimbursed (ML206) report has been deleted. |
| 9794(b) | Commenter opines that timely payment must be mandated, and the DWC must include provision for increased penalties and interest on late payments. If a doctor is expected to issue a comprehensive medical-legal evaluation report in 30 days, it is reasonable to expect the insurance carrier to issue the payment within 30 days. | Sharon Goldstein, PhD. – Psychology  November 18, 2020  Written Comment  James L. Deck, Ph.D.  November 24, 2020  Written Comment | The timing of payment for a QME bill is already addressed by Labor Code §§ 4621 et seq. Those provisions provide for Independent Bill Review, interest and penalties for late payment of medical-legal expenses. This is note the subject of this rulemaking. | None. |
| Future Increases and 9795(c) | Commenter states that this fee schedule proposal includes less of a reimbursement than he had hoped for; however, he offers his support going forward if an annual cost of living fee is included and if physicians are reimbursed based upon the number of pages that are received, whether there are duplicates or not. | Teo Ernst, Psy.D.,  ABPP (Forensic)  Clinical & Forensic Psychologist  November 18, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates.  The fee schedule provides for reimbursement at $3.00 per page for records reviewed by the physician. | None. |
| 9793(j)  9795(c) | Commenter states that the proposed fee schedule does not provide for reimbursement for Medical Research. He states that for many of the urology cases that he has evaluated as a QME, a significant amount of research is necessary in order to provide evidence and support for the conclusions reached on causation and apportionment. Commenter opines that a single fee structure cannot account for the varied and additional research that’s often required. | Alec Koo, MD, FACS, QME  Skyline Urology  November 23, 2020  Written Comment | In moving to a flat fee structure, it was decided in stakeholder meetings that complexity factors would be omitted from the new fee schedule because of their inherent susceptibility to varying interpretation. The complexity of an evaluation is taken into account by the structure of the fee schedule with the per page payment and consideration of modifiers. | None. |
| Future Increases | Commenter requests that the fee schedule include a cost of living adjustment (COLA) provision. Commenter acknowledges that this may take legislative action. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| 9795(c) | Commenter states that any and all records (pages) that are provided at any time should count toward the total page count. The applicant and defense should be obligated to work together to weed out duplicates and any unnecessary pages (ideally, the records would be provided electronically and they would be indexed and in order and the page count specified). For subsequent evaluations or any supplemental reports, it should be the obligation of the referral sources to not send duplicates but if sent, all sent records should be billable per page. There is the unfortunate circumstance where the QME is sent duplicate records which must be sorted through to make sure there is nothing new in those records. This is a costly and time-consuming job and this burden should not fall on the QME. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment | It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule. | None. |
| 9795(d) | Commenter states that the AME modifier should apply to the entire report charge including the base fee and the per page fee. This proposed change of only applying the AME modifier to the base fee, essentially emasculates the AME process where increased weight is given to the more senior and qualified physicians who handle the most difficult cases. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9795(c) ML206 | In reference to Unreimbursed Supplemental ML Evaluations, commenter recommends that there should be a separate referral form or highlighted and bolded section of the referral source letter clearly outlining issues to be addressed. There is too much room for abuse by referral sources unless this issue is very specific and clearly defined. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment |  | This section has been deleted, see update |
| 9793(g)  9795(c) ML202 | Commenter recommends changing the Follow-up Medication Legal Evaluation time period to 12 Months (instead of 18). Once a year has gone by, it is essentially a new case in terms of time spent by the QME. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment | Negotiations in the stakeholder meetings initially produced agreement on a 24 month time period for reevaluation reports. This agreement was later repudiated, which led to the 18 month time period being selected. The time period should allow for sufficient change in the medical condition or circumstances of the injured worker to justify resort to initial evaluation fee levels. | None. |
| 9795(c) | Commenter recommends that if the primary treating physician is also a QME, that he or she be allowed to bill the P&S report using the Medical Legal fee schedule. Commenter opines that this will strongly incentivize treating physicians to become QMEs. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment | Treatment reports are billed under the Official Medical Fee Schedule. There is already a provision for treating physicians to bill for medical-legal reports pursuant to Title Eight, California Code of Regulations § 9785 (f)(7) when requested by a claims adjuster. In addition, the time the treating physician writes the permanent and stationary report there may not be an issue in dispute to make the report eligible to be treated as a medical-legal report, pursuant to 8 CCR § 9793(h). | None. |
| General Comment | Commenter opines that the issue of lack of quality reporting and excessive billing can be solved by increasing the number of QMEs provided from 3 to 10-15. By giving increased number of choices, each side can strike QMEs known to not provide quality reports and/or to strike those who excessively bill. This simple solution would let the market place weed out poor reporting and over billing. Commenter acknowledges that this may take legislation separate from the Medical Legal Fee Schedule Regulations but is a very simple way to solve these problems with poor quality and excessive billing. | Steven D. Feinberg, MD, MD, MPH  Adjunct Clinical Professor  Stanford University School of Medicine  November 29, 2020  Written Comment | This is not the subject of this rule making. This suggestion would require legislative action to change the existing statute. Labor Code § 139.2(h) | None. |
| 9795(c) | As a psychiatrist, commenter states that virtually all of his initial examinations are billed at ML104 due to the additional complexity factor for this type of exam. While many who have traditionally billed at ML102 and ML103 will see an increase in reimbursement, even with the multiplier for psychiatry this proposal will result in a drastic cut in pay for him and all the physicians in his specialty. Commenter had anticipated that since there had been no change to the rate of reimbursement since 2006, any new fee schedule would actually lead to an increase in pay.  Commenter opines that the one size fits all approach is completely unreasonable. Some cases are rather straightforward and can be completed with a minimum of 2 hours of face-to-face time. However, cases are often extremely complicated due to important events at work-- extensive sexual harassment, repeated threats of violence-- that cannot be ignored. There may also be traumatic circumstances in childhood and adult life that have to be considered. Add to that a poor informant or an interpreter who is unable to discharge their duties well, and the exam can take several hours of face-to-face time to complete. The more complex the exam, the more time it takes to prepare the report.  To remedy this flaw in the proposed fee schedule, commenter opines that the best solution is the one in Suzanne Honor's proposal: an additional fee for every 15 minutes of face-to-face time in excess of the first two hours. It is simple and reasonable, resulting in more fair reimbursement. | David E. Sones, MD  November 30, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9795(d) | Commenter references the following paragraph:  **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.**  Based on the new regulations, commenter states that a psychiatrist performing an AME will received a significantly less increase in fees compared to other medical specialties.  To understand, please review the following calculations:  For an ML-201, the fee is $2015.  Using the multiplier of 1.35 for an AME leads to this calculation:  2015 X 1.35 = 2720.25  This is a **35%** increase of the base rate.  Using the multiplier of 2.35 from above for an AME in psychiatry leads to this calculation:  2015 X 2.35 = 4735.25  This is only a **17.5%** increase of the usual fee for a psychiatrist, which is twice the base rate, or $4030.  Assuming this was unintended, it is easily corrected by changing the modifier for ML-201-96-94 and ML-202-96-94 to 2.70  Using the multiplier of 2.70 for an AME in psychiatry instead leads to this calculation:  2015 X 2.70 = 5440.50.  This is a 3**5%** increase of the usual fee for a psychiatrist, which is twice the base rate, or $4030.  If the DWC actually intended for psychiatrists to receive a 17.5% increase instead of a 35% increase, then the reasoning for this needs to be explained. Commenter hopes that this was not intended, because he cannot imagine what the explanation might be.  Commenter recommends that the modifiers for -93 and -93 and -94 in combination for evaluations performed by psychiatrists be increased to at least 2.20 and 2.90 respectfully. Commenter states that an argument can be made that these should be considerably higher. On average, the amount of time spent in face-to-face time by a psychiatrist is 5-10 times longer than an orthopedist. Therefore, the modifiers for psychiatric exams with interpreters should be substantially greater, perhaps 2.60 and 3.30 respectively. | David E. Sones, MD  November 30, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule.  Comparisons of fees after the application of the modifier should only be made with the base rate prior to application of modifier. | None. |
| Future Increases | Commenter recommends that the proposed fee schedule incorporate automatic cost of living increases (COLA) noting that it has been 15 years since the last increase to the fee schedule. | David E. Sones, MD  November 30, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| 9795(d) | Commenter opines that the psych modifier is too low given the breadth and comprehensiveness of the reports that are required for these evaluations. A 3.0 modifier would be more realistic. Psych evals can range from 50-100+ pages depending on the evaluation and the complexity. The best evaluations include malingering testing beyond just using the MMPI-2 which is not a malingering instrument. Psych evaluators should be encouraged to utilize more of this type of testing and be compensated accordingly as ultimately this serves the whole system as only those who are truly struggling with a workplace psych injury would be granted treatment and benefits. | Jason Rowden, Psy.D., QME  Forensic/Clinical Psychologist  November 30, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| Future Increases | Commenter states that there should be a built in cost of living increase (COLA). | Jason Rowden, Psy.D., QME  Forensic/Clinical Psychologist  November 30, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| 9795(c) ML201 | Commenter states that any medical records reviewed should be billable and that the first 200 pages should not be free. | Jason Rowden, Psy.D., QME  Forensic/Clinical Psychologist  November 30, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9795(c) | Commenter opines that medical records that are resubmitted for a re-eval or supplemental should be billable. It should not be up to the QME to determine if the records were previously submitted when 1,000’s of pages are often sent. This burden should lie with the party sending the records. If they sent the records for the first eval, the burden is on them to assure they do not resubmit what they already did, otherwise the QME ends up having to review loads of records and doesn’t know if these records were previously submitted or not until they are done with the process. In this new system, a QME would never be paid for any of these records and could be disciplined for failing to realize that they sent 500 pages of duplicate records in the 3,000 pages they sent for the re-eval. Commenter opines that this is untenable. | Jason Rowden, Psy.D., QME  Forensic/Clinical Psychologist  November 30, 2020  Written Comment | The AD disagrees with the comment. It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule. A reading of the entirety of the description of an ML 202 makes clear that the intent was that billing for record review would be confined to records not previously reviewed as part of a prior evaluation or report. | None. |
| 9795(c) ML206 | Commenter opines that Unreimbursed Supplemental Medical-Legal Evaluations for failure to address some issue is much too vague and is an easily abused tool. Commenter states there needs to be much clearer guidelines about this and a clear due process rules and regulations to dispute this issue. | Jason Rowden, Psy.D., QME  Forensic/Clinical Psychologist  November 30, 2020  Written Comment |  | This section has been deleted, see update. |
| 9793(g)  9795(c) ML202 | Commenter opines that any evaluation after 9 months should be a new evaluation. He states there is significant change that can occur from a psychiatric and psychological point of view when the application is given treatment and that a full re-evaluation is necessary in this situation. | Jason Rowden, Psy.D., QME  Forensic/Clinical Psychologist  November 30, 2020  Written Comment | The Administrative Director disagrees. Negotiations in the stakeholder meetings initially produced agreement on a 24 month time period for reevaluation reports. This agreement was later repudiated, which led to the 18 month time period being selected. The time period should allow for sufficient change in the medical condition or circumstances of the injured worker to justify resort to initial evaluation fee levels. | None. |
| General Comment | After many years of various MLFS proposals, the latest proposal is one that he believes he can work with. He notes a pay increase and a way for the doctor to bill for the work that is actually done; however, there are some things that need to be addressed regarding pages counts, duplicates, material included with the medical reports and digital document submission. | Ashton Wolfson, CEO of a QME Management Service  December 1, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(l) | Commenter states that this subsection should be struck and that original language maintained.  Commenter finds the proposed language nebulous and opines that it appears to state all medical records and cover letters need to be submitted along with the report in order for the provider to be compensated.  He seeks clarification that if the provider received 2500 pages of medical records, the provider is now tasked with sending the complete medical records file along with his report and accompanying documents to the employer in order to be compensated? If correct, he opines that this is a really bad idea. | Ashton Wolfson, CEO of a QME Management Service  December 1, 2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”,  and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | None. |
| 9793(n)  9795(c) | Commenter wants to know "who counts the medical record pages?" Commenter does not have any problem counting the pages, but what happens when a TPA or attorney sends 500 pages in a sworn affidavit and after a secondary count there are 900 pages. What happens then? Does the doctor review 400 pages for free? Does the doctor have to file a grievance complaint with DWC? Does the doctor only review 500 pages and not the 400 other pages? Does the doctor play phone tag with a busy attorney or TPA to notify of the page count discrepancy? This scenario can significantly slow the QME process flow. Commenter states that these questions really need to be answered in a practical way before any rulemaking begins. | Ashton Wolfson, CEO of a QME Management Service  December 1, 2020  Written Comment | The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. This should minimize disputes over page count.  The prohibition on billing for records sent without an attestation should encourage parties to carefully select relevant records and send them to the physician in a timely manner. | This section has be amended, please see update. |
| 9795(c) | Commenter opines that medical record duplicates is going to be a problem. Commenter states that the parties sending the medical records should assume some sort of responsibility for what they send doctors. A QME should not be a dumping ground for random medical records that are sent at will from different parties and not be compensated for it. If the parties send the medical records the doctor should review them and bill for it... period. The idea that multiple parties can send the same or partial 600 pages of medical records to a doctor within a few weeks of each other and the doctor has to sort whether they are duplicates without billing in order to avoid DWC discipline is completely unacceptable. If doctors can bill for duplicates maybe the submitting parties will be more aware of what they send the QME, rather than throwing a random 800 medical record pages in a box and expect the doctor to sort it out. | Ashton Wolfson, CEO of a QME Management Service  December 1, 2020  Written Comment | The fee schedule as written does not proscribe billing for duplicate records. The fee schedule only prescribes billing for records previously reviewed or in some cases previously available to the QME. | None. |
| General Comment | Commenter states that he spends a fortune on paper, ink, and postage. Commenter does not understand why the State of California, with all its sustainable environmental policies, is still using regulations written in the 80s to mandate the submission of reports by mail or fax. Submitting data by mail is archaic and inefficient. There is no other industry that has these sorts of regulations. If the DWC is concerned about med-legal costs they can start with allowing a streamlined process for allowing reports to be submitted digitally via email or secure portal. This would dramatically lower the costs associated with processing a QME report. | Ashton Wolfson, CEO of a QME Management Service  December 1, 2020  Written Comment | The Administrative Director appreciates the sentiment of the comment. However, this is not an issue that can be addressed by regulations related to the fee schedule. | None. |
| 9795(d) | Commenter appreciates that an increased multiplier was added to the new proposed fee schedule; however she notes that the interpreter rate and AME rate is applied to the base rate rather than the total psych rate which does not make sense to her. | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9795(c) ML202 9795(c) ML203 | Commenter states that the new fee proposal contains the following language for payment for record review:  “*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*.”  Commenter opines this implies that it is up to the doctor to go through the newly received records and do a comparison of all records received for all previous evaluations and supplemental reports in order to ensure that none are duplicates. It also suggests that if there are duplicates, the doctor cannot charge for the time spent looking through the records and through the prior received records to identify those that are duplicates. This could take an extensive amount of time and resources that would not be billable for the doctor.  Commenter states that the burden of eliminating duplicates should be on the parties, not the doctor if the doctor will not be paid for this time. If duplicates are sent at the time of re-evaluation or supplemental report, the doctor should be paid for these as he or she will still have to review these in order to determine if they are duplicates; this time should be billable.  Commenter opines that if the intention of this language in the proposed fee schedule is to prevent the doctor from re-reviewing and billing for past records that were not sent again at the time of the current re-evaluation or supplemental report, then this should be more clearly worded.  Commenter recommends the following revised language options:  “The fee includes review of 200 pages of records and shall only include records, including duplicate records, that were submitted for the re-evaluation or supplemental report and attested to, and shall not include records that were provided at an earlier time in relation to any previous evaluation or supplemental report.”  Or,  “The fee includes review of 200 pages of records and shall only include records, including duplicate records, that were attested to at the time of the re-evaluation or supplemental report, including any duplicates contained therein, and shall not include any records that are not attested to at that time.”  **QUESTION:** Will this language be changed in one of these ways, or another, to reflect that the doctor be paid for all records submitted at the time of re-evaluation or supplemental report request?  **QUESTION:** If the above language is not changed, will a doctor be penalized for billing for records that were sent again and attested to, but were also sent at a previous time for review?  **QUESTION:** If this language is not changed, and the doctor is expected to not bill for the duplicates records that were sent again and attested to, there will be a discrepancy between what is being billed and what was attested to (the amount billed being less than the attestation)--how will the discrepancy be addressed or handled? | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | The AD disagrees with the comment. It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule. A reading of the entirety of the description of an ML 202 makes clear that the intent was that billing for record review would be confined to records not previously reviewed as part of a prior evaluation or report. | None. |
| 9793(n) | Commenter notes the language states: “*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.”*  **QUESTION*:*** Does this mean that the doctor is not required to review records until a declaration/attestation is received? The language says that a doctor may not bill for review of records not provided with this accompanying declaration, but will the doctor be penalized for not reviewing submitted records even if he/she has not received the declaration and cannot bill for them until the declaration/attestation is received?  **QUESTION:** If there is an error in the attestation, does the doctor only review the attested-to number of records? For example, the sending party attests to 101 pages when the page count is clearly 1201 pages and there was a typographical error. Is the doctor to only review 101 pages and then stop reviewing additional records until the attestation is corrected?  **QUESTION:** Will there be a penalty against the doctor for not reviewing all submitted records in a case of a disputed attestation such as this?  **QUESTION:** Will these records that were not accompanied by an attestation and then not reviewed, count as previously submitted or duplicate records at the time of supplemental or re-evaluation?  **QUESTION:** Will there be a mechanism to dispute errors in the declaration/attestation, and if so what will that be? | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | This requirement was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. | This section has been amended, please see update. |
| General Comment – Late receipt of records | Commenter notes that often times parties send late records that can include 1000s of pages sent within days of the 30-day final due date of a report. The way the proposed fee schedule reads, these would be required to be included in the report or cannot be billed for in future. Commenter opines that it would be nearly impossible for the doctor to review this number of pages in such a short time.  **QUESTION:** Will the DWC add a cutoff date for reviewing records for an evaluation and re-evaluation, for example “by the date of the evaluation,” or “within 7 days following the evaluation,” and state that otherwise these records shall be considered a supplemental report? | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician. This is not the subject of this rulemaking. | None. |
| 9793(l) | Commenter opines that proposed language that all reports and documents required by the administrative director is ambiguous and some QMEs are speculating this includes the original records submitted for review, which would result in astronomical printing and mailing fees if these records had to be submitted with every report.  **QUESTION:** Will this language be clarified further to specify exactly what is included in this? Also, will the language regarding “all correspondence” be expressly detailed for clarification as to what must be included with the QME report? | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”,  and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report.  The regulations do not require that the QME keep the original medical records in their file. Therefore, documents requested under this regulation would not include the original medical records. | None. |
| 9795(c) ML200 | Commenter notes that the amount of $503.75 for the missed appointment fee actually works out to be less than the cost of reviewing 200 pages of records (200 x $3=$600) So if there were 200 pages of records, the doctor would be providing 32 pages of record review for free and be paid nothing for the other costs incurred by a late cancellation. A remedy for this would be for the missed appointment fee to be $503.75 solely for the missed appointment, and records to be paid at $3 a page from the first page.  **QUESTION:** Will the DWC consider adjusting this to be more commensurate with the new proposed RV rate? | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | The missed appointment fee is separate from the payment for record review when a report is prepared. | None. |
| 9795(c) ML206 | In reference to the unreimbursed supplemental report, commenter would like to know the mechanism to resolve a dispute by the doctor as to whether the issue in dispute and being claimed as previously requested or required, was in fact a previously required or requested element. | Bobbie McDonald, MD,QME  Licensed Psychologist  December 3, 2020  Written Comment | Noted. | This section has been deleted, see update. |
| 9795(c) | Commenter is concerned that the wording of the regulations fails to clearly state that the QMEs will be paid $3 a page for **all** records reviewed. Commenter states that it does not make sense that attorneys are able to send duplicate records, but not pay for the time it takes to determine that these are duplicates.  Commenter recommends that this be clarified in the wording of the final regulations. | Susan C. Rose, Ph.D., QME  December 6, 2020  Written Comment | The fee schedule as written does not proscribe billing for duplicate records. The fee schedule only prescribes billing for records previously reviewed or in some cases previously available to the QME. | None. |
| 9793(n) | Commenter would like to know the remedy when mistakes, including typos, are made in “attestations” of records sent. Does the provider review all the records, but not get paid for those reviewed, if attorney offices fail to accurately determine what was sent? Does the provider review the records once the accurate attestation is received, but not get paid as these can only be provided in a supplemental report?  Commenter recommends that this be clarified in the wording of the final regulations. | Susan C. Rose, Ph.D., QME  December 6, 2020  Written Comment | This requirement was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. | This section has been amended, see update. |
| General Comment | Commenter opines that the QME continues to be penalized if records are sent late by the attorneys, i.e., after the applicant was seen. When a significant number of records come late in the assessment process, given the 30-day deadline requirement for the completion of reports, there is no way that they can be appropriately read, digested and integrated into my opinions and report. When extensive records arrive too late for a fair consideration before the report is completed, i.e., before or on the day the applicant is seen, commenter opines that they can only be fairly considered in a supplemental report. Commenter states that this option needs to be the norm when extensive records are sent after the applicant has been seen. And the text of the regulations needs to reflect this. Otherwise, QMEs are at a serious disadvantage in being able to do a reasonable job for all parties wanting a fair determination of medical-legal opinions, particularly regarding AOE/COE causative factors with specificity, per Rolda. | Susan C. Rose, Ph.D., QME  December 6, 2020  Written Comment | Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician.  Title 8, California Code of regulations § 38(c) provides a mechanism for the physician to seek an extension of time to serve the report. | None. |
| 9795(c) ML200 | Commenter states that if records are reviewed before the applicant cancels or fails to show, then the QME is not being adequately compensated. Commenter notes that one remedy would be for the missed appointment fee to be $503.75, and records to be paid at $3 a page from the first page.  Commenter would like to know how DWC is going to do to fairly compensate QMEs for the work they perform in good faith. Commenter would like know if the DWC will adjust the proposed regulations to be in accord with the new proposed RV rate. | Susan C. Rose, Ph.D., QME  December 6, 2020  Written Comment | The physician has the opportunity to provide a record review report which will provide compensation for records reviewed prior to the missed appointment.  The reimbursement amounts in the fee schedule are calculated using the increased relative value of $16.50. | None. |
| 9794 | Commenter would like to know the process to dispute the failure to pay for a supplemental report. | Susan C. Rose, Ph.D., QME  December 6, 2020  Written Comment | Disputes regarding payment of the QME bill related to a fee schedule are already addressed by Labor Code §§ 4621 et seq. Those provisions provide for Independent Bill Review, interest and penalties for late payment of medical-legal expenses. | None. |
| 9795(c) ML201 and ML 202  9793(n) | Commenter notes that the indication is that the reimbursement would include a per-page fee for review of records in excess of 200 pages. Assurance should be provided that the parties will provide records with enough lead time, without duplications, in chronological order, and with a list. The physician cannot be bogged down with clerical work, particularly because a physician's time is not respected in the system.  Commenter notes that clarification is necessary based on the reality that the parties do not send the information on a timely basis. They have to be contacted multiple times by office staff, and it is always at the last minute that one receives these records.  Commenter notes that the physician is to verify "under penalty of perjury the total number of pages of records reviewed." Commenter would like to know the mechanism for resolution when the total number of pages counted by the physician is different than the total number of pages asserted by the requesting party.  Commenter states that all requirements, concessions, and penalties seem to be required only of the physicians, and not the parties requesting the reports. Commenter would like to know what happens to the parties submitting medical information for failure to comply with these regulations.  Commenter states that psychiatrists almost always evaluate very complex cases which necessitates lengthy evaluations, where much time is necessary to produce a quality report because everything affects the psyche. | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor  UCLA School of Medicine, AME, QME  December 7, 2020  Written Comment | The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. This should minimize disputes over page count.  The prohibition on billing for records sent without an attestation should encourage parties to carefully select relevant records and send them to the physician in a timely manner.  Disputes regarding payment of the QME bill related to a fee schedule are already addressed by Labor Code §§ 4621 et seq. Those provisions provide for Independent Bill Review, interest and penalties for late payment of medical-legal expenses.  Failure to comply with the regulations on the part of a party could result in delay of receipt of a competent medical-legal report and/or requires unnecessary supplemental reports from the physician | Language has been amended please see update. |
| 9795(c) ML203 | Commenter opines that it is a nonstarter that a physician should have to work without pay. If no fee is allowed, one could not provide services in such a system.  Then comes the issue that the physician would not be able to charge if the "review of information 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."  Commenter wants to know how to guarantee that what was indicated as having been sent, actually had been provided as there are frequently missing items on a list, if there even is a list, and sometimes records are provided which are not on the list.  Commenter states that the physician cannot go through every page to see if it was already reviewed as that would take time away from providing the comprehensive report necessary for use in court.  Commenter opines that the idea that a physician would "not" be entitled to compensation because an issue requested by a party to be addressed in a prior report was said to have not been addressed. Where is the protection for the physician? What is to stop such a claim from being made simply because a report does not support a particular party's position?  Commenter questions what if the party actually never did ask the provider a particular question in the initial advocacy letter? To whom does the provider go to say that, actually, a particular question had not been addressed because it had never been asked? Commenter opines that a party disliking a physician's point of view could ask for another report, which the physician would be mandated to provide without compensation.  Commenter questions what happens if the point of view is not addressed to the satisfaction of the party because of the wording or the length of the response. Questions why she should have to write another report without being able to charge for it. | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor | The AD disagrees with the comment. It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule.  Disputes regarding payment of the QME bill related to a fee schedule are already addressed by Labor Code §§ 4621 et seq. Those provisions provide for Independent Bill Review, interest and penalties for late payment of medical-legal expenses. | Language regarding unreimbursed (ML206) report has been deleted. |
| 9793(n)  9793(l)  9795(c) | Regarding the verification of records, under penalty of perjury, of the total number of pages, commenter has questions about the parties providing the records. Do they not have to say the total number of pages? What happens when there is a difference? What happens when there is a difference of even a few pages?  Commenter states that the process of counting pages is fraught with difficulty. Commenter states that two people could sit and count pages, having to do it many times to try to get the same number because they're human and they make mistakes.  Regarding information provided on disc, commenter questions if the disc has to have the total number of pages, not separate files. Who is going to enforce this? What happens in the number of pages of the records received does not match the number in the certification?  Recently commenter received a list which was accurate to a T and had no duplicates except for one report; however, that is the exception rather than the rule.  Commenter questions the monitoring and enforcement of the regulation regarding the parties providing the records. Who is going to make sure they tell you how many pages are enclosed?  Commenter asks if she is expected to spend time counting pages and putting records in order, rather than spending that time providing the parties with a report which could be used to settle a case.  For the initial report and/or for a follow-up evaluation, one is told that the correspondence must be provided. Commenter seeks clarification if this mean letters, but not records.  In addition to providing the report with my medical-legal  thinking/assessment, it is commenter’s understanding that now one would need to provide certain documents when the report is submitted. Is this only for the initial report, or for a follow-up report as well? Where does it say that in the regulations? Commenter does not want to leave anything out of her comprehensive reports. Commenter states that is not clarified what is meant by this documentation, i.e., does one send all of the medical records to each party? For example, Form 110 (Notice of Evaluation): Does that form have to be sent with the report? What needs to go with the report, and does it go before or after the report? | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor  UCLA School of Medicine, AME, QME  December 7, 2020  Written Comment | The requirement of an attestation was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review.  The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. This should minimize disputes over page count.  The prohibition on billing for records sent without an attestation should encourage parties to carefully select relevant records and send them to the physician in a timely manner.  Correspondence is defined as “communication by exchanging letters with someone”, and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | Language has been amended please see update. |
| 9795(c) ML204 | Commenter notes that there is a specification of the fee being paid per hour, but the actual regulation refers to a reimbursement of "his or  her usual and customary fee, whichever is less," as compared to the" rate of RV7." Which is it really? When is the fee established? When will the check need to be in the hands of the physician, how much time prior to the deposition?  Commenter notes that there is reference to "reasonable preparation and travel time," and questions what is meant by this language. What is "reasonable preparation"? How many hours? Who determines it? Commenter opines that one would have to make that determination in advance, without knowing what kind of questions would be asked in the deposition. | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor  UCLA School of Medicine, AME, QME  December 7, 2020  Written Comment | The deposition fee is calculated at the hourly rate of 455/hr or the physician’s usual and customary hourly fee, whichever is lower. The timing of receipt of the fee by the physician is governed by the California Code of Civil Procedure.  Regulations are usually interpreted by reference to the plain meaning of the language used in the regulation.  Usually a physician submits a balance bill for the deposition after the deposition has been completed. | None. |
| 9795(c) ML206 | Commenter notes in terms of "addressing an issue that was requested by a party in a prior evaluation," one is to be "unreimbursed." Commenter states she has had many depositions, and has often been asked to write reports wherein she has already addressed those issues. That does not mean that the person agrees with the issue, or is satisfied with her opinion. Commenter states that it is neither right nor fair that one would not be compensated under such circumstances. She opines that such inequality sets physicians up to be victims of retaliation, and it sets the system up for corruption and/or unethical behavior, with no clear protection or resources for the physicians.  Commenter questions the morality and/or legality in not paying for services rendered. | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor  UCLA School of Medicine, AME, QME  December 7, 2020  Written Comment | Noted. | This section has been deleted, see update. |
| General Comment | Commenter states that she appreciates the need for all the work that has been done and that the DWC has tried the best to update the proposed fee schedule and she also appreciates the reality of human beings and frictions.  Commenter has been doing evaluations for more than 30 years in the system and understand medical-legal needs in terms of complexity and the ROLDA, the Benson and the KITE that are demanded to settle cases, and they require a lot of thought.  Commenter is a psychiatrist – sometimes there are not records and often the records that are sent for review do not have relevance or do not contain information that is helpful. Commenter states that she needs to talk to the patient, get the patient to be comfortable. It takes time to get the history and the history can be very involved with non-industrial as well as industrial issues.  Commenter states that there is an issue around doing administrative work - sorting pages, putting them in order, taking out duplicates which was mentioned a lot during today’s hearing. Commenter opines that a lot happens in 9 months and the 18 months is certainly too long. Commenter requests that more consideration be given to the needs of the system and that the time should be paid for. Commenter supports the recommendations submitted by CSIMS. | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor  UCLA School of Medicine, AME, QME  December 14, 2020  Oral Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule.  The Administrative Director disagrees. Negotiations in the stakeholder meetings initially produced agreement on a 24 month time period for reevaluation reports. This agreement was later repudiated, which led to the 18 month time period being selected. The time period should allow for sufficient change in the medical condition or circumstances of the injured worker to justify resort to initial evaluation fee levels. | None. |
| 9795(c) | Commenter states that review of all records should be paid at $3.00 per page and all duplicate records (evaluation or supplemental report) should be included in this fee. Commenter opines that the doctor should not be responsible for culling duplicate records. | Mark McDonald, MD – Adult, Child, and Adolescent Psychiatry  December 7, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(n) | Commenter opines that the page count or records received should not be determined by third party attestation without a clear mechanism in place for challenging and correcting errors made by the third party. Without this provision, the doctor will not be reimbursed for pages not included in the attestation and will be unable to review them. | Mark McDonald, MD – Adult, Child, and Adolescent Psychiatry  December 7, 2020  Written Comment | The requirement of an attestation was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. | None. |
| 9795(c) ML200 | Commenter states that the rate for late/cancelled appointments should be corrected to include payment for all records received, not only for records in excess of 200 pages. Commenter opines that record review is a separate work component.  Commenter recommends maintaining the $503.75 late cancellation payment with a separate record review payment of $3.00 per page, starting with the first page of records. | Mark McDonald, MD – Adult, Child, and Adolescent Psychiatry  December 7, 2020  Written Comment | The physician has the opportunity to provide a record review report which will provide compensation for records reviewed prior to the missed appointment. This reimbursement is in addition to the flat rate reimbursement for the missed appointment | None. |
| 9795(d) | Commenter notes that psychiatric evaluations that require an interpreter (or are considered an AME) receive a rate adjustment based on the base rate rather than the 2X psychiatric multiplier. Commenter recommends that the adjustment be based on the 2X psychiatric multiplier and not the base rate. | Mark McDonald, MD – Adult, Child, and Adolescent Psychiatry  December 7, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(c) | Commenter recommends that all records being reviewed be reimbursed at $3.00 per page, including duplicate records that are included. | Ren Hong, PhD, QME  December 8, 2020  Written Comment | The fee schedule as written does not proscribe billing for duplicate records. The fee schedule only prescribes billing for records previously reviewed or in some cases previously available to the QME. | None. |
| General Comment | Commenter opines that the proposed fee schedule will cause many doctors to give up QME work.  Commenter would like to know who is going to train the IBR on the interpretation of the proposed MLFS in order to prevent underground rules. Commenter finds this MLFS proposal ambiguous, confusing and open to individual interpretations.  Commenter recommends keeping the current fee schedule and increasing the RV fee per unit time. | Roger Nacouzi, MD  December 10, 2020  Written Comment | The Administrative Director disagrees with the comment. The substantial raise in rates for the physician represented in the new schedule is likely to attract physicians to the QME program.  The flat rate schedule provides objective criteria for reimbursement that are not subject to interpretation.  The objective nature of the new schedule will require very little if any training for the IBR personnel regarding the schedule’s implementation. | None. |
| 9795(c) ML201, ML202 and ML203 | Commenter opines that a lot of information can be condensed into 200 pages. Commenter recommends that the flat fee only include 50 pages or records (not 200).  Commenter states the fee for follow-up report is unappealing as much can change, and more review is necessary following an 18 month time period.  Commenter states that records previously reviewed can be re-submitted intermixed with new records which requires time to sift and sort records. Commenter states that this time should be compensated. | Roger Nacouzi, MD  December 10, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9795(d) | Commenter states that the evaluation of internal cardiac cancer and toxic cases is so complex that a 2X modifier should apply. | Roger Nacouzi, MD  December 10, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | This section has been amended. |
| 9795(c) ML206 | Commenter finds the idea of preparing an unreimbursed supplement report completely unreasonable. Commenter state that the majority of the time, a supplemental report is requested because of a need for clarification or a new discovery, rather than a failure to address the issue in the first report. Commenter recommends eliminating this option. | Roger Nacouzi, MD  December 10, 2020  Written Comment | Noted. | This section has been deleted, see update. |
| 9795(c) ML200 | Commenter opines that the changes are mostly positive for her their practice; however, she recommends changing the cancellation fee requirement from within six business days of the appointment to within ten business days or two weeks.  Commenter opines that 6 business days is not sufficient time to prepare for a medical legal appointment. Commenter states that preparation for the appointment begins three weeks in advance – contacting the client, arranging for completion of the intake packet, contacting the carrier or defense attorney to arrange for transmission of medical records. With the lead time needed to prepare for appointments, there is no way that another med-legal can be scheduled in that spot without four weeks’ notice at the minimum. | Sarah Pattison  Office Manager for  Thomas S. Pattison, MD  December 10, 2020  Written Comment | The criteria of six business days for cancellation was selected to conform with existing regulations regarding cancellation of the QME appointment as contained in Title 8, California Code of Regulations § 34 (d). | None. |
| 9795(c) ML205 | Commenter notes that the regulations indicate that physicians cannot be reimbursed for a supplemental report for records or a sub rosa video that was provided to the physician prior to preparing a comprehensive medical-legal report or a follow-up medical legal report.  Commenter opines that the use of the phrase “prior to preparing” is likely to lead to considerable friction. It could be argued that report preparation by a physician begins at the time the appointment for the examination is scheduled. This would obviously be completely impractical. On the opposite end, the phrase might mean when the examiner is in the final stages of report preparation. This is equally impractical. It would not be unusual to receive records well after the date of the evaluation. Imagine a situation when a physician receives 5,000 or more pages 28 days after the evaluation. It would be impossible to review all the records and incorporate them in a report before it was due on day 30. Under the proposal, the physician would be required to review all the records in an Unreimbursed Supplemental Medical-Legal Evaluation without any compensation. Commenter hopes that this is not the Division’s intent.  In order to remedy this situation, commenter recommends removing the phrase "prior to preparing.” Instead replace "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**” with "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 the date of a comprehensive medical-legal or a follow-up medical-legal evaluation**” or similar language. Commenter opines that this will eliminate any possible confusion or friction. It will have the added benefit of giving an incentive to the parties responsible for sending the records to provide them on a timely basis to spare the expensive of a reimbursed Supplemental Report. | David E. Sones, MD  December 10, 2020  Written comment | It is anticipated that physicians usually transmit their reports very soon after preparation. Therefore records received after preparation would not be subject to denial of reimbursement for review pursuant to a supplemental. If there is some rational reason for delay between preparation and transmission, Title 8, California Code of regulations § 38(c) provides a mechanism for the physician to seek an extension of time to serve the report. | None. |
| General Comment | Commenter views the current proposal as an improvement over the current state; however, he is concerned that some provisions may be amenable to abuse, in much the same way that DWC’s Statement of Reasons acknowledged that the current fee schedule has been abused. Commenter continues to see many of the same opportunities for improvement noted in his prior DWC Forum comments dated July 9, 2020. Commenter appreciates that DWC has pledged in its Statement of Reasons to propose more comprehensive reforms in the future.  As noted in his DWC Forum comments, the fundamental concern is that California’s Workers Compensation medical-legal evaluations are extremely costly compared to other states, yet these added costs have not resulted in higher-quality reports. The MLFS should be designed to incentivize medical-legal report quality while reducing cost, which would be a win-win for both injured workers and employers. | Peter Spalding  Network Specialist  December 11, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n) | Commenter acknowledges that record review is a key pain point that should be addressed in any reform. However, commenter does not support the proposed declaration requirement as it risks be counter-productive and provides the following reasons:   * + As noted in prior DWC Forum comments, the underlying issue is that the law is unclear as to which records should be sent to the examiner. The language in Labor Code 4602.3 is so broad that it often leads to disagreement, and the supporting regulations in 8 CCR 35 provide little or no clarification. In practice, this often results in the parties sending all available records to the examiner for review, regardless of whether it is reasonable or necessary on a given case. In some cases this amounts to thousands of pages, which are almost impossible to review within the 30 days allowed by law for a QME report. That, in turn, has caused unnecessary delays, costs, and frustration for all parties.   + The current proposal adds a requirement that any “provider of the documents” include a declaration under penalty of perjury, stating that the party complied with the provisions of Labor Code 4602.3 along with an attestation as to the number of pages of records provided.   + This proposed requirement does nothing to address the root cause of the problem. It provides no clarification around what records should be sent, nor does it encourage the parties to be judicious about what is sent. It simply adds a new step in the process, which adds to the administrative burden.   + This requirement also risks unintended consequences, as the proposal states that an examiner would not be allowed to bill for a review of documents that are missing the mandatory declaration. Although well-intended, this provision is likely to spur additional delays and disputes. For example, many medical-legal examiners now use third-party vendors to handle administrative tasks. If a third- party vendor misplaces a declaration—even if the parties sent it timely and correctly—the examiner is likely to refuse to review the records. That, in turn, may lead to any number of ripple effects that undermine the intent of this reform. | Peter Spalding  Network Specialist  December 11, 2020  Written Comment | The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. This should minimize disputes over page count.  The prohibition on billing for records sent without an attestation should encourage parties to carefully select relevant records and send them to the physician in a timely manner.  Title 8, California Code of regulations § 38(c) provides a mechanism for the physician to seek an extension of time to serve the report.  This suggestion would require legislative action to change the existing statute. Labor Code § 4062.3  The requirement of an attestation was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. | This section has been amended please see update. |
| 35  9793(n)  9795(c) | **Commenter recommends adding clarification around which records should be sent to the examiner.** Specifically, he recommends modifying CCR 35 to establish specific guidelines around what records should be sent, so that extensive record reviews are limited to cases in which they are truly reasonable and necessary. This would help limit unnecessary costs, while minimizing unintended consequences noted in his comments regarding proposed section 9793(n). Recommends the following revisions:   * By definition, a medical-legal examination exists for the purpose of proving or disproving a contested claim, pursuant to Labor Code section 4620. Therefore, the record sent to the medical-legal examiner should be treated similarly to trial exhibits: they should be organized and curated to illustrate the contested issues(s) and avoid duplicate or irrelevant information. * Under the current proposal, up to 200 pages of record review would be included in the flat fee for most codes (the exception being ML203, which only allows up to 50 pages of records review). We agree that these threshold are reasonable, as they should suffice for the vast majority of Workers’ Compensation cases. We recommend instituting a cap around these thresholds: the parties should only be allowed to send additional records upon mutual agreement, or when ordered by the Workers’ Compensation Appeals Board or the Administrative Director. * Certain records should be presumed irrelevant absent evidence to the contrary. The parties should only be allowed to send these records upon mutual agreement, or when ordered by the Workers’ Compensation Appeals Board or the Administrative Director. Examples include, but are not limited to, billing records, fax cover sheets, or other administrative records; physical therapy notes; nursing notes; reports of follow-up appointments that show no change in diagnosis, prognosis, work status, or treatment plan; and medical history that is unrelated to the contested issue(s) on the claim. | Peter Spalding  Network Specialist  December 11, 2020  Written Comment | The Administrative Director agrees that the new fee schedule would work much more efficiently if records are delivered in a timely fashion in an organized manner and without duplicates. However, the proposed change is to a regulation that is not part of the fee schedule.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule.  This suggestion would require legislative action to change the existing statute. Labor Code § 4062.3 | This section was amended, please see update. |
| 9795(c) ML200 | Commenter agrees that there should be some provision for missed appointments caused by the fault or neglect of the injured worker or his/her representative. However, he recommends modifying the current language to make it more readily enforceable, as follows:  * The current proposal states that in the situation described above, “the employer may seek to credit those [missed appointment] charges against the injured worker’s award.” However, it does not actually state that the employer is entitled to a credit. It only says the employer can ask for it, which is unlikely to have much if any real-world effect. * To remedy this issue, we recommend that the language be revised to state that an employer is in fact entitled to a credit if a missed appointment is caused by the fault or neglect of the injured worker or his/her representative. In addition, DWC may consider adding a disclaimer to documents sent to injured workers, such as the QME Appointment Notification Form outlined in CCR 110, to place them on notice of this provision. | Peter Spalding  Network Specialist  December 11, 2020  Written Comment | Issues regarding credit against a Workers’ Compensation award must be decided by a Workers’ Compensation judge. | None. |
| General Comment  9793(b) | Commenter recommends clarification around when a treating physician can bill a medical-legal code, as opposed to a treatment report code such as WC004. Commenter makes the following observations:   * The existing fee schedule contains no language around this, nor does the current proposal. The main legal authority on this issue is Labor Code section 4620 as well as Labor Code section 4621. However, that language is very broad and is difficult to apply in practice. * We often see physicians billing medical-legal codes for things like Utilization Review (UR) disputes, claiming that they meet the definitions in Labor Code sections4620-4621. This appears to run counter to the intent of Labor Code section 4061 and 4610.5, which state that UR disputes are to be resolved through Independent Medical Review (IMR) and expressly bar them from being resolved in medical-legal examinations. We also see a small subset of physicians provided ongoing treatment on denied claims and billing for a separate medical-legal examination for each visit. * This ambiguity risks becoming a significant area for abuse, given the increased reimbursements under the proposal. Under the current fee schedule, the maximum reimbursement for a treatment report code, absent mutual agreement, is $181.48 for code WC004. The reimbursement for a basic medical-legal examination is currently $625.00 for code ML102, while this proposal would increase it to $2,015.00 for code ML201. In other words, without clear guidelines in place, an unscrupulous provider could increase its reimbursement more than tenfold, simply by billing an unjustified medical-legal code. * To avoid these abuses, we recommend adding language to the MLFS stating that treating physicians can only bill medical-legal codes in limited circumstances. Specifically, the report would need to be capable of resolving a contested claim as defined in 8 CCR 9793(b). The MLFS should expressly bar the use of medical- legal codes when the treating physician is in fact billing for ongoing treatment, as that should instead be billed under the Official Medical Fee Schedule (OMFS). Similarly, the MLFS should expressly bar the use of medical-legal codes when the treating physician is addressing disputes that cannot be resolved through medical-legal examinations, including but not limited to UR disputes. On the limited occasions when treating physicians do bill medical-legal codes, only the initial medical-legal evaluation should be billed as a comprehensive medical-legal evaluation; any subsequent evaluations should be billed as a supplemental medical-legal evaluation. | Peter Spalding  Network Specialist  December 11, 2020  Written Comment | The issue of when a treating physician can submit a medical-legal report and bill for same is currently covered by Title 9, California Code of Regulations § 9785 and relevant case law. | None. |
| Future Increases | Commenter recommends that reimbursement rates should be updated to keep pace with inflation through automatic annual adjustments.  Commenter states, as noted in the Statement of Reasons, that the existing fee schedule was last updated in 2006, which has since caused it to fall out of step with inflation. This current proposal only makes a one-time update which indicates that this problem is likely to recur in the future. To prevent that from happening, commenter recommends automatically updating the rates based on an objective data source, as is done in other areas of the Workers’ Compensation system, such as the annual adjustments to Total Disability (TTD) maximum rates. | Peter Spalding  Network Specialist  December 11, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| General comment | Commenter is encouraged by the development of these regulations since his previous comments, and urges the Division to implement the draft regulations expediently. While the proposal is not perfect, it represents substantial progress towards creating a sustainable fee structure and encouraging physicians to increase participation in the QME system and better serve injured workers.  Commenter wants to see these regulations implemented not later than the proposed date of April 1, 2021. Since this new fee schedule will have a measurable positive impact on injured workers’ access to care, commenter encourages the DWC to implement the regulations prior to that date if possible. | Micha Scheindlin  Center for Health Policy  California Medical Association  December 11, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(g) | Commenter is pleased that DWC has maintained a time frame specifying when follow-up medical legal evaluations must be performed relative to the evaluator’s examination of an employee in a comprehensive medical legal evaluation. He has previously expressed that having a timeline creates predictability for Qualified Medical Evaluators (QMEs), allowing them to manage their workload and ensuring a timely resolution for the worker whose injury is being evaluated. | Micha Scheindlin  Center for Health Policy  California Medical Association  December 11, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n) | Commenter commends the DWC for including a definition of ‘record review’ in this section which specifies that documents sent to a physician for record review shall “contain an attestation as to the total page count of the documents provided”. Commenter is hopeful that this provision will reduce disputes between physicians and payors as to the amount of record review performed, which will be particularly important in ensuring a smooth transition to the new fee structure. Commenter is committed to working to address any issues that payors have in adapting to new processes around sending records, and believe this provision to be crucial for inclusion. | Micha Scheindlin  Center for Health Policy  California Medical Association  December 11, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section was amended, please see update. |
| 9794 | Commenter has no objections to the proposed changes to this section. Commenter has previously noted that §9794(b), the requirement that medical-legal expenses be paid within 60 days of receipt unless the liability for payment is contested, would be improved with clarifying regulations explaining the remedy if the payment is neither made nor contested in the allotted time period. Commenter does not consider this issue substantial enough to justify delaying implementation of this proposal as written. | Micha Scheindlin  Center for Health Policy  California Medical Association  December 11, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9795 | Commenter has reviewed these extensive proposed changes with two goals in mind – one, that the reimbursement of QMEs should be adequate to encourage more physicians to participate in the QME system and current QMEs to expand their workers’ compensation caseloads, and two, that the reimbursement system be designed in a way that limits billing disputes with claims administrators and avoids undue administrative burden on QMEs and their practices.  Commenter is encouraged by the structure of the proposed billing codes, including the rates and thresholds in this proposal associated with review of medical records. For instance, ML201, which would be billed at a flat rate of $2,015 including review of 200 pages of medical records, represents a substantial improvement over current regulations and previous proposals. Commenter suggested in his 2019 comments that DWC lower the number of pages included in the standard rate to no more than 200, and also increase the per-page reimbursement beyond that threshold. The current draft implements both these suggestions across the several billing codes, and serves the intent of the proposal to ensure adequate reimbursement of QMEs.  Commenter is also supportive of the inclusion of modifiers -96, -97 and -98, all of which are good steps toward helping injured workers gain appropriate access to QMEs. | Micha Scheindlin  Center for Health Policy  California Medical Association  December 11, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9795(c) ML203 | Commenter notes that this provision states that fees are not allowed for review of information which was available in the physician’s office for review or was included in the medical report provided.  Commenter opines that if the physician is not reimbursed for time spent, there will be a tendency not to spend the time. Many of these Medical Legal Evaluations are complicated and at times the answer to issues do not immediately present itself, thus requiring a re-review, second look, etc. Commenter suggests framing this in terms of a legal or insurance office – and he asks, wouldn’t the carrier or lawyer want to look back and be certain that the facts of the case were correct, in the correct order and for the correct patient? | Alfred Roven MD  December 11, 2020 Written Comment | The AD disagrees with the comment. It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule. | None. |
| 9795(d) | Commenter references -96 and -97 in this section. Commenter states that a Board Certified Otolaryngologist has 5 years of post-doctoral training which is more years than a Psychiatrist or Psychologist and may be the same as a Toxicologist or Oncologist, and thus, should be considered for re-imbursement at those multiplier levels (1.95 – 2.45) as well.  Commenter notes that the Board Certified Plastic Surgeon has an additional 2 years beyond the 5 mentioned above and thus should similarly be considered. | Alfred Roven MD  December 11, 2020 Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| Future Increases | Commenter recommends that the rate of medical-legal reimbursement be tied to the last year average inflation rate and/or the increase of the consumer price index for the State of California. This would allow for automatic cost of living increases without the need to meet for each increase. | Alfred Roven MD  December 11, 2020 Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| General Comment | Commenter and the over 2,000 members of his organization wholeheartedly support these proposed regulations.  Commenter opines that the compromises reached by this group were fair, agreeable, will encourage physicians to return to the QME system, will increase efficiencies within the system, and remove friction. All good things, for the system, but particularly for injured workers and their ability to get their disputes resolved in a timely manner.  A key element of the proposed changes is to create incentives and disincentives for stakeholders to change behavior and improve communication between the parties. Commenter opines that the proposed regulations accomplish that goal and will encourage physicians to participate in the QME system.  Commenter acknowledges that some payors are making last minute efforts to derail the proposed changes and start over in our negotiations. Commenter is very much opposed to these efforts. Commenter recommends the Division to move forward with adopting the regulations as proposed. In fact, commenter recommends the Division to implement the revised fee schedule at the earliest possible date – prior to April 1, 2021, if possible. | Lesley Anderson, MD, President  Michael Klassen, MD, First Vice President  Basil Besh, MD  Past President  California Orthopaedic Association (COA)  December 11, 2020  Written Comments | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. |  |
| General comment | Commenter recommends requiring medical-legal reporting physicians to document and submit the time spent for unique record review. That documentation would include the date, start time, end time, and number of pages reviewed for the charges related to unique record review. The payer would only be charged for review of unique records. Payment would comply with the record review schedule. The inclusion of the documentation would provide payers with important documentation and provide the Division of Workers’ Compensation with additional data points to assess quality and equitable reimbursement rates. Additionally, commenter recommends implementing a record review cap in the amount of $10,000.  Below are examples of billing under the current hourly charges and the result if billed under the proposed record review fee schedule. Currently, medical-legal reporting physicians are not required to provide the documentation suggested above.  **Example 1** – Dr. X charged 30 hours for a review of 3,057 pages. The charge was $62.50 per 15 minutes or $250 x 30 = $7,500. That is what was paid.  Under the proposed schedule the charge would be (201-3,057 pgs.) = 2,857 x $3.00 = $8,571  **Example 2** – Dr. Y reviewed 12,299 pages. It took 51.25 hours. = 51.25 x $250 = $12,812.50. That was the charge and the amount of reimbursement.  Under the proposed fee schedule the charge would be (201-12,299) = 12,099 x $3.00 = $36,297  Dr. X took approximately .59 minutes per page. Dr. Y took approximately .25 minutes per page. That means Dr. X took 136% longer to read a page of medical records than Dr. Y.  **Commenter notes several points addressed in two studies cited in the ISOR:**  Coupled with a continuing increase in the average paid amount for QME reports, the average QME earned 240% more from panel reports in 2017 than in 2007.  From 2007 to 2014 the aggregate spent for Medical-Legal expenses increased 46%, time based initial evaluations (ML104) increased from 44% to 54%, and the number of units billed increased from 30.6 to 45.0 (an increase of 3.5 hours in average length of time reported to conduct an exam). In 2007, the ratio for follow-up evaluations to initial evaluations was .43; by 2012, the ratio increased to .55.  Commenter states that billing by ML management companies should be reviewed to assess whether they are associated with the increase in ML104s and supplemental reports.  Noting the above documented increases in medical-legal charges and the proposed fee increase, commenter opines that it is not unreasonable to establish a cap related to record review. Commenter recommends that the DWC review the number of addresses listed per QME to ensure an equitable distribution of assignments are made in order to promote more qualified physicians to participate as QMEs. | Alex Rossi, CEO- RMB  County of Los Angeles  December 12, 2020  Written Commen | The suggestion would lead to collection of important data regarding record review by physicians. However, the additional administrative burden imposed upon the physicians would not be well received. It is anticipated that the requirement to pay three dollars per page will discourage parties from sending non-relevant records to the physician for review. It is also anticipated that the requirement that the parties actually comply with Labor Code § 4062.3 will also discourage the provision of non-relevant records to the physician. However, adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule.  Addressing the issue of the suggested cap on charges for record review coupled with the requirement that the physician report time spent on record review should be reserved for consideration after the results of a reasonable period of use of the new fee schedule can be assessed.  As part of the continued assessment of the efficacy of the new fee schedule, it is anticipated that empirical studies will be commissioned by the DWC. The study of billing by Medical Management Companies would be a proper subject of such an empirical study. | None. |
| 9793(n) | Commenter recommends the following revised language:  “Record Review” means the review by a physician of ***unique*** 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. | Alex Rossi, CEO- RMB  County of Los Angeles  December 12, 2020  Written Comment | Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and addresses any objection a party would have to a record being sent.  It is anticipated that parties would use this mechanism to address duplicate service from various parties. | This section has been amended, see update. |
| 9795(c) ML201 | Commenter recommends the following revised language:  *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 ***unique*** records. Review of *unique* 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 ***unique***records reviewed by the physician as part of the medical-legal evaluation and preparation of the report*.* ***In addition, the physician shall include the date, start time, and end time of all record review performed and billed.*** | Alex Rossi, CEO- RMB  County of Los Angeles  December 12, 2020  Written Comment | Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and addresses any objection a party would have to a record being sent.  It is anticipated that parties would use this mechanism to address duplicate service from various parties. | This section has been amended, see update. |
| 9795(c) ML202 | Commenter recommends the following revised language:  *Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation by a physician which occurs within eighteen 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 ***unique*** 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 ***unique*** 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 *unique* records reviewed by the physician as part of the medical-legal evaluation and preparation of the report. ***In addition, the physician shall include the date, start time, and end time of all record review performed and billed.*** | Alex Rossi, CEO- RMB  County of Los Angeles  December 12, 2020  Written Comment | Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and addresses any objection a party would have to a record being sent.  It is anticipated that parties would use this mechanism to address duplicate service from various parties. | This section has been amended, see update. |
| Future increases | Commenter makes reference to a recent report by Elaine Howell, state auditor that the Medical Legal Fee Schedule (MFLS) include an annual cost of living adjustment. Commenter notes that the DWC believes that it may not have the authority to include and adjustment factor into the regulations. Commenter does not agree with this assessment and references Labor Code section 5307.6(a) which requires “adoption and revision” of the MLFS. Commenter notes that this code ties the frequency of these revisions to take place “at the same time he or she adopts and revised the medical fee schedule pursuant to section 5307.1” Commenter notes that revision to the OMFS takes place on a routine and regular basis – several times each year – unencumbered by the Administrative Procedure Act. Commenter notes that the MLFS “enjoys” the same privilege as noted with the “Notice of Proposed Rulemaking.”  Therefore commenter states that a cost of living adjustment could be implemented as often as each revision of the OMFS without delay or debate. Commenter opines that the DWC has little choice but to eliminate this 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 section 5307.6. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment  December 14, 2020  Oral Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| DWC training of Maximums regarding interpretation of new MLFS for IBR (Independent Bill Review) | Commenter notes that the Division’s Medical Unit educates Maximum and its independent bill reviewers on how to interpret the MLFS to settle eligible reimbursement disputes. Commenter opines that this new proposed fee schedule is unlikely to eliminate the level of friction that is currently experienced and that, at best, will swap current ambiguities with new ones. Specifically in regard to reimbursable vs. un-reimbursable supplemental reports, the exact meaning of “available” as it is applied to medical records, issues surrounding reimbursement of “missed appointments,” the use of certified interpreters, etc.  In order to provide training without prejudice, commenter recommends that after the adoption of this new MLFS, a small team of industry participants with DWC staff be seated to address training issues. Commenter recommends the Division’s Medical Unit Staff be joined by billing experts from both the provider and payor community plus one or two members from the corps of evaluators. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment  December 14, 2020  Written Comment | The implementation of the flat fee structure of the new fee schedule is intended to alleviate ambiguity with respect to the application of the fee schedule. Any remaining ambiguities are ultimately the subject of the jurisdiction of the WCAB and or other administrative courts of competent jurisdiction under the administrative procedures act  The suggestions with regard to training of Maximus employees are well taken and will be reviewed with respect to possible implementation. However, training protocols for Maximus employees are not the proper subject of regulations addressing the medical legal fee schedule. | None. |
| 9793(g) | Commenter recommends changing the time frame from 18 to 12 months.  Commenter states that there is no data to support 18 months nor support for any change from the existing nine-month timeframe. Commenter states that the longer time between evaluations, the less familiarity with the former evaluation will exist. Commenter opines that this change to 18 months appears to be nothing more than an attempt to placate payor concerns regarding costs. He acknowledges that cost is an important consideration; however they should not outweigh the conditions under which a follow-up evaluation takes place. Commenter would like to know DWC’s factual basis and data supporting this change. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The Administrative Director disagrees. Negotiations in the stakeholder meetings initially produced agreement on a 24 month time period for reevaluation reports. This agreement was later repudiated, which led to the 18 month time period being selected. The time period should allow for sufficient change in the medical condition or circumstances of the injured worker to justify resort to initial evaluation fee levels. | None. |
| 9793(h) | In the last sentence of this subsection, commenter recommends replacing the word “report” with “evaluation.” Commenter states that supplemental reports do not require an evaluation as defined. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | Although a Supplemental Medical Legal Evaluation does not involve an examination of the injured worker it is still nominally an evaluation by way of review of submitted materials. The regulation is clear that it refers to the report that is produced as a result of this evaluation. | None. |
| 9793(h)(5) | Commenter recommends replacing “evaluation” with “narrative report.”  Commenter states that 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. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The existing language does not lend itself to ambiguity as to what is required to be served. | None. |
| 9793(l) | Commenter recommends adding the following additional sentence:  “Correspondence received by the physician from the parties to the action, does not include any medical records.”  Commenter states that notwithstanding recent pronouncements and assurances, the definition of “correspondence does not include any medical records, a direct reference clarifies this fact. He opines that a generally accepted definition of “correspondence” carries no weight or affect when one party seeks to obfuscate the med-legal evaluation process. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”,  and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | None. |
| 9793(m) | Commenter recommends the following revised language:  (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 …  Commenter states the addition to reference of LC section 40362.3(c) and (e) and other applicable code references will clear up any ambiguity or confusion in connection with the 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. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The administrative director does not believe that the word “available” lends itself to any ambiguity with respect to interpretation of the regulation. | None. |
| 9793(n) | Commenter recommends the following revised language:  (n) “Record Review” means the review by a physician of documents **~~sent to~~** **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.  Commenter states that “received” is the triggering event. “Documents sent” but not received are irrelevant.  Commenter states that reference to LC section 4062.3(c) and (e) and other applicable code references will clear up any ambiguity or confusion with the 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. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The Administrative Director does not believe that the requested additional wording adds any clarity as to how to interpret the regulation. However, the decision regarding whether clarifying language is necessary will be reserved for consideration after the results of a reasonable period of use of the new fee schedule can be assessed. | None. |
| 9794(a)(1) | Commenter recommends the following revised language:  “…No other charges shall be billed **or reimbursed** under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.”  Commenter states that it is incumbent on the DWC to require both the biller and payor to abide by the OMFS when required.  Commenter also recommend the addition of the following sentence as the end of the subsection:  **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.**  Commenter states that 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.  Commenter recommends the addition of the following subparagraph and re-labeling the current (2) as (3):  **(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.**  Commenter states that Medical-Legal expenses are not subject to discounts provided in a treatment setting. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The Administrative Director does not believe that the requested additional wording add any clarity as to how to interpret the regulation. However, the decision regarding whether clarifying language is necessary will be reserved for consideration after the results of a reasonable period of use of the new fee schedule can be assessed.  The Administrative Director believes that the specific language of the authorizing statute for utilization review does not lend itself to ambiguity with reference to this regulation. The proper interpretation of that statute is not a subject for fee schedule regulations.  The Administrative Director believes that since the services provided pursuant to this regulation are governed by the Official Medical Fee Schedule for payment, any limit on the application of that fee schedule is not a proper subject for regulation by the Medical-Legal Fee Schedule. | None. |
| 9794(c) | Commenter recommends the following revised language:  (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~~** **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 **~~e~~E**xplanation of **~~r~~R**eview **pursuant to Labor Code Section 4603.3.** Any notice of objection **must also** include or be accompanied by all of the following:  (1) An **~~e~~E**xplanation of **~~r~~R**eview 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 **~~e~~E**xplanation of **~~r~~R**eview 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~~** **factual basis used to determine** why its code more accurately reflects the service provided.  (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.  Commenter states that med-legal expenses for testing may not be eligible for the SBR and IBR. They are also not eligible for SBR and IBR in a med-legal setting. This language clarifies that eligibility for the med-legal SBR and IBR processes. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The indicated regulation implements or makes clear the application of the Labor Code sections dealing with Medical-Legal Expenses pursuant to Labor Code §§ 4620 et seq, and Independent Bill Review Provisions of Labor Code §§ 4603.3 et seq. The suggested changes to the regulations seem unnecessary if the regulations are read in conjunction with those Labor Code sections. | None. |
| 9794(e) | Commenter recommends the following revised language:  A**ny** **~~form~~** objection which does not **completely** identify the specific deficiencies of the report in question shall not satisfy the requirements of this subdivision. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The indicated regulation implements or makes clear the application of the Labor Code sections dealing with Medical-Legal Expenses pursuant to Labor Code §§ 4620 et seq, and Independent Bill Review Provisions of Labor Code §§ 4603.3 et seq. The suggested changes to the regulations seem unnecessary if the regulations are read in conjunction with those Labor Code sections. |  |
| 9794(f)(1)  9794(f)(2) | Commenter recommends the following revised language:  (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. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The indicated regulation implements or makes clear the application of the Labor Code sections dealing with Medical-Legal Expenses pursuant to Labor Code §§ 4620 et seq, and the petition for determination process. The suggested additional language is not necessary to facilitate the physicians use of agents to collect on billing. | None. |
| 9794(i)  9794(j) | Commenter recommends the following revised language:  (i) **~~Physicians~~ 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.  (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; | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The Administrative Director does not believe that the DWC needs to provide permission or sanction for the shifting of responsibility from physicians to their agents. | None. |
| 9795(b) | Commenter recommends the following revised language:  … 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. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The administrative director does not agree with the change in the regulation offered by the suggested language. The current language is not subject to ambiguity and the suggested change would limit the type of records reviewed. | None. |
| 9795(c) ML200 | Commenter recommends the following revised language:  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. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The Administrative Director does not believe that the suggested language will add clarity to the regulation or take into account instances where the interpreter is not provided by the employer. | None. |
| 9795(c) ML201 | Commenter references the following language:  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.  Commenter opines that the evaluator cannot be put at risk with respect to the number of pages. They have no control over what they receive. Commenter recommends that the parties submitting records be required to submit the affidavit of the contents of the records under penalty of perjury and that affidavit be considered part of the record that can be used to substantiate the pages billed.  Commenter states that the evaluator must be given a means to indicate a number of pages if different than what the affidavit indicates. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The requirement of an attestation was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. Verification of pages of records reviewed is a tool added simply to provide for accountability. It also provides a physician a means of disputing the page count in the attestation. | None. |
| 9795(c) ML202 | Commenter recommends changing the time period from 18 to 12 months as he noted in his comments regarding 9793(g).  Commenter opines that the evaluator cannot be put at risk with respect to the number of pages. They have no control over what they receive. Commenter recommends that the parties submitting records be required to submit the affidavit of the contents of the records under penalty of perjury and that affidavit be considered part of the record that can be used to substantiate the pages billed.  Commenter states that the evaluator must be given a means to indicate a number of pages if different than what the affidavit indicates.  Commenter requests that the DWC examine section 30 – regulation 35 which could expand outside the scope of the medical legal fee schedule. Commenter opines that with an emergency regulation, the DWC can allow cover sheets to be more substantial to be the verification that the physician and payor would need to eliminate some of the controversy with respect to what is billed for records on a per-page basis. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment  December 14, 2020  Oral comment | The Administrative Director disagrees. Negotiations in the stakeholder meetings initially produced agreement on a 24 month time period for reevaluation reports. This agreement was later repudiated, which led to the 18 month time period being selected. The time period should allow for sufficient change in the medical condition or circumstances of the injured worker to justify resort to initial evaluation fee levels.  The requirement of an attestation was added to encourage the parties to provide a clean copy of records to the QME. The prohibition against billing for records received without such an attestation logically assumes that the QME will take steps to correct the situation. Reasonable attempts to clarify the record by the QME would undoubtedly be approved in bill review. Verification of pages of records reviewed is a tool added simply to provide for accountability. It also provides a physician a means of disputing the page count in the attestation. | None. |
| 9795(c) ML203 | Commenter recommends the following revised language:  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 **~~available~~** **received pursuant to Labor Code Section 4062.3 (c) and (e)** at the time of the initial or follow-up comprehensive medical-legal evaluation. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The administrative director disagrees with the need for the changed language. The meaning of the word “available” is not subject to interpretation. Records must have been received by the physician at some time in order to be available to the physician. | None. |
| 9795(c) ML205 | Commenter highlights the following requirement:  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.  Commenter opines that this stipulation is an overreach and over simplification of compliance with its requirement. Commenter questions what is the evaluator to do if the sub rosa is received such that the time required to review and write/rewrite the report delays service of the report past 30 days? | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | Title 8, California Code of regulations § 38(c) provides a mechanism for the physician to seek an extension of time to serve the report. | None. |
| 9795(c) ML206 | Commenter recommends the following revised language:  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~~** **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;…  Commenter references the following language:  (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.  Commenter questions what this is based upon. Commenter opines that this applies only if the cover letter is fully compliant with current law and not a legacy checkbox form letter. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, please see update. |
| 9795(c) MLPRR | Commenter references his previous comment under ML201 and ML202 regarding the weight of the affidavit submitted when records are received. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The requirement to pay three dollars per page for record review should incentivize carriers and attorneys to carefully select and count the records that are provided to the physician. This should minimize disputes over page count.  The prohibition on billing for records sent without an attestation should encourage parties to carefully select relevant records and send them to the physician in a timely manner. | None. |
| 9795(d) -93 | Commenter opines that this modifier should also apply to tele-evaluations. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | Telemedicine for a QME evaluation is currently temporary though emergency regulation. This issue will be addressed if telemedicine is made a permanent part of the QME regulations | None. |
| 9795(d) -97 and -98 | Regarding the language “board certified” (Labor Code section 139.2), commenter states that all QME’s are board certified. If not, he opines that this stipulation will cause defense to choose non-board certified toxicologist or oncology QME’s which may compromise the clinical quality of the report and conclusions.  Commenter recommends increasing the modifiers as follows:  1.50 to 2.0  1.60 to 2.1  1.85 to 2.35  1.95 to 2.45  Commenter questions what is the data and evidence that suggest that these evaluations are any less complex than the mental health AME/QME. | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | Noted.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | This section has been amended, see update. |
| 9795(f) | Commenter recommends the following revised language:  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 pursuant to 8CCR Section 9795(c)** on or after April 1, 2021; | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | The administrative director does not believe that the clarifying language is necessary. If an appointment is missed after the effective date of the schedule is anticipated that carriers will pay the missed appointment fee pursuant to the new schedule. | None. |
| 9795(h) | Commenter questions what is the “appropriate modifier” to which this section refers? | Steve Cattolica  CWCSA  December 12, 2020  Written Comment | By the terms of the regulation the Workers’ Compensation Administrative Law Judge will determine the appropriate modifier. | None. |
| General Comment | Commenter states that he been a QME in Occupational Medicine/Toxicology since the inception of the program. In a typical case, he is asked to determine if there is a causal relationship between an exposure to a chemical or other hazard and the illness/symptoms reported by the applicant. Invariably, this requires extensive medical literature research. His reports are typically 15 to 20 pages long.  Commenter opines that is not a viable proposition for him to conduct evaluations and prepare reports for the proposed flat fee. Commenter states that he will not be able to continue performing QMEs if the proposed Medical-Legal Fee Schedule is put in place. Commenter states that he will be disappointed in not being able to continue. However, his “resignation” will adversely impact the ability of applicants to get toxicology evaluations. According to the QME database, there are currently only 4 QME toxicologists in a 200-mile radius of Walnut Creek, where his office is located. | Michael Fischman, MD, MPH  Clinical Professor of Medicine  Division of Occupational & Environmental Medicine  University of California, San Francisco  December 12, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| General Comment | Commenter notes that the DWC’s goal is to reduce friction by essentially simplifying billing for med-legal reports. Commenter is concerned that the new regulations substitute number of pages for the current fee schedule’s complexity factors, as a way to provide fair reimbursement for reports that require extensive time to complete. While this strategy might make sense for certain types of injuries, and certainly compensates QME’s and AME’s for the time needed to review large amounts of records, he is concerned about very complex cases in which medical records are minimal. Commenter has had several of these in his career. Especially in cases with direct psyche injuries, if the worker was not seen for mental health treatment, there will often be very few records; or even if seen, there are often less than 100 pages of medical records, since mental health treaters often submit summaries rather than individual session notes. And in complex cases with prior psychiatric history often the prior treatment notes are not submitted, or the applicant has never sought treatment in the first place. Yet diagnostically and from the standpoint of analyzing causation and apportionment issues, these cases are often very complex and time consuming. Therefore, it is highly likely that psyche QME’s will be presented with complex cases requiring extensive time for thoughtful, reasoned and probative analysis, and which have few medical records, and in this way will be woefully underpaid.  Commenter opines that adoption of this proposed fee schedule may cause many highly qualified QME’s to leave the system, pressure QME’s to cut corners, thereby producing inadequate reports, or increase the number of disputes that require resolution. | Adam Kremen, PhD, QME  Psychologist  December 13, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(l)  9793(n)  9794(h) | Commenter notes a problem with the requirement for attestation of medical records by both the sender and receiver. Commenter questions how differences in the attestations of number of pages for both the sender and receiver (typically because of miscounts) can be resolved. | Adam Kremen, PhD, QME  Psychologist  December 13, 2020  Written Comment | The requirement of an attestation was added to encourage the parties to provide a clean copy of records to the QME.  Strict compliance with Labor Code § 4062.3 should alleviate the problem of records being provided in multiple deliveries. Inaccurate page count by parties delivering records can be cross checked with page count performed by physician.  Disputes regarding payment of the QME bill related to a fee schedule are already addressed by Labor Code §§ 4621 et seq. Those provisions provide for Independent Bill Review, interest and penalties for late payment of medical-legal expenses. | None. |
| 9795(c) ML-202 | Commenter notes the following problems with the requirement to not charge for previous records, even if these are resent.   * It may take a lot of unpaid work to sort out old from new records.   Will lead to miscounts and disputes. | Adam Kremen, PhD, QME  Psychologist  December 13, 2020  Written Comment | The AD disagrees with the comment. It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  In stakeholder meetings it was acknowledged that there are different levels of review with regard to medical records. The time and attention necessary for review of records that have already been reviewed did not warrant reimbursement under the new fee schedule. | None. |
| 9795(c) ML206 | Commenter wants to know how disputes over whether an issue was previously addressed will be handled. | Adam Kremen, PhD, QME  Psychologist  December 13, 2020  Written Comment |  | This section was deleted, please see update. |
| General comments | Commenter offers the following general comments:   1. The QME system is dangerously understaffed, especially in key specialties like orthopedics, and the exodus of QMEs from the system has been accelerating in recent years. As a result, injured workers are having difficulty obtaining QME evaluations in a timely manner as evidenced by the growing numbers of replacement panels on the basis of QME unavailability. 2. QME demand is at a historic high and has been growing at the same time that the QME population has been shrinking. The **mismatch between QME physician supply and demand has never been greater**. 3. Inadequate reimbursement is one of the main drivers of QME physicians leaving the system. **QME fees have not been increased since 2006 despite DWC's statutory mandate under LC 5307.6(a) to do so regularly.** 4. QME report quality is consistently raised as a problem throughout the system. 5. **The proposed change to the fee schedule could reduce QME reimbursement on complex evaluations, further reduce report quality, and drive more providers out of the QME system**. This couldn’t come at a worse time. With the system already understaffed, these changes would further jeopardize the stability of the QME program. | Gabor Vari, MD  Chief Executive Officer  California Medical Evaluators  Board Member, California Society of Industrial Medicine & Surgery  December 13, 2020  Written Comment | Noted.  This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective.  In moving to a flat fee structure, it was decided in stakeholder meetings that complexity factors would be omitted from the new fee schedule because of their inherent susceptibility to varying interpretation. The complexity of an evaluation is taken into account by the structure of the fee schedule with the per page payment. | None. |
| QME History of MLFS Fee Schedule | Commenter has submitted a comprehensive history of the lead up to the current proposed Medical-Legal fee schedule, which includes the following:   * Howard v Baker lawsuit. * AB 1832 * Previous proposed versions of the Medical-Legal Fee Schedule with analysis * November 2019 California State Auditor Report 2019-102   Please note that this information is available for review upon request | Gabor Vari, MD  Chief Executive Officer  California Medical Evaluators  Board Member, California Society of Industrial Medicine & Surgery  December 13, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| Percentage increase to the current Medical Legal Fee Schedule | Commenter opines that that moving to the proposed flat fee, per page format is a mistake. Commenter states that the current fee schedule accurately captures complexity through its structure. Commenter is unaware of any data to suggest that the new proposed fee schedule will accomplish our shared goal of providing quality reports for injured workers. In fact, commenter opines that there is nothing in the current fee schedule that will incentivize quality and will accomplish the opposite.  **Commenter states that for the past *fifteen years*, DWC has failed to follow its statutory mandate under LC5307.6 (a) to simply grant QMEs a reasonable increase at the same time that it adjusts the OMFS.** While DWC has adjusted the OMFS over 60 times since 2014, ithas increased the medical-legal fee schedule zero times during this time frame. Thishas been further compounded in recent years by DWC circumventing the legislature and, most recently, ignoring the recommendations of the State Auditor. Commenter opines that California’s medical providers and injured workers deserve better than this.  Commenter opposes DWC’s proposed changes to the medical legal fee schedule and opines that these changes will add more friction and litigation to today’s broken QME system in addition to reducing reimbursement for complex evaluations. **Commenter states that a flat fee model will incentivize** **speed and efficiency, resulting in a decline in report quality. DWC has already** **identified that QME report quality is a problem system-wide. In this context, DWC’s proposal does not make sense**.  **Noting that the DWC has not increased the fee schedule since 2006, commenter requests that**  **DWC simply increase the existing fee schedule by 65%, the amount that State Average Weekly Wage has increased since 2006.** | Gabor Vari, MD  Chief Executive Officer  California Medical Evaluators  Board Member, California Society of Industrial Medicine & Surgery  December 13, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule.  Labor Code § 5307.6 was enacted in 1993. Labor code §5307.1 was subsequently amended to match increases in the OMFS to increases in Medicare rates. Labor Code § 5307.6 was never amended to account for these frequent increases in the OMFS and how it affected the Administrative Director’s obligation to revise the medical-legal fee schedule under § 5307.6.  The Administrative Director disagrees with the comment. The substantial rise in rates for the physicians represented in the new schedule is likely to attract physicians to the QME program.  The flat rate schedule provides objective criteria for reimbursement that are not subject to interpretation.  Empirical studies showing that QMEs have increased their net reimbursement some 240% since 2006 indicates that there is no actual correlation between report quality and fee schedule reimbursement. The Administrative Director must employ other means unrelated to reimbursement to address the issues with respect to report quality.  Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. None of the empirical studies indicate that a 65% increase in the fee schedule is indicated at the current time. | None. |
| 9795 | Commenter opines that the QME flat rate schedule for the most complex reports, such as those written for eye injuries and vision loss is a grave risk of being devastated economically by the proposed fee schedule changes.  Commenter states that the eye is the most complex organ in the human body, yet an ophthalmology QME report is compensated at the same rate as far less complicated reports to compose. Commenter states that during the November 16, 2020 Joint Legislative Audit Committee hearing, DWC committed to examining a rate multiplier for certain provider specialties. Commenter notes that his specialty of ophthalmology should fall into this category. He notes that a rate multiplier has been proposed for psychiatry, toxicology, and oncology while his specialty has been excluded.  Commenter states that ACOEM defines eye injures as 1% of all workers’ compensative claims, but 4% of the claims paid. Commenter recommends that before DWC enacts the proposed compensation rate, the scheme be adjusted to provide a rate multiplier to fairly compensate the fewer than 30 California ophthalmologist who are QME report writers.  Commenter recommends the following strategies to prevent loss of QME Ophthalmologists:  · Apply the proposed rate changes to the paramedical QME report writers only. Optometrists, dentists, chiropractors, podiatrists, and psychologists are not medically trained, and therefore their “medical conclusions” are inherently rebuttable. Furthermore, these paramedical professions are not bound by the same responsibilities as a medical doctor or osteopath. They may refer to themselves as “Doctor,” but they are still paramedical personnel. The hourly billing scheme can be kept in force for MD and DO QME report writers. While politically risky, this approach would preserve hourly compensation for the most complex cases across all medical specialties, as well as recognize medical doctors and osteopaths for their additional years of training.  · Provide a rate multiplier with a specific ML-201 modifier for ophthalmology reports in order to provide an estimated quadrupling of the base rate to incentivize the detail and precision demanded of the high quality ophthalmic QME report writer. The exceptional mathematical schema in Chapter 12 “The Visual System” of The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, is unique and inherently complex when properly applied. With fewer than 30 ophthalmologists for the entire California worker population according to the CWCI study, combined with the commonness of catastrophic eye injury and stroke, the cost-benefit of providing an incentive to ophthalmologists is self-evident.  · Permit “Prolonged Services” codes for complex specialties like ophthalmology. CPT codes 99354-99357 are specified when a physician provides direct prolonged service in either the face-to-face setting or not in-person, that goes beyond the usual service duration described for the billing code. The intrinsic complexity of ophthalmology reports requires many hours of preparation of test results, mathematical computation, and detailed medical research. Exclusive of medical record review, the proposed ML-201 flat rate estimates approximately 8 hours or less of billable physician time. When the in-person history-taking plus examination and psychophysiological testing takes 4-5 hours, this leaves an inadequate amount of time to compose a high quality and comprehensive report. A relatively straightforward eye injury report can take 10 or more hours to research and compose, yielding, on average, a 30-40-page report. A medically complex report takes proportionately longer to compose, yielding reports of 50 or more pages in length.  Commenter submitted detailed information to support his request wherein he sites:   1. Wynn, Barbara O. Research Analyst, RAND Corporation, Working Paper: *California Workers’ Compensation Medical-Legal Fee Schedule - Analysis and Recommendations,* October 2018. 2. Jones, Stacy L., Senior Research Associate, California Workers’ Compensation Institute, Research Update re: *Changes in the QME Population and Medical-Legal Trends in California Workers’ Compensation,* February 2018.   A copy of his complete December 13, 2020 submission if available upon request. | Daniel Schainholz, MD, MPH, QME  December 13, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule.  The Administrative Director disagrees with the comment. The substantial rise in rates for the physicians represented in the new schedule is likely to attract physicians to the QME program.  The flat rate schedule provides objective criteria for reimbursement that are not subject to interpretation.  Empirical studies showing that QMEs have increased their net reimbursement some 240% since 2006 indicates that there is no actual correlation between report quality and fee schedule reimbursement. The Administrative Director must employ other means unrelated to reimbursement to address the issues with respect to report quality.  Diagnostic testing is already compensated under the official medical fee schedule. Mixing treatment codes with evaluation code within the same fee schedule can only lead to confusion and increased frictional costs. | None. |
| General Comment | Commenter opines that the proposed flat fee schedule does not address the complexity of the case nor the complexity of the report that needs to written. Commenter states that the eye is by far the most complex organ. This fee schedule reflects no differentiation between an eye injury, a nail injury and lower back pain. Commenter understands that there are rate multiplier provided for psychology and psychiatry, due to the additional time necessary for both the report preparation and the time spent with the Applicant. Commenter opines that this is at least as true for an Applicant with catastrophic vision loss, or for an Applicant who is feigning vision loss.  Commenter states that these are complex cases, and a flat fee, in his opinion would not lead to efficiency but rather to mediocrity which damages all parties. It causes damage to the Applicant who receives an inaccurate W.P.I. rating due to so-called added efficiency. It causes damage to the defendant, because the opportunity to identify occult disease or other causative factors is, essentially, eliminated by the need to rush through such an evaluation.  Commenter opines that the RAND study, upon which these decisions appear to be based is fundamentally flawed. First, it said that there would be a generalized increase in the rates, but that is for the least complex cases and for those that are seen regularly. Eye cases tend to come at the very end of the process – the judges are waiting, the defendants are waiting, and the Applicants are waiting for the final determination.  Commenter requests that the DWC provide an equitable rate modifier for ophthalmology. | Daniel Schainholz, MD, MPH, QME  December 14, 2020  Oral Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9795(c) ML201 and ML202 | Commenter makes the following observations and recommendations regarding to the Comprehensive and Follow-up Medical Legal Evaluations:   * By proposing a “flat-fee”, the spirit of the Medical-Legal Evaluation is changed from the evaluator being able to take adequate time to gather history and perform examination, to reducing time spent with the applicant to make up for the time it takes to review records and issue a report and opinions. The flat fee encourages evaluators to spend less time with the applicant and will, in the long-run, short-change the applicant. * In typical workers’ compensation practices, the practitioners are hurried and do not always have the time to spend to obtain the extensive history necessary to make medical-legal determinations. The Qualified Medical Evaluation is the “fail-safe”, the oversight for missing and inaccurate information that may be found in the medical records. * If the flat-fee is approved, there will be incentive for evaluators to “cut corners” in the history and examination to save time. * My recommendation for the solution to this issue is to keep the same fee schedule but allow the evaluators to charge for any additional face-to-face time spent over 60-minutes, in increments of 15-minutes. * This solution would solve the dilemma that examiners face when dealing with complex cases such as multiple body parts, and multiple dates of injuries. These cases need much more time to obtain a thorough and adequate history, as well as to determine causation and apportionment. | Lori Schroeder, DC, QME  December 13, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies are determined after a reasonable period of use of the new fee schedule. | None. |
| 9793(n)  9795(c) | Commenter has questions regarding what exactly records review encompasses, such as:   * Does it include Medical-Legal Intake Forms? * Does it include Personal Review of Diagnostic Imaging such as CT, MRI, and X-ray images? Comparison of sequential imaging? * Physician Mensuration Time to perform line drawings and analysis of radiographs per the *AMA Guides*? * Is there a minimum font size? There are medical records with font size so small, one must use a magnifying glass. If the font is undersized or if the notes are handwritten and difficult to decipher, may additional fees be charged? * If the parties provided duplicate, triplicate, and quadruple copies, are these included in the page count? If not, then can time be charged to determine which are duplicate? * If previous QMEs have been performed, does records review include the time for the evaluator to review their past reports and records? (Suggestion: This should be included if it is over 6 months.) * Is the evaluator allowed to charge for records out of order, or pages from reports interspersed with pages from other reports? In other words, is there an allowance for collating records? (For instance, I have received records on more than one occasion in which it seems that someone threw them up in the air, and then collected them in their random order and presented them for review.) * Is there an additional allowance when reports are provided on DVDs but saved one at a time? When you are reviewing 50-separate-reports, it might take the evaluator an additional 30-minutes just to get into and out of each report? |  | Record review is defined by Title 8, California Code of Regulations § 9793(n). To the extent the documents sent to the physician fit within the definition in the regulation, they are the proper subject of review if necessary to resolve the issues presented by the medical-legal evaluation.  The fee schedule as written does not proscribe billing for duplicate records. The fee schedule only prescribes billing for records previously reviewed or in some cases previously available to the QME.  Record review is defined by Title 8, California Code of Regulations § 9793(n). To the extent the documents sent to the physician fit within the definition in the regulation, they are the proper subject of review if necessary to resolve the issues presented by the medical-legal evaluation.  The fee schedule provides for reimbursement at $3.00 per page for records reviewed by the physician. | This section was amended, please see update. |
| 9793(l) | Commenter makes the following observations and recommendations regarding the service of medical-legal reports:   * Most insurers require that medical-legal reports and billing be mailed despite all having fax and email accounts. * The cost of mailing can be exorbitant for a 40-50-page report, as well as the detrimental effect to the environment in terms of paper. Is the evaluator allowed to add a cost for the mailing fee? * My suggestion for the solution is that the insurers be required to accept the QME Report and billing via fax services as they are required to accept fax service for RFAs. (Email would be even better) * Also, it would be helpful if the claims administrator be required to provide both their fax and email. | Lori Schroeder, DC, QME  December 13, 2020  Written Comment | The issue of electronic service of QME reports is being addressed in regulations that do not fall within the parameters of the Medical-Legal Fee Schedule. | None. |
| 9794  9795 | Commenter has the following questions, concerns and recommendations regarding diagnostic studies:   * If the Qualified Medical Evaluator requires diagnostic studies, who determines their necessity? The Claims Examiner? Utilization Review? * Are requests for diagnostic studies required to be submitted on an RFA? Is the examiner allowed to charge for additional time for this? * Is there an appeal process if the request for the diagnostic study is denied? Does it go through IMR? The WCAB? * My suggestion is that the evaluator be permitted to obtain one study of any type of any body area with reasonable justification. Any subsequent studies by the Qualified Medical Evaluator need to go through the RFA and Utilization Review process. But the first diagnostic study of any body part required by the QME should be authorized. This will stop the denials that will likely ensue and prevent further delays (which already plague the system). | Lori Schroeder, DC, QME  December 13, 2020  Written Comment | Issues relating to the determination of the necessity for diagnostic testing and how that testing is approved or authorized are beyond the scope of the medical-legal fee schedule. Issues related to the reimbursement for diagnostic testing services are covered by title 8, California Code of Regulations § 9794 | None. |
| 9795(c) ML204 | Commenter states that depositions are scheduled and cancelled like blinks of the eye. It is her experience that more than 50% of scheduled depositions are cancelled around 6 days prior. This makes it very difficult to schedule anything else in that time slot. Commenter recommends more stringent guidelines are needed in order to protect Qualified Medical Evaluators.  Commenter recommends that payment must be made 30-days prior to the appointment to hold the time slot. Commenter recommends that the cancellation be the same as the QME cancellation policy of 6 business days, not 8 calendar days. | Lori Schroeder, DC, QME  December 13, 2020  Written Comment | The criteria of six business days for cancellation was selected to conform with existing regulations regarding cancellation of the QME appointment as contained in Title 8, California Code of Regulations § 34 (d).  The deposition fee is calculated at the hourly rate of 455/hr or the physician’s usual and customary hourly fee, whichever is lower. The timing of receipt of the fee by the physician is governed by the California Code of Civil Procedure. | None. |
| 9795(c) ML206 | Commenter notes that uncompensated supplemental reports can be requested if the referring party doesn’t believe an AME has addressed an issue in the original report. Commenter recommend that insurance carriers and their counsel be held accountable for the cover letter they send so that QMEs can address the specific issues the parties want clarified. | Mark Kimmel, PhD  December 13, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, please see update. |
| 9793(n)  9795 | Commenter opines that the number of pages being reviewed by a QME should be stated by the referral source and be verifiable. Additionally, records should be provided for review at least 2 weeks prior to the evaluation. | Mark Kimmel, PhD  December 13, 2020  Written Comment | The language is clear that the party providing the record shall include an affidavit of the number of pages sent. Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and is not the subject of this rule making. | None. |
| 9795(d) | Commenter states that the AME rate for psychology/psychiatry should be 2.7 and the modifier for ML-201-96-94 and ML-202-96-94 should be 2.70 (2015x2.70 = $5440.50). | Mark Kimmel, PhD  December 13, 2020  Written Comment | Comparisons of fees after the application of the modifier should only be made with the base rate prior to application of modifier. | None. |
| General comment | Commenter opines that this is a terrible schedule and disproportionally benefits those doing easy evaluations while disproportionality harming mental health and other complicated evaluations.  Commenter states that the DWC model has been described by physicians as you win some and lose some. Meaning that there is a realization that physicians will actually lose money on some evaluations and hope to even this out on other evaluations. That means, the DWC has built in bias against applicants with complicated evaluations because those will be deemed the evaluations that will lose money. Commenter opines that the DWC model is also falsely based on believing that the number of records equals complexity. Some of the most complicated evaluations come with no records. This is because the parties are in charge of getting records. So you can have an extremely complicated injured worker that takes many hours to evaluate and get paid the same as someone who did an evaluation of a simple claim. Commenter states that the DWC is proposing a system where the savviest of evaluators will be able to screen out complicated injured workers who will cause them to lose revenue or will tailor their evaluations to give them a shoddy evaluation so as not to take too much time with these injured workers.  Commenter states that if a worker has a multi-year harassment claim, has complicated medical injuries, is a first responder and needs a detailed report, etc., they will not get the time needed to fully explain their claim, the defense will not get a good assessment of non-industrial factors, and judges will get opinions that are less based on research and a thorough evaluation of evidence and more on speculation and bias.  Commenter states that the incentive by the DWC is a race to the bottom. The less time you spend, the more per hour you make. That is the new corruption the DWC is implementing.  Commenter states that the proposed new fee schedule is poorly written. Not one QME/AME out of many, has been able to fully explain this schedule and it is riddled with holes. Commenter questions whether the DWC done a survey to find out how many QME’s understand fully understand the proposed schedule. His guess is zero. That is not being said in jest. There is literally no doctor, out of many, that can adequately explain this schedule. They can get what it means and possible ways to deal with it. Commenter questions whether the DWC makes the regulations purposefully ambiguous to allow for underground regulations to be implemented at will as they did years ago. Commenter remembers when the DWC implemented underground regulations and then provided a series of disastrous proposals to retaliate against QMEs for a period of years when QMEs sued the DWC.  Commenter recommends that the DWC redo this proposal. The last proposal received overwhelming negative comments. Commenter questions if the DWC think it is doing a great job by just going to rule making instead of putting out a schedule that most people will like or can at least adequately understand. Commenter states that the DWC has not achieved making a clearer and simpler schedule and has not achieved paying all evaluators a greater amount for this work. Commenter states that the DWC was presented with data previously that medical legal costs have not been significantly rising. The fact that the DWC has upset payers and employers with this proposal supports that the DWC and not medical legal evaluators are increasing costs. Commenter opines that if you are interested in developing a better system, keeping an hourly schedule that is adjusted for the cost of living is the most equitable and reasonable schedule for all parties involved. Commenter opines that the current system is much better thought out than the current proposal. | Anonymous  December 13, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule.  The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  AD disagrees that this fee schedule is in need of a COLA at this time.  A study on the implementation of the fee schedule should be undertaken prior to implementing a COLA. | None. |
| 9793(l)  9793(n)  9795(c) | Commenter questions if the DWC thought to provide compensation for hours of uncompensated time counting records. Commenter states that the records that the parties say are sent often do not reflect the records that are received. Under this schedule, the DWC is making doctors count the pages and then sign under penalty and perjury the number of pages counted. That can take hours  Commenter would like to know how evaluators are supposed to resolve page count disparities. Are they supposed to store thousands of physical pages in their office for a period of years while these get resolved? Do the evaluators send the attestation to the DWC along with boxes of records when a DWC does a billing dispute so that the DWC staff can count the pages and make sure payment is given to evaluators appropriately?  Commenter notes that the DWC is expecting that physicians spend time trying to figure out what records are duplicate. The DWC did not provide any compensation for this. Basically, an evaluator can get sets of records that have some duplicates. Does the DWC understand that trying to find duplicates can be as difficult to looking at for a needle in a haystack? Commenter opines that this can be an opening for underground regulations that the DWC likes to use to go after physicians. All duplicates should be counted. It can also be important from a legal perspective to know what provider was given a certain set of records as it can help the evaluator assess another evaluator’s data. In that case, counting and reviewing duplicates is especially important. | Anonymous  December 13, 2020  Written Comment | Verification of pages of records reviewed is a tool added simply to provide for accountability.  The letter of attestation is intended to be mandatory. Disputes over page count are subject to current billing dispute resolution methods.  The fee schedule as written does not proscribe billing for duplicate records. | None. |
| 9795(c) ML206 | Commenter questions if the DWC realizes that an uncompensated supplemental is also an easy way to abuse QMEs and also to allow the DWC to utilize underground regulations. For example, if the QME addressed apportionment but now the parties are challenging that, is that a zero-compensation supplemental? That is can be many hours of uncompensated work. The parties can also phrase their cover letters to essentially cover any future supplementals they request. Commenter recommends that there be a mechanism for QMEs to appeal a party’s determination that a supplemental is uncompensated. Commenter opines that this situation just introduced bias into the system because when a party abuses an uncompensated supplemental, the QME can potentially become upset at that party and lose objectivity. | Anonymous  December 13, 2020  Written Comment | Noted. | This section has been deleted, please see update. |
| 9793(l)  9795(c) | Commenter questions why evaluators have to send in an attestation from the parties as to how many records they send. If the parties properly served the attestation, shouldn’t all sides have that? Commenter opines that this makes no sense. Commenter questions why physicians need to send cover letters from the parties. The parties are already supposed to have sent that to each other. Commenter opines that this is ripe for underground regulations and just serves to deny payment. Can you imagine getting denied payment because you did not send in an attestation from one party as to the number of pages to the insurance company when the insurance company already received this from the other party? | Anonymous  December 13, 2020  Written Comment | Verification of pages of records reviewed is a tool added simply to provide for accountability. | None. |
| 9795(d) | Commenter wants to know why the AME modifier for mental health is less than that for other specialties. Commenter opines that the 2.0 modifier is too low for mental health practitioners. | Anonymous  December 13, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule.  Comparisons of fees after the application of the modifier should only be made with the base rate prior to application of modifier. | None. |
| 9795(c) ML204 | Commenter states the current medical legal fee schedule only allows for one hour of deposition time and one hour of preparation time. Commenter opines that this is not because of the wording of the regulations but because parties reply on underground regulation of only paying for two hours. Commenter states that parties often cite DWC for only paying a total of two hours, thereby undercutting payment of actual preparation time for depositions. Commenter recommends that the Division make certain that deposition time and all preparation time is compensated. | Anonymous  December 13, 2020  Written Comment | The fee schedule only provides billing a minimum amount of time for a deposition, any fee dispute would be resolved by the current billing dispute resolution methods. | None. |
| 9795(c) ML200  9795(c) ML201 | Commenter recommends that the DWC allow mental health evaluators to charge double the rate for missed appointments. This is because many evaluations can take an entire day. Less complicated evaluators do much better because they may only miss an hour of their time if an injured employee does not show. Also, for missed appointments, if you review 200 pages of records and the injured worker does not show up and the appointment is never rescheduled, then under the proposed regulations, you get paid 0 dollars. You basically just spent hours for nothing. If you read 201 pages, you get 3 dollars for 201 pages of record review. Similarly, for complicated evaluations, it really does not make sense to bundle 200 pages into a flat fee. Those doing complicated evaluations spend more time on records and should be compensated for those separately and not based on the false premise of reading 100 pages an hour. Does anyone at the DWC review reports at the rate of 100 pages an hour? Do lawyer and adjusters review pages at 100 pages an hour? Of course not. | Anonymous  December 13, 2020  Written Comment | The AD disagrees. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the missed appointment fee and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule. This physician may bill under Labor Code § 5307.6. | None. |
| 9793(c)(2) | Commenter states that it is not clear when a Primary Treating Physician (PTP) can charge for medical legal evaluations. Commenter states that proposed regulations are vague. Commenter opines that it is clear that PTPs do complicated medical legal work and should be appropriately compensated for initial consultation and PR-4s. There is no difference in work or medical legal responsibilities between PTPs and QMEs. Commenter requests that the DWC clarify the regulations to spell this out clearly so that insurance companies cannot deny paying appropriately for these evaluations. Commenter opines that one of the reasons QME evaluations have gotten more complicated is because the DWC destroyed compensation for consultations. | Anonymous  December 13, 2020  Written Comment | Treatment reports are billed under the Official Medical Fee Schedule. There is already a provision for treating physicians to bill for medical-legal reports pursuant to Title Eight, California Code of Regulations § 9785 (f)(7) when requested by a claims adjuster. In addition, the time the treating physician writes the permanent and stationary report there may not be an issue in dispute to make the report eligible to be treated as a medical-legal report, pursuant to 8 CCR § 9793(h). | None. |
| General comment | Commenter is glad that a new fee schedule is being considered and that the long stagnant payment schedule is being addressed. | Robert Egert MD  December 13, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n) | Commenter hopes that one of the goals of this new fee schedule is to minimize friction that occurs between the insurance company and physician’s office. Most disputes center’s around reimbursement but the issue of processing medical records is also of concern.  Commenter requests that the proposed fee schedule state that the party submitting the medical records needs to provide a statement/attestation under penalty of perjury as to the number of pages being submitted with a listing of the medical records by provider name and date. [Many carriers already include a listing of records by provider name and date.] Commenter states that the physician preparing the report should be allowed to bill for that number of pages of records.  Commenter also requests that the proposed fee schedule include the statement that records to be considered in the preparation of any report be submitted no later than 28 calendar days after the notification of appointment scheduling is submitted to the carrier.  Commenter states that far too often records do not arrive on a timely basis. He opines that this does a disservice to the injured worker and creates the need for supplemental reports. Having records submitted sufficiently ahead of the evaluation allows for the review of those records, and opens the possibility to clarify potential issues at the time of the QME evaluation. For example, an injured worker may state that they do not recall any injuries to a particular body part, but if records are available indicating for example that there was an x-ray of that body part, it may trigger a memory regarding that *event,* or allow for the possibility that the injured worker could state that the record was inaccurate. If this information is not available prior to the evaluation, the presence of a diagnostic imaging report suggesting an injury that the injured worker has not acknowledged only serves to potentially hinder the timely resolution of the claim.  Commenter states that having a QME report be complete and addressing all potential issues virtually mandates that the records be reviewed prior to the QME appointment.  Commenter opines that asking the carrier to submit the records prior to the evaluation and attest to the number of pages involved would help mitigate the concern that there would be billing for excessive record review.  Commenter states that such a protocol would be fair to both sides. The insurance company does not need to be concerned that they will be billed for excessive record reviews. The physician will know what is being requested. This will *remove* the potential point of friction as to whether the records had previously been reviewed. Leaving open the possibility of disputes regarding whether records had previously been reviewed or not may create a major headache as it would not be possible to prove exactly what pages had been submitted by the carrier, nor whether they were duplicates of prior reports. [Oftentimes reports are submitted which contain the same record duplicated two or three times in differing formats. Given the current state of medical record documentation, which is rife with cut and paste, and boiler plated reporting, determining whether 8 or 10 pages differ from the next 8 or 10 pages can require a significant amount of time.] | Robert Egert MD  December 13, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective.  AD disagrees. The language provides for declaration under penalty of perjury that the party has complied with Labor Code section 4062.3 and provided an attestation as to the total page count of documents provided, AD opinions that is sufficient.  Receipt of records by the physician prior to an evaluation is not the subject of this rule making. Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records.  AD opinions that the text of the language is clear that the documents sent to the physician must include an attestation as to the number of pages. | None. |
| 9795(c) ML206 | In regard to Unreimbursed Supplemental Medical Legal Evaluations commenter requests that consideration of further definition of what constitutes a legitimate "issue that should have been addressed" or "an issue requested by a party". Commenter has received multipage forms submitted by a party requesting detailed information regarding work restrictions which almost exactly mimic the forms required for Social Security disability qualification. At other times multipage letters will be submitted including dozens of questions, usually in a format that suggests that they were taken from a legal textbook on deposition testimony. Finally, it is not at all uncommon to receive multiple requests regarding the same question because the author of the request was not happy with the previous answer and is hoping for me to alter my opinion. | Robert Egert MD  December 13, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9793(l) | Commenter recommends clarifying what is meant by “any correspondence received by the physician form the parties to the action.”  Commenter opines that as currently written is appears to require that all the medical records that were submitted by forwarded to the administrative director. | Robert Egert MD  December 13, 2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”,  and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | None. |
| 9793(m) | Commenter opines that a better definition of “not available” will avoid the potential for misinterpretation. Commenter recommends that a better phrase would be “not submitted to the physician no later than 28 calendar days after the QME Appointment Notification Form is submitted. | Robert Egert MD  December 13, 2020  Written Comment | It is unclear what the commentator is referring to, this language does not appear in 9793(m). | None. |
| 9793(n) | Commenter requests that this subsection be amended to read “the declaration must also contain an attestation as to the total page count of the documents to be provided and an itemized listing of those documents which would be presumed correct absent rebuttal. If the carrier does not provide an itemized listing, the listing and page count provided by the physician performing the record review shall be presumptively correct.”  Commenter requests that the DWC consider adding the following language:  “The carrier is not required to submit records previously reviewed as part of the initial comprehensive medical legal evaluation or as part of any intervening supplemental medical legal evaluation. However, if the carrier re-submits records for review, it is considered presumptive evidence that they are requesting that these records be reconsidered.” | Robert Egert MD  December 13, 2020  Written Comment | AD disagrees. The language provides for declaration under penalty of perjury that the party has complied with Labor Code section 4062.3 and provided an attestation as to the total page count of documents provided, AD opinions that is sufficient. | None. |
| 9794(b) | Commenter opines that allowing 60 days for payment of claims is archaic and simply a giveaway to the insurance carrier. Commenter states that there are no other carriers in the state of California which require 60 days to make reimbursement and that this time frame should be no more than 21 calendar days. | Robert Egert MD  December 13, 2020  Written Comment | This is not the subject of this rule making. | None. |
| 9795(c) ML200 | Commenter notes that it is laudable that reimbursement for missed appointment times has been included; however, the RV 31 reimbursement should be limited to the time lost due to the cancellation.  Commenter opines that including a baseline of 200 pages of record review for missed appointment detracts from this appropriate level of reimbursement. Record review for a missed appointment should be separately billable. | Robert Egert MD  December 13, 2020  Written Comment | The AD disagrees. The proposed fee schedule, including the payment for pages were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. These pages would not need to be reviewed again when the face-to-face evaluation occurs. | None. |
| 9795(c) ML201 | Commenter requests that the language be amended to include “the fee includes review of 200 pages of records delivered to the physician’s office no later than 28 calendar days after the QME Appointment Notification Form is submitted.” | Robert Egert MD  December 13, 2020  Written Comment | Receipt of records by the physician prior to an evaluation is not the subject of this rule making. | None. |
| 9795(c) ML202 | Commenter requests that the language be amended as follows:  "…which occurs within *12 months* of the date on which a prior comprehensive medical legal evaluation was performed by the same physician."  Commenter states that leaving this at 18 months is too long and not reasonable.  Commenter requests that the language to amended as follows:  “The fee includes review of 200 pages of records, itemized by date and provider as attested by the carrier, delivered to the physician office no later than 28 calendar days after the QME Appointment Notification Form is submitted, the carrier is not required to submit records previously reviewed as part of the initial comprehensive medical legal evaluation or as part of any intervening supplemental medical-legal evaluation. However, if the carrier re-submits records for review, it is considered presumptive evidence that they are requesting that these records be reconsidered.” | Robert Egert MD  December 13, 2020  Written Comment | The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system.  As stated above, receipt of records by the physician is not part of this rulemaking. AD opinions that the requirements for the service of records as written is sufficient. | None. |
| 9795(c) ML203 | Commenter requests that the language be amended to read "or records that were not delivered no later than 28 calendar days after the QME Appointment Notification Form is submitted  Commenter opines that this entire section is unduly ambiguous. If new information is submitted, for example sub rosa video recordings, is the time spent reviewing the information which was previously available not considered reimbursable? Should the review of the new information be performed in isolation?  Commenter opines that the language "… (2) addressing an issue that was requested by a party to the action…" is overly broad and will inevitably lead to disputes. For example, if commenter addresses an issue such as apportionment, and one of the parties does not agree with his assessment, and asks the question "Doctor did you consider the applicant's avocational activities" would this be considered and unreimbursed report even though the issue was addressed previously. Commenter opines that it would be appropriate to state that a report will not be reimbursed if it completely and totally failed to address the issue in a prior report. As the language is currently written, it appears that if a party disagrees with an opinion, and requests further clarification, that the report is not reimbursable.  Commenter opines that failing to specify the types of issues that are intended in this paragraph leaves open the possibility that the parties may submit overly detailed inquiries.  Commenter opines that this section also needs to explicitly state that if a party determines that the request Is not reimbursable that it will be explicitly stated in the supplemental report request. | Robert Egert MD  December 13, 2020  Written Comment | Timeline for the receipt of records is not the subject of this rule making.  AD disagrees the language is clear, physician can bill for review of information that was not previously reviewed or received.  AD disagrees, the language is clear a physician shall address all contested issues and all issues presented to the physician.  AD disagrees. The physician has an obligation to bill for a report based on their services and the carrier has a right to review and pay for services received. | Language of ML206, unreimbursed supplemental report has been deleted, see update. |
| 9795(c) ML206 | Commenter states that unless there is a detailed listing of the medical records previously submitted, the question of whether the review of information "was available in the physician's office for review" will result in disputes.  Commenter states that additional clarification is needed regarding "an issue that was requested by a party to the action" as does the phrase "addressing an issue that should have been addressed in a prior" report.   * Commenter opines that if a party is requesting an unreimbursed supplemental medical-legal report, they should so state or there will be inevitable conflict when billing is submitted for a report, and reimbursement is denied. | Robert Egert MD  December 13, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9795(c)  9795(d) | Commenter supports the decision for a flat rate and the proposed 2.0 modifier for psych. | Jill Torres, PhD, QME – Psychologist  December 14, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(g)  9795(c) ML202 | Commenter opines that 18 months for a re-evaluation at a reduced rate is far too long. Commenter notes that the current industry standard is 9 months so she would like to know the rationale behind increasing this time frame. Commenter recommends revising the language from 18 months to 9 months. | Jill Torres, PhD, QME – Psychologist  December 14, 2020  Written Comment | The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9793(n)  9795(c) | Commenter opines that this proposal places and unfair burden on the QME with regard to the records. If the parties send records to the QME then they should be responsible for making sure they have not sent duplicate records. If they send records that are duplicates or records previously reviewed then a QME still needs to go through every single page and determine whether it is an old record or a new record and should be able to bill for that. Often times when commenter receives records, most of the records are new records, but some records previously reviewed are intermingled.  Commenter notes that there is no mechanism in the proposal regarding what to do if the provider’s page count for records is not the same as the sender's or if one party has not provided the attestation with regard to the number of pages. If there is no attestation or the record count differs is the provider still supposed to review the records? Can the provider charge for record reviews sent without an attestation or when the page count differs? If the provider does not receive the attestation are they supposed to send the report out without reviewing the records? If the provider does not receive the attestation are they supposed to wait until they get it and then issue a supplemental report and bill accordingly for the supplemental report? What happens if the parties refuse to provide the attestation or simply take a long time to send it? Commenter opines if the intent was that a QME cannot go back to an old report, re-review the records in the old report and bill for this then that should be clarified. Another issue with records is when they are received. As currently written in the proposal the records need to be reviewed and incorporated into the original report if they are receipt before the report goes out. Commenter states that this is unreasonable. Commenter has 30 days to get a report out. If on day 27 commenter receives 2000 pages of records there is no way she can incorporate that into her report, Commenter recommends that there be a cut-off date of five days after the evaluation for records to be incorporated into the report. If records are received after that date the QME should be allowed to review them as part of a supplemental report. Commenter opines that if parties truly want a quality report it is necessary to get the records out to the QME at least 10 days in advance of the evaluation so that the QME has time to review the records before seeing the worker. Commenter states in reality this is rarely done. When records are received after the evaluation the QME cannot question the employee about disparities between information in the records and history they provide. | Jill Torres, PhD, QME – Psychologist  December 14, 2020  Written and Oral Comment | It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  Disputes over page count are subject to current billing dispute resolution methods. | None. |
| 9795(c) ML206 | Commenter states that the criteria for the unreimbursed supplemental report needs to be clarified. Commenter opines that it is unreasonable for the parties requesting a supplemental report not to have to indicate upfront that they believe it should be a non-reimbursed report. If there is something that was left out of the report, such as addressing causation or apportionment it should be the burden of the QME to send a supplemental report at no charge. Commenter opines that the proposal as written indicates that anything that "should have been” addressed could be considered fruit for an unreimbursed supplemental report. Commenter opines that this is open for abuse and further friction between parties. Commenter recommends that apart from the standard issues addressed in every QME report, that any specific questions the parties wish to have answered needs to be placed in bold face and numbered in the cover letters so that it is clearly delineated. | Jill Torres, PhD, QME – Psychologist  December 14, 2020  Written and Oral Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9795(c) | Commenter has been a psychiatry QME and AME in Southern California for twenty years. He is a professor of psychiatry, clinical psychiatry at UCLA, and is a solo practitioner with a minimal office staff in the conduct of his QME evaluations and his work with injured workers. Commenter is a member of CSIMS and his particularly grateful to Drs. Rosenberg, Fienberg and Vari. Commenter states that Dr. Vari has raise a number of issues regarding problems where the proposed regulations do not address disputes adequately and dispute resolutions of which he is in full support.  Commenter would like to highlight four matters that are of particular importance to solo practitioners with limited administrative time and resources.  With regard to record page counts, commenter opines that the burden to establish the number of pages needs to be with the insurer or the party providing records and not with the doctor to count the pages. There should be some type of dispute resolution regarding page counts since money is at stake. Commenter reiterates Dr. Torres’ concern that if the evaluator is provided with records for a reevaluation that the evaluator be paid for review of those records provided at the time of the reevaluation, whether or not they constitute duplicate records. There is no way to establish whether they are duplicates without reviewing them which takes time.  Commenter is concerned about unreimbursed reports – being asked to address matters that should have been established.  Commenter opines that 18 months is too long a period for a Follow-up Medical Legal evaluation and that the standard should remain 9 months. | Joshua Pretsky, MD, DFAPA, QME  Associate Clinical Professor of Psychiatry  Director, Concentration in Psychodynamic Psychotherapy  David Geffen School of Medicine at UCLA  December 14, 2020  Oral Comment | This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective.  The party sending the records is required to provide an attestation as to the number of pages provided to the physician, the physician is to bill for the number of pages reviewed.  Disputes over page count are subject to current billing dispute resolution methods.  It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive  The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | Language of ML206, unreimbursed supplemental report has been deleted, see update |
| 9795(d) -96 | Commenter notes the following problems with the proposed psychiatry modifier:  Based on the new regulations, a psychiatrist performing an AME will receive a significantly **less** increase in fees **compared to other** medical specialties.  To understand, please review the following calculations:  For an ML-201, the fee is $2015.  Using the multiplier of 1.35 for a non-psych AME leads to this calculation:  2015 X 1.35 = 2720.25  This is a **35%** increase of the base rate.  Using the multiplier of 2.35 from above for an AME in psychiatry leads to this calculation:  2015 X 2.35 = 4735.25  This is only a **17.5%** increase of the psychiatry base rate of $4030 (2015 x 2).  Assuming this was unintended, it is easily corrected by changing the modifier for ML-201-96-94 and ML-202-96-94 to 2.70  Using the multiplier of 2.70 for an AME in psychiatry instead leads to this calculation:  2015 X 2.70 = 5440.50.  This is a 3**5%** increase over the $4030 base fee for a psychiatry QME  If the DWC actually intended for psychiatrists to receive a 17.5% increase for AME designation instead of a 35% increase, then I believe the reasoning for this needs to be explained. Frankly, I hope this was not intended, because I cannot imagine what the explanation might be.  I also hope it goes without saying that the modifiers for -93 and -93 and -94 in combination for evaluations performed by psychiatrists also need to be increased to at least 2.20 and 2.90 respectfully. However, I would argue that these should be considerably higher. On average, the amount of time spent in face-to-face time by a psychiatrist is 5-10 times longer than an orthopedist. Therefore, the modifiers for psychiatric exams with interpreters should be substantially greater, perhaps 2.60 and 3.30 respectively. | Joshua Pretsky, MD, DFAPA, QME  Associate Clinical Professor of Psychiatry  Director, Concentration in Psychodynamic Psychotherapy  David Geffen School of Medicine at UCLA  December 14, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule.  Comparisons of fees after the application of the modifier should only be made with the base rate prior to application of modifier. | None. |
| General Comment | Commenter congratulates the DWC on looking outside of California to other systems that seem to be working better and have less friction to them. He opines that the current system does not work and he believes this is a great step in the right direction.  To the extent that there are problems, commenter states that there is a need to tighten up to define any dispute resolution with particular attention paid to the need to get the records on time before the appointment by the carrier.  If there is need for further members of any specialist panels, commenter believes that being flexible in the specialty multipliers a great idea. Track the numbers of participants in the panels and then adjust accordingly. For example, commenter is unsure if there is a great need in Psychologists, but infectious disease panels are problematic.  After having debated this schedule for three years, commenter stresses the need to get going on it. It has been well-thought-out. Commenter thanks the DWC for its hard work on this contentious issue. | Thomas Pattison, QME  December 14, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comments | Commenter states that it is important to note that the current MLFS has not been updated to account for inflationary costs as well as increased complexity issues since 2006. As a quick comparison, the minimum wage in California in 2006 was $6.75. Although it has been explained to him by the DWC that the proposed MLFS cannot include a COLA, he feels that a provision for cost-of-living adjustments would help the entire system avoid friction in the future.  Commenter has been made aware of payer interests regarding the proposed changes and the additional costs that the proposed MLFS may bring. In the spirit of the stakeholder meetings, commenter opines that the workers compensation community should listen to the interests of all stakeholders and be prepared to make changes where necessary. The payers seem to be particularly concerned with the $3/page issue and the occasional large volumes of records that must be served on the QME/AME. Commenter notes that the concern is a legitimate one, especially when one considers the scenario when there is a relatively minor injury, but the patient has had decades of treatment records, and possibly tens of thousands of pages of records. One can imagine a physician performing a few hours of work and getting paid $10,000 or more, simply based on the page count.  Commenter requests that physicians use their discretion in order to assist in the preservation the AME/QME system, not only because it makes good sense, but also because having a QME or AME as part of the system is beneficial for injured workers to be heard and have their cases addressed more equitably. Most doctors in the QME system have heard this from injured workers: “This is the most time a doctor has spent with me – thank you.”  Commenter states that in the history of California Workers Compensation, the elements of the system that cost the most tend to be weeded out. Commenter cites the old Vocational Rehabilitation system and the “treating doctor’s presumption” among the examples. Commenter opines that just because a doctor can bill a large amount under the proposed MLFS, does not mean that s/he should do so. Again, discretion is encouraged. | Scott Thompson, CEO – Arrowhead Evaluation Services  December 14, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates.  Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General comments | Based on this morning's Public Hearing testimony, commenter states that pages of records are at best, a faulty surrogate for complexity. Commenter opines that the current proposal offers no improvement in the number or depth of the points of friction that will present themselves.  But for the further delay it would cause, commenter opines that there is substantial support for improving the current Medical­ Legal Fee Schedule rather than completely replacement based on an unfounded, relatively arbitrary substitute.  Commenter recommends that compliance with 8CCR Section 35 be emphasized regardless of how medical record review is reimbursed or including as a complexity factor. Commenter notes that this regulation is outside the scope of the current rulemaking but could be a focus of emergency records as a critical support for any success of the current proposal. | Steve Cattolica  CWCSA  December 14, 2020  Written Comment | The AD disagrees. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule.  As to regulation section 35 this is noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n)  9795(c) | Commenter notes that since page count continues to be the basis for reimbursement, payors and providers alike are leery of both sides' motives. Commenter’s position is that the burden of proof cannot be upon the medical provider solely. Those submitting records are the primary and best source of verifying the amount of content. Commenter acknowledges that relevance remains the responsibility of the evaluator. Nevertheless, the expression of the amount of content (i.e., the attestation) has the potential to be awarded standing as the source of billable page count. Evaluators must be provided the opportunity to refute the coversheet if necessary, but using a recognized standard puts responsibility where it belongs. | Steve Cattolica  CWCSA  December 14, 2020  Written Comment | Disputes over page count are subject to current billing dispute resolution methods. | None. |
| 9793(g)  9795(c) ML202 | Commenter is in support of the point made by the California Applicant Attorneys Association (CAAA) with respect to the timeframe for qualifying a report as Supplemental (that the timeframe remain at 9 months and not be increased to 18 months because there is no rationale for the increase other than a cost saving measure). Commenter states that this comment applies whether the current proposal goes forward, or the Division opts to revise the current MLFS. Commenter opines that any number of months is fundamentally arbitrary. Proposing 24 months is clearly nothing more than cost containment. Commenter opines that this is an insult and affront to the corps of evaluators - Agreed Medical Evaluators included.  Commenter acknowledges that both “sides" can abuse even the shortest supplemental report timeframe by simply requesting re­ evaluations before the given timeframe for paid supplemental reports is tolled. The longer the timeframe, the greater opportunity for abuse. Commenter states that there is no verifiable basis for 24, 18, 12 or even the current nine months. In the instant case, the critical issue boils down to data that indicates a change is necessary. Commenter states that the Division has produced no such data; therefore, there is no basis for any change. | Steve Cattolica  CWCSA  December 14, 2020  Written Comment | The time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| General comment and Future Increases | Commenter states that he is an Orthopedic Surgeon who has been a QME since 1992 and he states that the proposed changes in the Official MLFS are overdue.  Commenter states that the current proposal from the DWC Is good, thoughtful and thorough and he supports it.  Commenter requests that a built-in cost of living adjustment be considered. | Joseph M. Mann III, MD, QME  December 14, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective.    Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| General Comment | Commenter opines that an update of the medical legal fee schedule is long overdue (last updated in 2006).  With the ongoing attrition in the number of QMEs remaining in the workers compensation system willing to evaluate injured workers commenter states that it would be extraordinarily short sighted to fail to have any plan in this fee schedule to reward evaluators for doing complex work in a timely and thorough fashion.  Commenter opines that this proposal continues to prioritize the “bottom line” for the payors for the most basic medical legal evaluations, and leaves adequate compensation on the more complex cases on the cutting room floor.  Commenter states that all parties will be negatively impacted by an inadequate fee schedule, although injured workers the most.  Commenter notes that the unrepresented injured worker is not considered anywhere in this regulatory proposal which now includes significant burdens and requirements on the party seeking an evaluation, which in the vast majority of claims is an unrepresented worker.  Commenter states that adequate QME/AME compensation is critical to the ability to obtain substantial medical evidence required to prove a claim. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written and Oral Comments | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comment | Commenter opines that the goal of this proposal when it is finalized should be threefold. One is not to drive out existing QMEs and to attract new QMEs, because as many people have testified to, it is difficult to get new evaluators to come into the system since the fee schedule is too low. Commenter opines that by increasing frictional costs and difficulties with doctors getting paid, that the DWC is going in the wrong direction.  Commenter recommends that the DWC go back to the table and look at this from the eyes of someone that does not have a legal, medical or claims adjuster background to see how they would navigate this which is something that has not been factored into any of the discussions over the last couple of years. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Oral Comments | The AD disagrees. Injured workers and their benefits are at the forefront of our decision making and injured workers have access to services in workers compensation to help them navigate the requirements of this rulemaking. Your comments are noted. | None. |
| 9793(g) | Commenter notes that this subsection has been amended to extend the time from nine months to eighteen months in which an evaluation performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician is to be considered a “Follow-up evaluation” following the evaluator's examination of the employee in a comprehensive medical-legal evaluation.  Commenter notes that the statement of reasons sets forth no rationale for this change other than it is done to “comport with the new regulations under 9795” which simply sets forth the change as well.  Commenter opines that this change is clearly nothing more than a “cost cutting” revision reducing payment to the evaluating physician of almost $700 if they need to re-evaluate an injured worker’s condition within nine to eighteen months.  A lot can happen in an injured workers’ case including a significant change in their medical condition and diagnosis in 18 months. This proposal would preclude adequately addressing these changes in a worker’s condition due to this lower payment.  Commenter opines that a solution without a problem in a system being drained of qualified medical legal evaluators should be avoided at all costs.  The nine-month period for a follow up medical legal evaluation should not be changed as it has never been proven to be a problem. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written and Oral Comments | The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9793(n) | This subsection has been added to define record review and includes the following:  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.  Commenter opines that this language is so poorly written that it will likely create many unnecessary frictional disputes.  Subsection (n) requires the party submitting records to sign under penalty of perjury that they have complied with Labor Code section 4062.3.  Commenter states that this section is a swamp of undefined terms and vague requirements that many attorneys interpret quite differently.  This will become a new subject of procedural conflicts benefitting no one.  Labor Code section 4062.3 (l) states "no disputed medical issue in subdivision (a) may be the subject of a declaration of readiness” However, Labor Code section 4062.3 (a) contains no list of issues.  How is a party to comply with that?  Commenter inquires what happens when the carrier sends a mass of records to the QME without this page count and declaration.  The QME can't read them and bill for that.  So we get a non-substantial medical evidence report of no use to either party, and that does not move the dispute forward towards resolution.   Commenter wonders what if the carrier says there are 501 pages but sends 792.  If the carriers want to count their medical record pages and list that number in their letter to the QME nothing in the current law stops them from doing that, but to require a declaration and forbid the evaluator from billing for their work if they don’t goes overboard.  Commenter opines that this new sub-section language is unnecessary and likely to slow down the entire medical legal process with needless procedural red tape.  Commenter opines that this provision is not really a fee schedule but rather an attempt to add superfluous complicated procedural impediments to a system already drowning in bureaucratic paperwork.  Commenter wonders what happens to the unrepresented injured worker who doesn’t know they must provide a declaration. Commenter opines that under this language, it is unlikely they will get an evaluation as the evaluator can’t bill for it.  What happens if you get the page count wrong? Off to jail?  Commenter notes that one of the physicians testifying asked what does he do if the declaration states 500 pages, but there are actually 1500 pages.  Commenter states that it is the defendant is primarily responsible for providing records to the evaluating physician, but this seems to shift the burden.  Commenter finds this subdivision is extremely impractical.  Commenter questions that if the defendant is doing their job, and providing all records, why is this subdivision necessary?  Shouldn’t the burden to count pages and verify the number be on the physician who is billing for them?  Commenter notes that the requirement for physicians to provide a verified page count under penalty of perjury is already set forth in section 9795 making this language unnecessary and superfluous in section 9793.  Because this section is poorly drafted and extremely impractical it is the commenters recommendation is that this language simply be eliminated from the proposed revisions to avoid unnecessary friction and disputes. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written and Oral Comments | Verification of pages of records reviewed is a tool added simply to provide for accountability.  Disputes over page count are subject to current billing dispute resolution methods. | This section has been amended, please see update. |
| 9795(c) ML202 | Commenter requests that the “new” eighteen month time period for a “follow-up” medical legal evaluation be changed back to the existing nine month period for the reasons she elaborated when commenting on section 9793(g). | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written Comments | The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9795(c) ML206 | Commenter notes that this section provides for no payment for a supplemental med legal evaluation where the supplemental report follows…“ the physician's review of: (1) 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.”  Commenter opines that the terms in this new section continue to be extremely vague, difficult to measure, and may be prone to abuse by carriers, who will be allowed to deny payment under this section, without any oversight or semblance of neutrality.  Commenter recommends that that circumstances under which a reduced payment is owed for a supplemental medical legal evaluation be more narrowly defined and the reduction in payment should only be due for repeat violations by a QME that can be independently documented, not simply determined by the carrier. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written Comments | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9795(d) | Commenter stats that ML 201 through 203 modifiers should include record review. Commenter opines that it does not seem logical to exempt record review from the AME modifier. It’s usually what’s in those records and gaining a good understanding of them that takes time and makes a case so difficult and complex to evaluate. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written Comments | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| Future increases | Commenter states that she continues to believe that a Cost of Living Adjustment (COLA) is needed in these regulations.  Commenter notes that the State Auditor’s report from last year expressly recommended a “COLA”, but this has been ignored by the Division of Workers Compensation.  ” To ensure that the DWC maintains a sufficient supply of QMEs and appropriately compensates these individuals, the Legislature should amend state law to specify that the DWC review and, if necessary, update the medical-legal fee schedule at least every two years based on inflation. “State Auditor (11/2019)  Commenter recommends that rather than waiting for the lengthy legislative process, particularly with the challenges of these COVID 19 times, a “COLA” modifier should be built into these regulations, which can easily be linked to the Consumer Price Index for inflation. | Diane Worley  Executive Director  California Applicants’ Attorneys Association (CAAA)  December 14, 2020  Written Comments | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| General Comment | Commenter is aware of the urgency driving the adoption of new regulations, and appreciates the need to draw more QMEs into the system. However commenter opines that adjusting the fee schedule makes limited sense without also addressing the *quality* of medical-legal evaluations – how to define it, measure it, ensure it and improve it.  Commenter is neutral on the proposed changes, and looks forward to the point when the QME system is dealt with as a whole. | Erik J. Won, DO, MPH, MBA, FACOEM  Western Occupational & Environmental Medicine (WOEMA)  December 14, 2020  Written Comment | Noted. Report quality is not the subject of this rule making. | None. |
| Percentage Increase to Current Fee Schedule | Commenter opines that the proposed change to a flat fee schedule, regardless of complexity of the evaluation, will incentivize speed instead of quality.  This will result, in many cases, in a reduction in QME report quality which will negatively impact all stakeholders, but most importantly, injured workers.  As a QME, commenter takes pride in providing careful evaluations and detailed reports which serve all interested parties. Commenter states that these proposed changes will make it difficult, if not impossible, for her and others like her to continue to serve in this capacity.  Commenter recommends that the DWC make a simple, non-controversial adjustment to the existing fee schedule. Commenter states that there were no issues with the current fee schedule structure until DWC began imposing underground regulations in 2016, thereby destabilizing the system which had been functional.  Commenter opines that what is required is an increase of the 2006 rates by a reasonable percentage, keeping in mind the 65% adjustment that injured workers have received since 2006.  Commenter states that QMEs want this, payors want this, and it is the simplest, most conservative change that can be made to an unstable QME system. | Karen L. Wrubel, MD, DPM, FACFAS, QME  December 14, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| Percentage Increase to Current Fee Schedule | Commenter requests that the DWC just make a simple correction to the existing fees. Rather than reinvent the billing system, please apply an appropriate increase to the fee schedule, which hasn’t been increased in 14 years.  Commenter states that many of his colleagues have already left the QME system due to the DWC underground regulations. Commenter opines that the current proposal will drive more QME’s away, resulting in greater delays to case resolution, and will adversely impact employers and injured workers. | Charles McDaniel, MD, QME  December 14, 2020  Written and Oral Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| Percentage Increase to Current Fee Schedule | Commenter opines that the proposed change to a flat fee schedule will incentivize speed not quality. This will result in a reduction in QME report production which will negatively impact all stakeholders including employers, QMEs, and, most importantly, injured workers.  Commenter recommends that the DWC make a simple, non-controversial adjustment to the existing fee schedule. There were no issues whatsoever with the current fee schedule until DWC began imposing underground regulations in 2016. Commenter recommends that the DWC leave well enough alone and increase the 2006 rates by the same 65% adjustment that injured workers have received since 2006.  QMEs want this, payors want this, and it is the simplest, most conservative change that can be made to an unstable QME system | David Narang, Ph.D.  December 14, 2020  Written Comment | The AD disagrees, see response above to Karen L. Wrubel, MD. | None. |
| Percentage Increase to Current Fee Schedule | Commenter states that she has been following the proposed change to a flat fee schedule and would like to state how disastrous this will be.  Commenter is a Designated Doctor in Texas which is the Texas equivalent to a California QME. Commenter has been one for 8 years. Texas uses a flat fee schedule and it is bad. This past year commenter performed over 100 exams in Texas alone. Commenter notes that she was not able to perform exams for 3 months due to Covid-19. Commenter states that she is compensated at the rate of $350 for an exam, $300 for an impairment rating, and $500 for the first ‘question’, $250 for the second ‘question’ and $125 for each question after that. Commenter states that they are only allowed 4 different questions, none as complex as California. On average commenter earned $806 prior to Covid-19, but since Covid-19 she is only allowed 2 questions and her average has dropped to $525. She must travel to 50 counties and is considering withdrawing from the system, due to lack of compensation.  When commenter started in Texas 8 years ago, there were over 1500 doctors. Now they are down to just under 300 which is hardly enough. Most of the doctors who have left the system because of lack of compensation. Commenter state that her time is not valued here. She states that she could receive 20 pages of medical documentation or 2000 pages, there is no accounting for the time she must spend. Commenter states that her reports in Texas average 9 pages, have no research and that she spends around 30 minutes with the applicant. Also, because she is paid separately for the impairment rating, there is incentive to put an applicant at MMI (P&S) when they may not be quite ready.  In comparison with the California system, she averages and hour and 45 minutes with the applicant. She is able to research and apply it to each case. Small cases can be done quickly and efficiently, large cases can have the time that is required of them to get an accurate independent opinion.  Commenter opines that the proposed changes will dis-incentivize time with applicants, research, and negatively impact report quality. Commenter believes so strongly that the current California system is beneficial to both the doctor and the applicant, she has personally recruited 8 of the current QME’s and 2 more that will be taking the exam in April.    If the commenter were to make improvements to the fee schedule in California, she would eliminate every level except ML104. Each report would be paid based on the time spent, as that will adequately reflect the effort put into them. There has been no increase to the rate since 2006. Commenter states that a simple 65% increase to the current rate will rectify any COLA failings and will help bring stability to the QME system. | Stephanie Janiak, DC, DD, IIE, QME  December 14, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6.  Research could be billable and reimbursable under Labor Code §5307.6.  Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| Percentage Increase to Current Fee Schedule | Commenter is concerned about the proposed changes to the QME fee schedule. Commenter opines that the proposed change to a flat fee schedule will incentivize speed, not quality. Commenter states that this will result in a reduction in QME report production which will negatively impact all stakeholders including employers, QMEs, and, most importantly, injured workers. As an evaluator, commenter spends significant time helping the people I meet with, trying to be fair and take time to review and understand all relevant data.  Commenter recommends that the DWC make a simple, non-controversial adjustment to the existing fee schedule. Commenter states that there were no issues whatsoever with the current fee schedule until DWC began imposing underground regulations in 2016. Commenter recommends leaving well enough alone and increasing the 2006 rates by the same 65% adjustment that injured workers have received since 2006.  QMEs want this, payors want this, and it is the simplest, most conservative change that can be made to an unstable QME system. | Shivani Patel Escamilla, PsyD, MHA, QME  December 14, 2020 | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| Percentage Increase to Current Fee Schedule | Commenter is an Ophthalmologist and a newly credentialed QME and he looks forward to providing quality QME examinations and reports for injured workers.  Commenter opines that a flat fee schedule will negatively impact the employers, QMEs and most importantly the injured workers.  Commenter states that the proposed fee schedule changes will make it impossible for a QME to devote the time needed to provide proper care.  Commenter requests that the DWC not jeopardize the ability of QME providers to give quality examinations and reports as all parties will suffer. | Robert Rende, MD, QME  December 14, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| Percentage Increase to Current Fee Schedule and Future Increases | Commenter is a new physician/QME, performing his first evaluations in 2020. These are musculoskeletal /orthopedic evaluations. Commenter enjoys meeting applicants and hearing their stories, reviewing disputes that may be at play, and with an objective eye creating a fair and equitable set of recommendations in his reports for the parties involved. Commenter is now questioning whether he will continue in this line of work that has oversight from the DWC. Commenter finds that being thorough and creating a good quality report that is useful to the parties, and potentially to a WC judge, requires quite a lot of time. Commenter is an experienced physician, but new to QME work. Commenter has 35 years of clinical experience and would like to be remunerated fairly for his time, as would any attorney or other experienced consulting professional. Commenter opines that the proposed overly simplified, flat-fee schedule would significantly reduce his hourly reimbursement, unless he spends significantly less time on preparing QME reports. Commenter states that his report quality and usefulness will likely suffer. Commenter states that he may not participate in the QME process if it becomes unenjoyable, and not worth his time due to unfair fee changes.  Commenter is alarmed at the idea of eliminating complexity factors completely.  Commenter opines that the proposed change to a flat fee schedule will incentivize speed not quality that will result in a reduction in QME report production which will negatively impact all stakeholders including employers, QMEs, and, most importantly, injured workers. Commenter states that the proposed changes do not acknowledge that case complexity does not correlate well with numbers of pages received.  Many orthopedic cases that involve multiple injury dates, employers, and/or sites of injury can require many hours to sort through and to perform the cognitive processing to reach a well-crafted, fair and useful conclusion. And, in some cases may only include 100-200 pages of records.  Commenter recommends that the DWC make a simple, non-controversial adjustment to the existing fee schedule. Commenter opines that there were no issues whatsoever with the current fee schedule until DWC began imposing underground regulations in 2016. Commenter recommends leaving well enough alone and increasing the 2006 rates by the same 65% adjustment that injured workers have received since 2006. | Louis Rosen, DO, QME  December 14, 2020  Written and Oral Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| General comment | Commenter appreciates the DWC’s efforts to hear from stakeholders and craft a proposal that sets up a more transparent and equitable fee structure.  Commenter is concerned that the structure of the payment system mitigates in favor of report efficiency instead of quality - medical legal analysis is more often than not complex with respect to psychiatric issues, and complexity should be fairly compensated.  Commenter opines that neither the page rate for review of records, nor the numbers of pages under review, may correlate to the complexity of the report the psychiatrist may produce. This acts as a disincentive to produce quality reports or to participate in the workers compensation system. | Randall Hagar, Legislative Advocate  Psychiatric Physicians Alliance of California  December 14, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The medical record per page review and the modifier for psyche evaluations take into account the relative complexity. | None. |
| 9795(c) | Commenter is concerned that the examining psychiatrist has the burden of showing that a  supplemental report is necessary, coupled with the seeming presumption that the  psychiatrist was negligent in omitting elements in the report hence the need for a non-compensated  supplemental report | Randall Hagar, Legislative Advocate  Psychiatric Physicians Alliance of California  December 14, 2020  Written Comment | Noted. | Language in ML206 has been deleted, see update. |
| 9795(c)  9795(d) | Commenter recommends a higher base fee for complex exams and a higher deposition hourly rate because the market value for a psychiatrist's time is greater than those fees proposed. | Randall Hagar, Legislative Advocate  Psychiatric Physicians Alliance of California  December 14, 2020  Written Comment | The levels of reimbursement in the proposed fee schedule, were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| 9795(c) ML204 | Commenter states that deposition arrangements should contain a requirement for a cancellation fee, or a no show fee, to fairly compensate the psychiatrist for their time when depositions are rescheduled or cancelled on short notice. | Randall Hagar, Legislative Advocate  Psychiatric Physicians Alliance of California  December 14, 2020  Written Comment | The AD disagrees, the language is clear that a physician is entitled to reimbursement for a minimum of one hour if the deposition is canceled in fewer than eight calendar days. | None. |
| General Comment | Commenter would like to recognize the Division, physicians, and stakeholders for their continued commitment to development of the medical legal fee schedule despite the challenges of the year 2020. Commenter acknowledges the difficulties associated with change and that different entities or physicians have different ideas as to what constitutes improvement. Commenter represents a multi-specialty group supporting a wide variety of physicians throughout the state, and has spoken with nearly all of them as to their thoughts and considerations. Commenter has also spoken with other industry professionals, practice management groups, and leaders. For the past two years, a day hasn’t gone by in which he has not discussed the fee schedule. As a result, he believes his organizations’ perspective on the issue to be comprehensive and sound.  Commenter opines that the proposed fee schedule, is a positive step in the right direction and will serve as the foundation for further constructive reform. With continued work and collaboration, commenter is confident in the ability to improve remaining areas in need. | Andrew Roberts, Vice President  San Laws, General Manager  ExamWorks  December 14, 2020  Written and Oral Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comments | Commenter states that he does not believe that the stakeholder process resulted in the type of clear consensus described in the Notice of Proposed Rulemaking. Commenter notes that members of his organization participated in those meetings, and their recollection is that employers and insurers were vastly outnumbered by physicians, and that any consensus in that group, established through a vote process, was reflective of physician rather than employer or insurer opinions about the proposal. Commenter opines that any level of employer or insurer comfort with the approach now reflected in the proposed fee schedule was predicated on the inclusion of other provisions that are not included in this fee schedule, such as a record organizing process that weeds out duplicate medical records and processes to ensure that QMEs produce high quality reports.  Commenter appreciates the work that has been done by the DWC throughout the stakeholder and regulatory process, but opines that the most common-sense approach to the current fee schedule would be to maintain the existing structure and provide the 25% increase that is described in the Initial Statement of Reasons. This approach would be predictable and could be modelled effectively. Commenter states that this approach would stabilize the situation and create room for the parties to negotiate a final fee schedule that reflects consensus across stakeholder groups and pursue the types of improvements to report quality that are outlined by the California State Auditor in their report. | Jason Schmelzer  California Coalition on Workers’ Compensation  Ashley Hoffman  California Chamber of Commerce  December 14, 2020  Oral Comments  Jen Hamelin  Public Risk Innovation, Solutions and Management  Jeremy Merz  American Property Casualty Insurance Association  Faith Borges  California Association of Joint Powers Authorities  December 14, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6.  Report quality is not the subject of this rule making. | None. |
| 9795(c) | Commenter notes that in addition to the flat fee, the proposed regulations include a $3.00 per page fee for record review. Commenter does not believe that the current proposal represents a 25% increase as described in the ISOR, nor does it equal the 30% raise identified in the audit report. Standard billing practices are currently $250 per hour of records review, with one hour generally equaling one inch of records. One inch of records is approximately 250 pages, for a current fee of roughly $1.00 per page.  Commenter opines that this $3.00 per page amount was selected because, based on the average number of pages to be reviewed in a medical-legal report, it results in a 25% increase. Commenter states that it appears to be a 300% increase over the current per page fee. While this steep increase might work when comparing averages, commenter is concerned that the structure of the fee schedule will leave employers open to massive bills on larger cases with significant amounts of records. Commenter notes that low page counts will still be reimbursed adequately because there are 200 pages of records review included in the base fee.  Commenter opines that a $3.00 per page fee for records review is acceptable only if there is a system for identifying and removing duplicate records. Commenter provides the following reasons:   * Employers are required to submit the complete set of records to physicians prior to medical legal evaluations, and there is great discomfort with removing duplicate or otherwise unnecessary records (fax cover sheets, blank pages, etc.). If records are removed, then the claims administrator cannot certify that a complete set of records has been submitted (which is required under penalty of perjury). * Medical records for these cases contain a heavy volume of duplicate records, and this is especially true of records obtained via subpoena. Research shows that these records can be up to 1/3 duplicate records. * Both sides of a dispute can submit records to a medical legal evaluator. Even in cases where employers curate records and remove duplicates, which many are not comfortable doing, the attorney on the other side can submit duplicate-ridden sets of records. This leaves employers helpless to fix this problem through their own actions. * The adoption of electronic medical records in hospitals and clinics has also created long standardized forms and reports that have drastically expanded the number of pages contained in medical records, making duplicates an even more significant problem. * There are many records contained in a file that are frankly irrelevant to the issues being evaluated, but still must be included. This includes records like patient instructions, pharmacy refills, records on unrelated conditions, etc. * At the present time responsible QMEs will very quickly discard/dispatch many of types of duplicate records outlined above. If the $3.00 per page were instituted, there is concern that all QMEs will automatically count every page and bill $3.00 per page creating monstrous bills. The per page fee therefore does not accurately capture the amount of time it may take a QME to prepare a report and will lead to disparate bills between similar cases.   Commenter requests that if the DWC proceeds with this per-page records review fee that there be a cap on the records review portion of the fee in the amount of $7,500. Commenter states that this would be equal to over three full days (roughly 72 hours) of work at $325 per hour. | Jason Schmelzer  California Coalition on Workers’ Compensation  Ashley Hoffman  California Chamber of Commerce  December 14, 2020  Oral Comment  Jen Hamelin  Public Risk Innovation, Solutions and Management  Jeremy Merz  American Property Casualty Insurance Association  Faith Borges  California Association of Joint Powers Authorities  December 14, 2020  Written Comment | The per page fee was a compromise agreement that came out of several stakeholder meetings held in 2019 and early 2020.  The $3.00 per page is a compromise of an increase in current reimbursement at an hourly rate of $250.00 and the new hourly reimbursement rate of $312.50, taking into consideration not all records are the same.  Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and addresses any objection a party would have to a record being sent.  It is anticipated that parties would use this mechanism to address duplicate service from various parties.  A records organizer is not subject of this regulation and would require separate legislative and/or regulatory action.  The AD will continue to monitor the implementation of this fee schedule and can make adjustments as needed in the future therefore a cap on fees at this time is not suitable. | None. |
| 9793 | Commenter opines that the term “extraordinary circumstances” requires a definition.  Labor Code Section 5307.6(b) states that a physician “shall not be paid fees in excess of those set forth in the fee schedule” except when documented because of “extraordinary circumstances related to the medical condition being evaluated”. The prior fee schedule addressed what it meant for an exam to meet this statutory definition, but the proposed fee schedule removes that language and leaves this term undefined. Commenter is concerned that this will ultimately cause unnecessary litigation.  Commenter notes that the stakeholders at the meetings did reach a consensus on the modifier to both AME and for Extra-Ordinary Services, with a definition for the latter to satisfy the requirements of LC § 5307.6(b). In terms of the modifier that agreement was 1.5 for both services. At no time was a 2.0 modifier considered for an AME. It is commenter’s understanding that the stakeholder group had consensus that “extraordinary circumstances related to the medical condition being evaluated” should be defined as evaluations performed by all psychiatric disciplines, oncologists and toxicologists performing medical legal services for issues within their respective specialties. | Jason Schmelzer  California Coalition on Workers’ Compensation  Ashley Hoffman  California Chamber of Commerce  Jen Hamelin  Public Risk Innovation, Solutions and Management  Jeremy Merz  American Property Casualty Insurance Association  Faith Borges  California Association of Joint Powers Authorities  December 14, 2020  Written Comment | The AD disagrees, the schedule as proposed addresses the requirements of Labor Code § 5307.6. Complexity is provided for in the page count and in the modifiers. | None. |
| Additional Reforms Needed | Commenter opines that a meaningful increase in reimbursements for medical-legal reports, in an amount that is clearly responsive to the November 19, 2019 report from the California State Auditor, should be paired with the other recommendations from that report. Commenter notes that while the DWC has proposed a fee increase, there has been little meaningful action on the other recommendations. Commenter understands that the proposed regulations can only address the fee schedule portion of the recommendations, but is unaware of meaningful progress on the items below and requests that the Division act promptly and aggressively on the other suggested improvements.  **Ensure Quality Reports**  Employers and insurers generally agree with the State Auditor that not enough has been done to ensure that QMEs produce high quality reports that help resolve disputes timely. The State Auditor correctly notes that the Division has failed, since at least 2007, to utilize any of the tools at their disposal for ensuring high quality reports. State law currently requires the Division to continuously review the quality and timeliness of medical legal reports, and then annually submit a report outlining the results and recommendations to improve the system. State law also allows reports rejected by judges to impact the reappointment of QMEs. Commenter opines that based on recent testimony to the legislature provided by the DWC, that efforts are now under way to make use of existing law, but little else has been done related to quality.  Employers, who fund the entire workers compensation system and the Division’s regulatory and oversight activities, frankly, deserve better service for the money that is being spent. It is somewhat frustrating for employers to see the Division move ahead so boldly with a fee schedule increase while continuing to make only cursory efforts to improve the quality of the reports.  Commenter recommends the following actions, at a minimum to be considered as a companion to any fee increase:   * The Division should create a standardized format for both covers letters and the actual QME report. Uniformity in the submissions to QMEs and the report produced will help ensure and track quality. * The Division should create a process of systematic oversight and enforcement to ensure timely and quality reports, like the type of oversight on the important functions of claims administrators. * The Division should create uniform training for QMEs to ensure that education is consistent and uniform. This will help improve the quality of reports by creating consistency amongst the various training options, which are currently left to outside contractors. * New QMEs should have some number of their initial reports reviewed in detail by the Divisions so that appropriate feedback and training can be provided to new physicians. Additionally, the Division should establish standards to imposing higher oversight and review requirements on QMEs that have demonstrated a lack of quality.   **Increase Number of In Demand QMEs**  Commenter states that California has done a poor job of ensuring that all QME specialties, especially those in the most demand, have adequate numbers to service the demand timely. When there are not enough QMEs to service the demand, then injured workers experience delays in resolving disputes over medical treatment, disability, and more. The audit report points out that the number of QMEs have been in steady decline since 2013-2014 while demand has increased. Commenter agrees with the auditor that the Division should proactively ensure that they have done the work necessary to ensure that there are enough QMEs in the system to service the need.  Commenter requests that the Division follow up on this recommendation from the State Auditor to develop a plan for increasing the number of QMEs in the specialties with the greatest shortages. As the audit report indicates, there is a correlation between the lower number of QMEs in the system and the higher number of panels that need to be reissued.  **Establish Written Policies for Discipline**  Commenter supports the Division’s efforts to discipline QMEs for behavior in the workers’ compensation system, but opines that it is important for the Division to establish written policies that protect due process rights. Commenter is in agreement with the auditor that the Division should utilize its written policies, and to update those processes where necessary. It appears as though some progress has been made in this area, but it is important to have these policies in full effect as the fees are raised. | Jason Schmelzer  California Coalition on Workers’ Compensation  Ashley Hoffman  California Chamber of Commerce  Jen Hamelin  Public Risk Innovation, Solutions and Management  Jeremy Merz  American Property Casualty Insurance Association  Faith Borges  California Association of Joint Powers Authorities  December 14, 2020  Written Comment | Noted. This comment is not the subject of this rule making.  This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None.  None. |
| 9795 | Commenter opines that this fee schedule lacks appropriate reimbursement for complex cases, for example, professional athletes require head to toe examinations, ratings, and apportionment between numerous teams. These evaluations take excessive time and necessitate additional reimbursement as they often come with little to no medical records. **MEDICAL RECORDS ARE NOT A DIRECT INDICATOR OF COMPLEXITY.**  Commenter states that additional fees should be added for complex apportionment analysis in excess of two injuries or employers.  Commenter states that additional fees should be added for rating analysis for in excess of two body parts.  Commenter states that the only way to establish that a records is a duplicate is to review it. Commenter states that doctors deserve to be paid for the review of all records served by the parties.  Commenter states that for records to be included in a face-to-face evaluations report that they must be received by the date of the evaluation. Commenter opines that given existing timelines, it is not feasible to serve them at the 11th hour and expect them to be included or face an “unreimbursed supplemental” in the future. | Spencer Chelwick, Administrator  Orthopaedic Medical Group of Santa Ana, South Coast Orthopaedics, West Coast Orthopedics  December 14, 2020  Written and Oral Comment | The AD disagrees, the flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. The modifiers and the per page fee was a consideration for complexity. A physician may continue to bill under Labor Code 5307.6.  It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive.  Receipt of records by the physician prior to an evaluation is not the subject of this rule making. Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician. | None. |
| 9795(c) ML206 | Commenter opines that the “unreimbursed supplemental” code language is too vague. The only time this code is acceptable is when a doctor makes an error and needs to amend his initial reporting or if he leave out a required portion of the report for no reason. There is no other reason to deny payment for a valid medical legal report. Commenter states that this code must be limited to only when a physician is alleged to have violated 16082(b) without just cause.  Commenter recommends that there must be exceptions for when a patient is not yet permanent and stationary as certain issues cannot be addressed until the patient has reached maximum improvement.  Commenter states that there must also be exceptions for when a physician is not provided the appropriate information in advance and cannot address certain portions of 16082(b) without that information. | Spencer Chelwick, Administrator  Orthopaedic Medical Group of Santa Ana, South Coast Orthopaedics, West Coast Orthopedics  December 14, 2020  Written and Oral Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9793(g)  9795(c) ML202 | Commenter states that reevaluations should be left at the current definition of within 9 months. Commenter opines that doctors see many patients annually and cannot be expected to have recall of 18 months on specific cases. | Spencer Chelwick, Administrator  Orthopaedic Medical Group of Santa Ana, South Coast Orthopaedics, West Coast Orthopedics  December 14, 2020  Written and Oral Comment | The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9795(d) -94 | Commenter opines that the modifier must be applied to the entire value of the report. If not, AME doctors will suffer a pay cut, which is unfair punishment to the best doctors in the industry. | Spencer Chelwick, Administrator  Orthopaedic Medical Group of Santa Ana, South Coast Orthopedics, West Coast Orthopedics  December 14, 2020  Written Comment | The AD disagrees the modifiers were adopted after extensive stakeholder meetings and discussions. | None. |
| Future Increases | Commenter states that an annual COLA increase should be incorporated into this fee schedule to prevent such a long period of no increase from happening again.  Commenter recommends that the DWC apply the DWC’s State Average Weekly Wage inflationary metric or the Consumer Price Index (CPI) for Medical Care in California. | Spencer Chelwick, Administrator  Orthopaedic Medical Group of Santa Ana, South Coast Orthopedics, West Coast Orthopedics  December 14, 2020  Written and Oral Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates. | None. |
| General comment | Commenter states that the proposed change to a flat fee schedule will incentivize speed not quality. Commenter opines that this will result in a reduction in QME report production which will negatively impact all stakeholders including employers, QMEs, and, most importantly, injured workers.  Commenter states that the quality of evaluation and report helps physicians to determine how the applicant is injured, or if they are injured at all. Otherwise too many people will be slipping through the cracks. Commenter states that she puts her best effort into the evaluation and report to make sure that the system is used justly and not taken advantage of. The needy get the care they deserve while the others are proven otherwise.  Commenter recommends that the DWC make a simple, non-controversial adjustment to the existing fee schedule. Commenter opines that there were no issues whatsoever with the current fee schedule until DWC began imposing underground regulations in 2016. Commenter recommends that the DWC leave well enough alone and increase the 2006 rates by the same 65% adjustment that injured workers have received since 2006.  QMEs want this, payors want this, and it is the simplest, most conservative change that can be made to an unstable QME system. | Anish Chandra, DC, CCSP, QME  December 14, 2020  Written Comment | The AD disagrees. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| General Comment | Commenter opines that this proposed fee schedule will incentivize speed over quality and would discourage physicians from becoming QMEs or continuing to practice as QMEs. Commenter states that under this new schedule, he will not be able to continue to practice as a QME. Comment states that this proposed new fee schedule would significantly lower the reimbursement if he were to continue to put the same amount of time into each report to maintain report quality.  Commenter opines that this proposed fee schedule will result in a reduction in QME report production and will negatively impact the employers, QMEs, and, most importantly, the injured workers.  Commenter recommends that the DWC either make a simple adjustment to the existing fee schedule by increasing the 2006 rates to account for cost of living increases, or to look into implementing the Sue Honor recommendation. The current proposal effectively slashes reimbursement for time consuming evaluations and report writing. | Karl Robinson, DC,RN | The AD disagrees. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| 9793(c)(2) | Commenter notes that this section indicates that a comprehensive medical-legal evaluation may be conducted by a Primary Treating Physician, however there is much controversy regarding when it is appropriate for a PTP to perform such an evaluation. Commenter states that clarification needs to be added to the definitions, either here or under paragraphs (h) or (k) regarding under what circumstances a PTP is permitted to perform an evaluation payable under the MLFS. Commenter opines that the regulation needs to be consistent with the requirements of Labor Codes 4060 (d), 4061 (i) and 4062 (a) and *Brower vs. David Jones Construction 79 Cal. Comp. Cases 550*. This would help eliminate friction when a PTP bills under this schedule. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | Treatment reports are billed under the Official Medical Fee Schedule. There is already a provision for treating physicians to bill for medical-legal reports pursuant to Title Eight, California Code of Regulations § 9785 (f)(7) when requested by a claims adjuster. In addition, the time the treating physician writes the permanent and stationary report there may not be an issue in dispute to make the report eligible to be treated as a medical-legal report, pursuant to 8 CCR § 9793(h). | None. |
| 9793(j) | Commenter states that this definition should be eliminated as medical research no longer plays a part in determining how a medical-legal evaluation should be paid. There is no reference to medical- legal research in any other section of the regulations. It only adds to confusion. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | AD disagrees, a physician may continue to bill under Labor Code section 5307.6. | None. |
| 9793(l) | Commenter opines that including the addition of “any correspondence received by the physician from the parties to the action” to the definition of “Reports and documents required by the administrative director” adds an undue burden to the physician. First, that definition can include anything received by the medical provider from the parties including voluminous medical records. The parties already have a legal obligation to exchange any correspondence sent to the physician and the physician has an obligation to list anything reviewed in the course of the evaluation. Commenter questions what purpose is being served by requiring the physician to send copies of everything received from the parties as a condition to being paid. Commenter states that this adds administrative costs to the physician in the form of copying expenses, postage and staff time for no clear purpose. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | Correspondence is defined as “communication by exchanging letters with someone”,  and therefore logically refers to the letters of instruction sent to the QME by the parties to the action. The regulation does not specify correspondence and attachments, therefore medical records and/or other evidence is not contemplated to be appended to the QME report. | None. |
| 9793(n) | Commenter opines that the final sentence of this section puts the physician in a difficult position. “A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider.” Commenter states that this provision, in conjunction with rules in several other sections which do not pay the physician for records previously received – particularly supplemental reports – effectively prevents the physician from ever billing for record review when an initial submission of records doesn’t include the declaration. This is a problem created when a party or parties fails to follow the regulations, but the cost of this failure is passed on the physician, who had nothing to do with it. The language needs to be revised to permit the physician to receive payment for the record review portion of the billing once the declaration has been received. Additionally, consistent with regulation 35 (i), the records should not be considered to be received until the party submitting the records has complied with the regulation. If the declaration is not received within 10 days of the evaluation, the physician will send a preliminary report and be permitted to submit a payable supplemental report upon receipt of the signed declaration which will include payment for the complete record review. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | Noted. | Language has been amended please see update. |
| 9793(c) ML202 | Commenter states that the following provision in the payment of the Follow Up Medical-Legal Evaluation again puts an undue burden on the 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.” The physician is required to review all records received and to indicate what was reviewed in the report. The physician may get copies of previously received reports with variations that need to be reviewed. It puts the responsibility of comparing previously received records with newly received records on the physician rather than requiring the parties to refrain from resending records previously provided to the physician. Commenter opines that the physician should be permitted to include in the record review count all records sent in conjunction with the follow up evaluation and not be required to determine which records had been received previously. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive. | None. |
| 9793(g)  9793(c) ML202 | Commenter states that the 18-month time period is too long as a follow up time frame and proposes the time frame be no longer than 12-months. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | The AD disagrees the time period of 18 months adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9793(c) ML203 | Commenter opines that the following provision in the payment section for the Supplemental Medical-Legal Evaluation creates potential friction for the physician receiving correct payment for this service: “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.” If records are sent to the physician for the initial or follow up evaluation and there is a failure on the part of the party sending the records to provide the mandatory declaration, the physician would not be allowed to bill for a supplemental evaluation based on how this is written. This can be remedied by exempting records received without the declaration from being considered received for review until the declaration is received as described above. Additionally, if the records are not received in compliance with the regulations, any issues that the physician is asked to address which cannot be addressed without a review of records should not be considered an impediment to being paid for a supplemental report once the records or the declaration are received. The physician should be permitted to issue a reimbursable supplemental report at that time. |  | Noted. | This section has been amended, please see update. |
| 9793(c) ML206 | Commenter refers to her comments regarding ML203. Commenter opines that there is no point in having a non-payable code because it confusing and should be deleted. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9795(d) -94 | Commenter states that this modifier does not identify which procedure codes it applies to. Does this mean that it applies to all services performed by an AME? If that is the case, then the other modifiers are not consistent with this interpretation as the modifier -96, -97 and -98 imply that it only applies to ML 201 and ML 202. Commenter states that modifier -94 should apply to all services performed by an AME. The only possible exception would be ML PRR, which she opines was left out due to the 10% additional increase overall for all AME services. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | AD disagrees. The language is clear. Modifiers apply to procedure codes ML201 through Ml 203 only. | None. |
| 9795(d) -96,  -97 and -98 | Commenter states that all three of these modifiers have the same issue that she outlined for -94 nor do the calculation examples appear to lead to the correct totals as demonstrated below.  This is an AME example, but using the same analysis, it would apply to the other three modifiers:  For an ML-201, the fee is $2,015.00.  Using the multiplier of 1.35 for an AME leads to this calculation:  $2,015.00 X 1.35 = $2,720.25  This is a 35% increase of the base rate.  Using the multiplier of 2.35 from the new regulations for an AME in psychiatry leads to this calculation:  $2,015.00 X 2.35 = $4,735.25  This is only a 17.5% increase of the usual fee for a psychiatrist, which is twice the base rate, or  $4,030.00.  Assuming this was unintended, it is easily corrected by changing the modifier for ML-201-94-96 and ML-202-94-96 to 2.70  Using the multiplier of 2.70 for an AME in psychiatry instead leads to this calculation:  $2,015.00 X 2.70 = $5,440.50.  This is a 35% increase of the usual fee for a psychiatrist, which is twice the base rate, or $4,030.00. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule.  Comparisons of fees after the application of the modifier should only be made with the base rate prior to application of modifier. | None. |
| General Comments | Commenter recommends a standard letter format be used by the parties to submit the medical records which will provide needed information for the physician in addition to the page count of records; including, but not limited to: claim demographic information; party names and addresses; whether the claim is accepted, delayed or denied; accepted body parts; specific issues to be addressed by the physician; and the list of medical records. Commenter opines that this will make it easier for the physician to write a pertinent report and answer all the questions the parties need addressed.  Commenter states that there is nothing in these regulations to address timeframes for future updates. Commenter opines that the schedule should be reviewed for an annual increase based on a reasonable index such as the CPI for Medical.  Commenter states that there should be a paragraph added to indicate that physician may exceed the fee schedule amounts listed provided they meet the criteria set forth in Labor Code 5307.6 (b). This will assist physicians presented with extraordinarily complex cases in obtaining additional payment without violating the regulations. | Suzanne Honor, Esq.  Honor System Consulting  December 14, 2020  Written Comment | This is not the subject of this rule making.  This is not the subject of this rule making.  Commenter is directed to regulation section 9795(g). | None. |
| 9793(g)  9793(c) ML202 | Commenter requests that the follow-up time remain at 9 months and not be changed to 18 months. | Andrea R. Bates, MD, MBA, EdS, QME  December 14, 2020  Written Comment | The AD disagrees the time period of 18 months was adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9795(c) | Commenter opines that $3.00 per page for the review of records is ridiculous as the number of pages is not tightly correlated to the complexity of the report. | Andrea R. Bates, MD, MBA, EdS, QME  December 14, 2020  Written Comment | The AD disagrees. Stakeholders at meetings held in 2019 and 2002 found that one complexity factor is number of pages sent to a physician for review. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| General Comments | Commenter opines that the proposed fees schedule is not a pay raise, just a different system. Commenter states that reimbursement with the current system or with a new system should be $350 an hour minimum.  Commenter recommends that there be a higher base fee for the complex exams. The reasoning for the higher payment of fees is not only that there hasn’t been a price increase in 14 years but psychiatrists in the marketplace make a lot more money than the current or proposed QME rates.  Commenter notes that sometimes the language in the Workers Comp system assumes that doctors may be fraudulent trying to get something undeserved. Commenter opines that is it’s an inappropriate approach, i.e., to have to swear under the threat of perjury, for example. AS a group, commenter states that doctors in the systems are good providers and evaluators should be treated respectfully.  Commenter states that while waiting and trying to negotiate with an opposing attorney, many times, lawyers build up costs through ordering depositions of doctors and asking for many supplemental reports. Commenter opines that insured payors ought not to try to keep doctors from charging for their time. Instead, they should work on finalizing and closing out open claims. It is unfair to aim cost-cutting and fine doctors for systems’ issues that do not have to do with doctors. Doctors are often stuck in the middle, under more and more pressure to explain every nuance – of course explaining those nuances takes time to explain and research to substantiate. | Andrea R. Bates, MD, MBA, EdS, QME  December 14, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| General Comment | Commenter opines the proposed fee schedule would reduce report quality and that the current system encourages better quality reports.  Commenter recommends maintaining the current fee schedule with the following changes:   * No-show exam fee of $750 for 7 days. * $750 an hour for depositions. * $750 cancellation fee for deposition within 7 days. * ML102 and ML103 should be twice as much as the system now pays. * Reimbursement should be at the rate of $350 per hour. | Andrea R. Bates, MD, MBA, EdS, QME  December 14, 2020  Written Comment | The AD disagrees. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| 9795(d) | Commenter states that if the DWC goes with the new system, she approves of the multiplier of 2.0 for a psychological or psychiatric case. | Andrea R. Bates, MD, MBA, EdS, QME  December 14, 2020  Written Comment | The AD disagrees. The modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| General Comment | Commenter supports the proposal recommended by the Gabor Vari of the California Society of Industrial Medicine (increase the current fee schedule by 65%). Commenter is concerned that any schedule not based on time utilization is going to be problematic - trading in one set of problems for another, and finds this unfortunate given the task should be focused on addressing the needs of injured workers.  Commenter opines that the proposed schedule is workable once some potential problem areas are addressed. Concerns include how to manage discrepancies in page numbers. Commenter had a case where she received nearly 27000 pages of records, many highly relevant and not the usual fluff from Kaiser medical appointments. Nearly 50% were duplicates. Most of those records came in over several weeks including 3 weeks into her 30 (now 45) day report writing period. Commenter states that she should have had them in advance. Adjustors should provide the records in advance. Commenter opines that it is not fair to complain about report quality if physicians do not have the support needed to conduct a decent evaluation. Commenter estimates that in more than 80% of the cases, she is provided records after the date of her evaluation which compromises what she is able to accomplish during her interviews. Commenter states that she should not have to provide a free supplemental report or integrate records into her report if the data comes in late, after her evaluation.  Commenter is concerned that there will be a lot of conflict in dealing with this sort of thing, and also that the schedule will not survive once a payor gets an astronomical bill for a report for which she will currently end up billing around 10 - 11K. | Alexandra Clarfield, PhD, QME  Licensed Psychologist  December 14, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  Disputes over page count are subject to current billing dispute resolution methods.  Receipt of records by the physician is not the subject of this rule making. | None. |
| 9795(c) ML206 | Commenter is concerned that supplemental reports be required at no charge. Commenter states that many times she is provided lengthy legal case materials and asked for Kite analyses. Not sure why she should have to do that for free and that it is hard work. Commenter opines that she already puts in a lot of her own time trying to increase her skills. Having to give away her work as well is unfair. Commenter charges as little as possible if the request is nominal or something she should have addressed previously. | Alexandra Clarfield, PhD, QME  Licensed Psychologist  December 14, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9794 | Commenter would like to have some support from the DWC to get paid for the psychological testing that is required and done. Commenter states that 50% of insurance companies process her bills improperly and lower the cost billed for her time testing. She does not have office staff so normally she takes the loss, or alternatively has to put in more hours educating herself on how to do the billing and assemble numerous other documents to get paid what she is owed for work that I she puts a lot into.  Commenter states that she has driven hours to get to appointments on time only to have the injured worker not show up and then be belligerent when contacted to ask them to come in. Her minimal no show charge of $500 is not paid. | Alexandra Clarfield, PhD, QME  Licensed Psychologist  December 14, 2020  Written Comment | This is not the subject of this rule making. | None. |
| General Comment | Commenter is very angry with the proposed flat rate increase which she states is ridiculous, insulting to doctors and dangerous to injured workers. Commenter states that she has provided the same feedback to the division five or more times and is tired of being ignored.  Commenter opines that this fee schedule will result in a sham system that will be based on a superficial check-box approach, rather than an actual evaluation. That's not healthcare. That's the opposite.  Commenter objects to the "supplemental report for free" proposal. Commenter opines that this is ripe for abuse and designed to punish QME doctors.  Commenter is angry that QMEs have not had a raise since 2006 and it is now almost 2021.  Commenter states that she is psychologist. Psychologists and psychiatrists cannot use a checkbox approach. Mental health evaluations are, by the very nature of human experience and the psyche, complex. They have to take into account a person's entire life history.  Commenter requests that the Division propose a fee schedule that compensates doctors what they are worth for their skills. Commenter opines that this about due healthcare for injured California workers, not should not be a pawn in some state budgetary game or insurance company fever dream about profits.  Commenter states that this is supposed to be a neutral system and questions the DWC requires that the injured workers suffer.  Commenter requests that the DWC stop playing around and pay QME doctors according to the standards of 2021. People's lives are at stake. | Kari Tervo, Ph.D, QME, Psychologist  December 14, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. Adjustments to the fee schedule are contemplated if actual deficiencies of determined after a reasonable period of use of the new fee schedule. | ML206 “supplemental report for free” has been deleted, please see update. |
| 9795(c) ML201 | Commenter did a quick analysis of the last two QME evaluations she completed and under the newly proposed structure, both would pay her a little less, and not a little more than she billed for under the current structure. Both evaluations had records ranging from about 350 to 650 pages for record review. Amounts of time for interview and writing varied a little, but for a standard evaluation, the current proposed structure would not be a raise in reimbursement for her, it would be a slight decrease. Commenter states that she has heard other QMEs say that the future assessments with lower pages would be counter balanced with evaluations with a higher number of records for review, but in her experience, she only receives a case with extensive records about twice, or perhaps a few times per year. Commenter states that her average case includes less than 500 pages of records for review. Once or twice a year she receives a case with several thousand pages.  Commenter requests that a new requirement be added that the physician get paid a fee for every page if there are less than 500 pages submitted for review. | Angela M. West, PhD, QME  December 14, 2020  Written Comment | The AD disagrees. The levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and included in the flat fee were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| 9795(c) ML202  9795(c) ML203 | Commenter references the following sentence:  “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.”  This requirement is of major concern to the commenter. Whether she receives the request for a supplemental or second evaluation promptly, or even more than a year later, the records submitted for review can be intricate, and there are often multiple progress notes included that are from the same practitioners. It takes time and labor hours to go over all of these documents and sort out which ones are duplicates that have been reviewed in the past and which ones are new. Commenter states that if she has not reviewed a record for months, she deserves to be paid to review it again to assure that she incorporates the content in the context of the new referral questions. Commenter opines that it is reasonable, ethical, and important to be paid to review all documents submitted for any re-evaluation or supplemental evaluation, and there should be *no burden on the QME* to do a page by pages, and apples to apples, comparison (which may take hours) to determine exactly which documents are entirely new and which have been reviewed before.    Commenter requests that this language beadjusted so that there is no burden on the QME to determine which documents have been submitted in the past and which documents are now being submitted for the first time. | Angela M. West, PhD, QME  December 14, 2020  Written Comment | The inclusion of 200 pages of records in the flat fee addresses the need to have a fixed cost system with predictability.  The language cited only relates to a follow-up evaluation within 18 months.  It is not logical to assume that review of records previously reviewed takes as long as the initial review. Most physicians review their own reports as part of a follow-up or supplemental evaluation. This would yield at the very least the date range of previously reviewed records which would make the repeat review of records considerably less onerous and time intensive. | None. |
| 9793(n) | Commenter requests that this proposed language be revised to explain whether or not the QME should or should not review records that are not accompanied by the required attestation. Commenter request that a process be put in place to reconcile discrepancies if there is a different page count tallied by the provider of the documents and the QME in receipt of those documents. | Angela M. West, PhD, QME  December 14, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been amended, please see update. |
| 9793(n)  9795(c) | Commenter requests that the proposed language be adjusted to assure that QMEs either have a week or 14 days before the report is due to review and incorporate submitted records, and if not, will it be assured that the QME will be paid to complete a supplemental report and be paid for review of all of those records that arrived any less than a week or 14 days before the report or supplemental was due to be served to the parties.  Commenter is the mother of a small child and as the main and only income earner for her household she has a very busy week every week with three streams of income earning responsibility. QME is one of those streams, and the other two are also very important with requisite deadlines. The current proposed language suggests that she could potentially receive hundreds or even thousands of records to review the day before the report is due to be submitted on time. Commenter states that QMEs statutorily do the majority of their practice doing non-QME work. Therefore it may be entirely impossible for her to review and incorporate records that arrive only a few days or even hours before the report is due to be submitted. Commenter requires a weeks’ notice to competently review and incorporate all records submitted before the report is due to be served. | Angela M. West, PhD, QME  December 14, 2020  Written Comment | Labor Code 4062.3 and title 8 California Code of Regulation §35 provides for service of records to a physician. Timeline for the service of or receipt of records is not at issue for this rulemaking. | None. |
| 9795(d) | Commenter requests the DWC correct adjustments for an interpreter so that the multiplier applies to the full rate rather than only the base rate.  Commenter notes that the interpreter rate is applied to the base rate and not the QME rate for psychology and psychiatry. Commenter states that every fourth or fifth QME interview she does requires an interpreter. Commenter allots extra time because interviews with an interpreter always require more time. Commenter opines that is reasonable that the interpreter rate be applied for the QME rate for psychology/psychology applying to the entire evaluation. | Angela M. West, PhD, QME  December 14, 2020  Written Comment | Comparisons of fees after the application of the modifier should only be made with the base rate prior to application of modifier. | None. |
| General Comment | Commenter would like to know if the DWC will consider increasing the number offices allowed by each QME from 10 to 12 or 15 in the next five years.  Commenter envisions a day when technology will make it simpler to assign cases. As such, commenter requests that the DWC consider allowing some day in the future for QMEs to maintain 12 to 15 offices and not only 10. QME is one of her most enjoyed professional activities and if she had the opportunity to have 12 offices, while also earning income, she would do so. | Angela M. West, PhD, QME  December 14, 2020  Written Comment | The number of office locations is not the subject of this rule making. | None. |
| General Commenter and Future Increases | Commenter recommends that a cost of living adjustment be included if even it requires legislative action.  Commenter recommends that the DWC update the proof of service forms to allow for an option of electronic service. Each year millions of pieces of paper, toner cartridges and unnecessary postage are purchased and utilized because of these outdated forms. Commenter opines that there is no go reason to continue this environmentally disastrous police and recommends that the DWC enter the 21st century by allowing for electronic service QME reports. | Michael Amster, MD – Pain Management QME  December 14, 2020  Written Comment | Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates.  Proof of service forms are not the subject of this rule making. | None. |
| 9795(c) | Commenter opines that any and all records (pages) that are provided at any time should count toward the total page count. The applicant and defense should be obligated to work together to weed out duplicates and any unnecessary pages (ideally, the records would be provided electronically and they would be indexed and in order and the page count specified). For subsequent evaluations or any supplemental reports, it should be the obligation of the referral sources to not send duplicates but if sent, all sent records should be billable per page. There is the unfortunate circumstance where the QME is sent duplicate records which must be sorted through to make sure there is nothing new in those records. Commenter opines that this is a costly and time-consuming job and this burden should not fall on the QME. | Michael Amster, MD – Pain Management QME  December 14, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| 9795(c) ML206 | Commenter states that there should be a separate referral form or highlighted and bolded section of the referral source letter clearly outlining issues to be addressed. There is too much room for abuse by referral sources unless this issue is very specific and clearly defined. Commenter opines that the concept of an "Unreimbursed Supplemental Report" is flawed. It is prone to abuse by carriers and will result in increased friction and provider disengagement. Commenter recommends that this be removed from the fee schedule. | Michael Amster, MD – Pain Management QME  December 14, 2020  Written Comment | Correspondence with the QME is not the subject of this rule making and is covered by title 8 California Code of Regulations §35. | Language of ML206 has been deleted. |
| 9793(g)  9795(c) ML202 | Commenter requests that the time period be changed from 18 months to 12 Months. Once a year has gone by, it is essentially a new case in terms of time spent by the QME. | Michael Amster, MD – Pain Management QME  December 14, 2020  Written Comment | The AD disagrees the time period of 18 months was adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. |  |
| 9795(d) | Commenter states that the AME modifier should apply to the entire report charge including the base fee and the per page fee. This proposed change of only applying the AME modifier to the base fee essentially emasculates the AME process where increased weight is given to the more senior and qualified physicians who handle the most difficult cases. | Michael Amster, MD – Pain Management QME  December 14, 2020  Written Comment | The AD disagrees the proposed fee schedule and modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| General Comment – Cost in WC System | Commenter states that there is very little discussion, if any, as to what is actually being spent on the med-legal evaluations over time. In reality, the costs of med-legal evaluations have remained stagnant for years (or in the context of inflation, actually decreased).  Metrics regarding cost distribution in the CA WC system are available through the [WCIRB](https://www.wcirb.com/) (Worker’s Compensation Insurance Rating Bureau of CA). This independent private organization publishes an excellent annual report that is available for review at https://www.wcirb.com. Anyone interested in understanding WC costs in CA is encouraged to review this information. Referencing the WCIRB 2019 annual report, analysis of some basic metrics pertinent to med-legal costs is revealing.  Med-legal costs have risen little or potentially dropped in comparison to other costs in the WC system, particularly when adjusting for inflation:  Total Paid Medical Benefits total $4.9 Billion in 2013 and $4.4 Billion in 2019.  The total percentage paid medical benefits attributed to med-legal evaluations is 6% and the total amount spent is $264 Million for both 2013 and 2019.  Total amount spent adjusted for inflation for 2013 is $321 million (in 2019 $$) and for 2019 is $241 million (in 2013 $$).  Analyzing this data, the costs spend on medical legal evaluations have dropped approximately 18% since 2013. | Bradley Bower, MD, QME  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comment – Cost in WC System | Commenter provides the following additional data regarding cost to the system:   * Of the 3.5 billion paid in claim frictional costs in 2018, med-legal evaluations remain the least costly of the six categories (8%), while the combined costs for insurer claims staff (26%) + attorney fees (24% + 11%) = nearly 2/3 of all frictional costs (61%). Allocated loss adjustment expenses (ALAE) i.e. the cost of defending WC claims when there are disputes (defense attorney fees and other ALAE: 24% + 18%) plus medical cost containment programs (such as UR: 12%) comprise over 50% of the frictional costs paid out. Med-legal evaluations are not the cost driver. * Medical Costs per Indemnity Claim: While CA had previously been among the top 5 states for average medical costs per claim, recent medical cost reductions in CA have reduced the average cost of medical per claim to $27,217 – just 6% above the median state. Combined, total medical costs paid per claim have decreased by 23% since 2012. * Ratio of Allocated Loss Adjustment Expenses (ALAE) to Losses: The ALAE includes the cost of attorney and other legal expenses in defending claims, the cost of medical cost containment programs (UR, etc.) and other legal expenses in defending claims. The CA ratio of 22.9% is significantly greater than any other state (the countrywide median is 10.6%). The high figure is driven by a high proportion of PD claims and CT claims, high rates of representation and litigation, and longer duration of claims.   Commenter opines that given the large number of frictional cost drivers in the CA WC system, it’s surprising that the monies spent on med-legal evaluations have not tripled; rather, the cost of med-legal evaluations when adjusted for inflation has decreased nearly 18% since 2013. While the med-legal evaluation process and associated billing practices are not without flaw, a review of CA WC cost metrics demonstrate that the issues are relatively minor in comparison to the many frictional cost drivers that plague the CA WC system. *Med-Legal evaluations are not the cost-drivers.* | Bradley Bower, MD, QME  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9795(d) | Commenter notes that the proposed fee schedule pays psychologist / psychiatrists twice as much for their time than most other QME’s, and provides reimbursement for separate testing. Commenter questions under what basis the DWC concludes that a psych QME requires greater effort than a QME in Internal Medicine, Pulmonary medicine, Cardiology, etc. Most psychology / psyche QME’s provide the same set of 5 or 6 diagnoses, state the 51% threshold has been met, and provide for a period of TTD. If you’ve read one, you’ve nearly read them all.  Commenter is a QME that has read hundreds of psych QME’s and he attests that there is a plethora of mediocrity and homogeneity that permeates this QME reporting. | Bradley Bower, MD, QME  December 15, 2020  Written Comment | The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. Tile 8 California Code of Regulation §49-49.9 state the minimum amount of face-to-face time required of a physician for an evaluation, this was taken into consideration for the modifier when psychiatric or psychological evaluation is the primary focus. | None. |
| Quality of QME Reports | Commenter states that Med-Legal Evaluations are produced along a spectrum of quality (and it’s not a bell-shaped curve) Commenter opines that if the DWC and other stakeholders have concerns about the quality of QME reports, the approach that is currently being taken to manage the fee schedule will not improve the situation. Many QME reports fail to meet the standard of substantial evidence. The reports are commonly non-explanative, lack data to support conclusions, and amount to nothing more than speculation. Often, reasoning to support conclusions is either absent or of poor quality. QME’s that generate reports that meet the standard must spend significant amounts of time and energy formulating reports that all parties can understand and utilize to move any given case forward. Demonstrable medical research is often required. Commenter states that under this fee schedule, these individuals will be forced with a decision to either work for $50-100/hour (or less) or move on to other positions where their time is valued; this decision will be clear for many. Medical research should not be dissuaded; it should be encouraged.  Commenter recommends that rather than lower reimbursement for QME reports, it makes more sense to develop improved standards that are enforceable. Commenter states that most QME reports fail to address the relevant issues in an evidence based manner and he opines that paying less for the services will improve this situation. | Bradley Bower, MD, QME  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9795(d) | Commenter states that there is a shortage of QME’s that are capable of formulating viable reports for oncology and toxicology.    NOTE: As noted in Escobedo, the seminal case on the quality or lack of quality of an expert witness’s conclusions is People v. Bassett [(1968) 69 Cal.2d 122, 443 P.2d 777, 70 Cal. Rptr. 193], which states that “the chief value of an expert’s testimony rests upon the material from which his or her opinion is fashioned and the reasoning by which he or she progresses from the material to the conclusion, and it does not lie in the mere expression of the conclusion; thus the opinion of an expert is no better than the reasons upon which it is based.”  Commenter states that the has reviewed QME reports written by toxicologists and oncologists that raised more questions than answers, falling far short of the standard of substantial evidence (in his opinion). Commenter opines that board certification in a particular area does not necessarily translate to the ability to write effective QME reports. The ability to formulate effective QME reports is based on discipline, studying the labor code and case law, and adhering to strict evidence-based structure in the formulation of diagnoses and causation. As an internist with a broad range of training, commenter has formulated reports in both of these areas that have held up under intensive review.  Commenter opines that if a QME in Internal Medicine or subspecialty demonstrates the capacity to formulate reports that meet the standard of evidence in these arenas, on what basis should they be paid less if their opinion demonstrably rises to the level of expert opinion?  Toxicology and Oncology require intensive forensic effort to formulate supportable conclusions; research is often indicated to explain these conclusions to those that have to review the report with little or no medical knowledge. Noting these facts, commenter would like to know what objective measures the DWC utilized to grade the value of a psychology QME over that of a toxicology or oncology QME. | Bradley Bower, MD, QME  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been amended, please see update. |
| General Comment | Commenter states that the proposed change to a flat fee schedule will incentivize speed not quality. Commenter opines that this will result in a reduction in QME report production which will negatively impact all stakeholders including employers, QMEs, and, most importantly, injured workers.  Commenter recommends that the DWC make a simple, non-controversial adjustment to the existing fee schedule. Commenter opines that there were no issues whatsoever with the current fee schedule until DWC began imposing underground regulations in 2016. Commenter recommends leaving well enough alone and increasing the 2006 rates by the same 65% adjustment that injured workers have received since 2006.  QMEs want this, payors want this, and it is the simplest, most conservative change that can be made to an unstable QME system. | Tigran Garabekyan, MD, Board Certified Orthopedic Surgeon, Sports Medicine & Joint Replacement  Southern California Hip Institute  December 15, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The flat fee structure and levels of reimbursement in the proposed fee schedule, were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The new fee schedule is calculated to fulfill the requirements of Labor Code § 5307.6. | None. |
| General Comments | Commenter is 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. Commenter shares her concerns about the entire premise of the proposed Medical-Legal Fee Schedule regulations, as follows:   * 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.   Commenter opines that 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. Commenter recommends the Division 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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective.  A records organizer is not subject of this regulation and would require separate legislative and/or regulatory action.  Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and addresses any objection a party would have to a record being sent.  It is anticipated that parties would use this mechanism to address duplicate service from various parties.  The AD will continue to monitor the implementation of this fee schedule and can make adjustments in the future therefore a pilot program or cap on fees at this time is not suitable. | None. |
| 9793(c)(2) | Commenter recommends the following revised language:  (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). | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | Treatment reports are billed under the Official Medical Fee Schedule. There is already a provision for treating physicians to bill for medical-legal reports pursuant to Title Eight, California Code of Regulations § 9785 (f)(7) when requested by a claims adjuster. In addition, the time the treating physician writes the permanent and stationary report there may not be an issue in dispute to make the report eligible to be treated as a medical-legal report, pursuant to 8 CCR § 9793(h). | None. |
| 9793(g) | Commenter recommends the following revised language:  “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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | AD disagrees the language is clear as to effective date of the regulation. | None. |
| 9793(l) | Commenter recommends the following revised language:  “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). | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | AD disagrees the language is clear as to effective date of the regulation. | None. |
| 9793(n) | Commenter recommends the following revised language:  “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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | AD disagrees the language is clear as to effective date of the regulation. | None. |
| 9793 | Commenter has a longstanding concern regarding 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. Commenter recommend 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.  Commenter notes that 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.  Commenter recommends that language be added to permit the signed declaration required under this subsection to be made electronically.  Commenter 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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | Treatment reports are billed under the Official Medical Fee Schedule. There is already a provision for treating physicians to bill for medical-legal reports pursuant to Title Eight, California Code of Regulations § 9785 (f)(7) when requested by a claims adjuster. In addition, the time the treating physician writes the permanent and stationary report there may not be an issue in dispute to make the report eligible to be treated as a medical-legal report, pursuant to 8 CCR § 9793(h). | None. |
| 9795(b) | Commenter recommends the following revised language:  (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~~T~~he complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the time~~s~~ 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.  Commenter 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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | AD disagrees the language is clear as to effective date of the regulation. | None. |
| 9795(c) ML204 | Commenter recommends changing the amount from $455 to $425 per hour.  Commenter recommends the following revised language:  Fees for Medical-Legal Testimony. The physician shall be reimbursed at the rate of RV 7, or ~~his or her~~their 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, including preparation and testimony time. 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.  Commenter state that during the stakeholder meetings, a figure of $425 was suggested by attendees. Inasmuch as the current rate for deposition testimony is $250, commenter opines that 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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | The fee for ML204 was adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. The AD disagrees that the fee should be reduced. | None. |
| 9795(c) ML206 | Commenter recommends eliminating this provision.  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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been deleted, see update. |
| 9795(f) | Commenter recommends the following revised language:  (f) Amendments to ~~T~~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 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.  Commenter states that 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. Commenter notes that 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. Commenter 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, commenter requests that the Division 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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | The AD will continue to monitor the implementation of this fee schedule and can make adjustments as needed in the future therefore a pilot program or cap on fees at this time is not suitable.  AD disagrees the language is clear as to effective date of the regulation.  A records organizer is not subject of this regulation and would require separate legislative and/or regulatory action. | None. |
| 9795(g) | Commenter recommends the following revised language:  (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.  Commenter notes that during 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, commenter opines that 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. | Ellen Sims Langille, General Counsel  Stacy L. Jones, Senior Research Associate  California Workers’ Compensation Institute (CWCI)  December 15, 2020  Written Comment | The AD disagrees. Stakeholders at meetings held in 2019 and 2002 found that one complexity factor is number of pages sent to a physician for review. The flat fee structure and levels of reimbursement in the proposed fee schedule, including the payment for pages reviewed and the modifiers were adopted after extensive stakeholder meetings and discussion of all factors by representatives from all stakeholders in the QME system. | None. |
| General Comment | Commenter acknowledges that the medical-legal fee schedule certainly needs to be updated; however, she requests that the DWC do so in such a way that does no harm. Under the proposed regulations, the flat rate will significantly cut the remuneration for a QME. Commenter is always conscious of the costs associated with QMEs, but she is more concerned that the overall result of these changes will be fewer doctors willing to do the work. Commenter opines that this could delay treatment disputes for months, resulting in higher costs associated with longer periods to obtain a determination of maximum medical improvement. Delays would also further increase the payment of temporary total disability, which has increased by over 4% for maximum wage earners. Since the passage of SB 863, commenter states that the industry has had ten years of progress in the administration of workers’ compensation claims. Commenter requests that the DWC ensure that QMEs are fairly compensated. | Amy B. Donovan, Esq., Vice President, Legislative & Regulatory Affairs  Keenan  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comment | Through her organization’s own research and analysis of their internal billing data, commenter opines this proposed schedule will create a substantial increase in costs beyond the intended 25% as stated in the Initial Statement of Reasons, which would result in an unanticipated impact to the payor community of the industry. Their analysis projects this could be a minimum impact of a $250 million increase in yearly costs to the California Workers’ Compensation System, a significant increase that may have not been foreseen by the DWC when drafting these regulations. This reflects a 53% increase in ML yearly costs. The proposed changes also lead to administrative burdens on existing processes and workflows related to the sending of records to physicians and a payor’s reimbursement system. | Andrea Guzman  Claims Regulator Director  State Compensation Insurance Fund  December 15, 2020 | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n) | Commenter notes that the DWC proposed a new term in its list of definitions under paragraph (n) with “Record Review” and made a subsequent amendment to this definition since June 2020. This subsequent revision is concerning for parties that provide documents to a physician related to a medical-legal evaluation or request for a medical-legal report.  Here, the declaration under penalty of perjury combined with an attestation requirement will be challenging to implement for most parties that submit documents to physicians on a large scale and frequent basis, such as claims administrators and copy service companies that send records to physicians on behalf of a requesting party. Such requirements create an additional administrative burden on the staff and resources of these organizations to modify their processes with providing documents to a physician. This includes system changes and revising workflows for department(s) involved with sending documents to a physician.  Combining the attestation with declaration provides limited capability to work within established processes within an organization. In addition, copy service companies send records directly to physicians and would be additionally burdened with having to meet this requirement as currently proposed. Making these separate would provide flexibility for the industry.  Commenter notes that the regulations are silent on the remedy or course of action to take should a mistake occur or certain conditions are not met with the declaration requirement. For example, the regulations are silent on what the remedy is for when a page count is incorrect. The regulations provide no guidance on what to do if a declaration does not accompany records sent to the physician nor whether an electronic signature is acceptable. Clarity is needed in order to not delay the record review and provision of the findings.  Commenter states that it should be noted that physicians can review records from various parties: the claims administrator, the injured worker, the injured worker’s attorney, or copy service companies that send records to a physician on behalf of a requesting party. Payors are liable for payment to the physician yet cannot control what “pages” are sent by the respective parties for the physician to review, including duplicate records. Although the proposed text requires the provider of records to attest to the total number of pages provided to the physician, payors have no ability to verify the accuracy of what another party provides to the physician. Taking additional steps to verify creates an additional administrative burden on the payor.  For the reasons commenter recommends the DWC reconsider the declaration with attestation requirement in its entirety or look at less burdensome alternatives for the provider of records. Commenter suggests two options as less burdensome alternatives on a provider of records. The first option suggested is to eliminate the need for a declaration under penalty of perjury requirement acknowledging compliance with the provisions of Labor Code section 4062.3, and instead require the provider of records to only enclose an attestation form as to the total page count of documents provided to the physician. The second option suggested is to separate the declaration under penalty of perjury requirement acknowledging compliance with the provisions of Labor Code section 4062.3 from the attestation as to total page count, resulting in two separate forms that accompany the records when provided to the physician. This second approach would alleviate the concerns noted above regarding both claims administrators and copy service companies sending records directly to physicians.  Should the DWC decide to keep the declaration requirement for the provider of records, commenter requests clarity where the regulation is silent on remedies as noted above and recommends adding language to the definition as follows:  *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. There must also be an attestation attached ~~declaration must also contain an~~ ~~attestation~~ as to the total page count of the documents provided. The declaration and attestation may be signed electronically. A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider~~.~~ and may not bill for more pages than the total page count as indicated on the attestation. A physician may not bill for reviewing duplicate records sent by the parties.* | Andrea Guzman  Claims Regulator Director  State Compensation Insurance Fund  December 15, 2020 | Verification of pages of records reviewed is a tool added simply to provide for accountability.  The letter of attestation is intended to be mandatory. Disputes over page count are subject to current billing dispute resolution methods. | This section has been amended, please see update. |
| 9795(c) | Commenter notes that the DWC proposes a reimbursement rate that includes a physicians’ review of records based upon the number of pages reviewed. As indicated in her comments under the definition of “Record Review”, commenter notes that physicians receive records from various parties. As the party responsible for payment, claims administrators are liable for reimbursement for the ML services and cannot control the number of records being sent to the physician by other parties, including duplicate records.  Commenter acknowledges that the DWC’s proposed changes intended to provide an approximate 25% raise in the reimbursement rate for ML reports. Commenter opines that with the proposed $3.00 per page fee for review of records above 200 pages, the payor community will see a substantial increase in costs, more than what the DWC may have intended with the current proposed changes. As proposed, there is no limit to what an ML report can cost. Not all documents are the same and vary in content, yet each document is a cost to review. A physician’s review of a blank document that is included in the records carries the same weight as a review of a hospital discharge summary report, if included in the page count.  Commenter’s organization completed an analysis of over 34,000 ML fees paid within the last two years. They determined the average number of pages of medical records they sent. They then calculated what they would pay under the new proposed fee schedule taking account of the $3 per page for record review. Their analysis projects the new proposed fee schedule could at a minimum increase yearly costs by $250 million for the California Workers’ Compensation System, a significant increase overall that may have not been foreseen by the DWC when drafting these regulations. This reflects a 53% increase in ML yearly costs. Although the increase is significant, their data shows the increases would be inconsistently applied across the ML procedures codes. The most significant increases in cost were found in the procedure codes ML100 and ML 102 and a decrease in ML 104. Commenter offers to share with the Division the methodology used in their analysis.  Commenter supports the DWC’s intent to increase fees paid to physicians under the fee schedule. If alternatives are being explored, consider an increase to the current fee schedule structure to meet the DWC’s intent of increasing fees paid to physicians.  Commenter recommends placing a cap on fees for record review. As proposed, there is no limit to what an ML service may cost and is dependent on the type of report and number of records sent/reviewed by the physician.  Commenter recommends that the Division consider a pilot program or a sunset provision within these proposed regulations to evaluate this per page fee system and determine if the DWC’s expected impact on the industry is the actual impact on the industry. This gives the DWC the opportunity to re- evaluate if the increase in fees paid to physicians by way of the per page fee system truly served the DWC’s intent “*to provide certainty as to what amount is payable and thereby reduce frictional costs*”, as stated in the Notice of Proposed Rulemaking. Commenter recommends a two-year pilot program and sunset clause | Andrea Guzman  Claims Regulator Director  State Compensation Insurance Fund  December 15, 2020 | Labor Code 4062.3 and Title 8 California Code of Regulation §35 provides for service of records to a physician and addresses any objection a party would have to a record being sent. It is anticipated that parties would use this mechanism to address duplicate service from various parties.  The AD will continue to monitor the implementation of this fee schedule and can make adjustments as needed in the future therefore a pilot program or cap on fees at this time is not suitable. | None. |
| 9795(c) ML200  9795(c) ML201  9795(c) ML202 | Commenter is concerned that processing billing when the regulations are silent on the remedy or course of action to take should the declaration requirement not be met or if the declaration does not accompany records sent to the physician. Clarity is needed. | Andrea Guzman  Claims Regulator Director  State Compensation Insurance Fund  December 15, 2020 | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | This section has been amended, please see update. |
| 9795(c) ML203 | Commenter state that clarification is needed when a physician has not adequately answered a question previously asked and reimbursement would be appropriate. Clarity is needed. | Andrea Guzman  Claims Regulator Director  State Compensation Insurance Fund  December 15, 2020 | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | Language in ML206 has been deleted. |
| 9795(c) ML205 | Commenter states that there is a concern that documentation is needed to determine if a report is payable when a physician receives the sub rosa prior the issuance of a pending report. The proposed text of this section is not clear on how to establish this.  Commenter requests clarification for guidance on payment processing under this section. | Andrea Guzman  Claims Regulator Director  State Compensation Insurance Fund  December 15, 2020 | AD disagrees, language is clear when viewed with Regulation 41. | None. |
| 9795(c) | Commenter states that as a psychologist the instruments that he uses to analyze and 'tease out' possible apportionable factors are very different, and often more time consuming, then those used in physical medicine. Commenter opines that with a time constraint, as a result of reduced reimbursement, he is concerned about a possible impact on the precision and accuracy of his reporting. Commenter’s personal goal has always been to try to make each new med-legal report an improvement from those he has issued before. Commenter endeavors to better the precision of his analysis, knowledge of changing statues, pane! decisions and improvement of writing style. Commenter’s goal is to prevent his QME reports from resembling U/R boilerplate responses.  Commenter is concerned about changes in reimbursement for record review. Last week he received hundreds of pages of emailed records on an upcoming med-legal re-evaluation. These records were found in over 40 separate files that had tobe unzipped individually--80% of the 'new' records turned out to be  records that he had previously reported on. | Jeffrey S. Friedman PhD, Psychologist, QME  December 15, 2020  Written Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comment | Commenter is curious as to why the DWC decided to redo the entire medical legal fee schedule instead of simply updating the current one. Commenter recommends just increasing the rate to the current fee schedule.  If the revised fee schedule is adopted, commenter requests 90 to 120 days advanced notice of the changes. This would give physicians a chance to decide if they want to continue doing these reports. | Marshal Lewis, MD, QME  December 14, 2020  Oral Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system.  The effective date will be April 1, 2021. | None. |
| 9795(c) | Commenter would like to know how the DWC came up with the amount of $3.00 per page for record review. Commenter opines that he has never heard of such a low amount and finds it an inappropriate fee. Commenter states that he took the Western Institute of Legal Medicine Course and the attorneys get paid $650 per hour.  Commenter states that he is aware of a young woman in Oaxaca, Mexico that gets paid $0.06 per word for doing translation and typically a page has 100 words on it, so that equals $6.00 per page. Commenter opines that she can probably translate a lot faster than he spend interpreting a page of medical records.  Commenter also objects to the 200 pages of free records review in this schedule.  Commenter wants to know what he gets paid for research.  Commenter states that often the medical records are not provided in time to review before the exam. Commenter recommends $10 per page in order to ensure that companies send records on time and do not have extra pages included. | Marshal Lewis, MD, QME  December 14, 2020  Oral Comment | The per page fee was a compromise agreement that came out of several stakeholder meetings held in 2019 and early 2020. The $3.00 per page is a compromise of an increase in current reimbursement at an hourly rate of $250.00 and the new hourly reimbursement rate of $312.50, taking into consideration not all records are the same.  The inclusion of 200 pages of records in the flat fee addresses the need to have a fixed cost system with predictability.  Research is not reimbursed unless the physician bills under Labor Code §5307.6.  Receipt of records by the physician prior to an evaluation is not the subject of this rule making.  If an evaluation is cancelled 8 business days prior to the evaluation the missed appointment fee is not billable. | None. |
| 9795(c) ML200 | Commenter states the amount of $503.75 does not cover expenses. Commenter asks what happens if someone cancels the appointment 8 days before, instead of six, then there is no fee.  Commenter states that the cost of living is very high in California and 660 companies just left for this reason. | Marshal Lewis, MD, QME  December 14, 2020  Oral Comment | AD opinions the language is clear. | None. |
| General Comment | Commenter understands the need to control costs and that it is sometimes necessary; however, he feels that physicians have been target for a long time. Commenter opines that cost control should be statewide as well as nationwide, meaning that it should be at full market price.  Commenter offer the example of his home septic system – he called the plumber and the plumber came and charged him $275 per hour. The plumber offers special services that not everyone can perform. Commenter states that when he hired a legal service, he had to pay $650 per hour. Commenter states that the cost of living is more than double what it was 14 years ago. Commenter states that the current medical legal fee schedule is within five to ten percent about that level so it is not a fair system. | Suresh Mahawar  December 14, 2020  Oral Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| General Comment | Commenter has been a teacher for 40 years on two faculties. Commenter is a hand surgeon that enjoys mentoring young people but his problem is that none of them are becoming hand surgery specialty AMEs, QMEs, consultants or treating physicians. Commenter has only had one or two that have remained in California interested in doing med-legal evaluations – most have departed the state, as well as many others are doing at an accelerated pace due to shutdowns, in a setting of a 50 percent decrease in nationwide physician income since the shutdowns occurred starting in mid-March, in addition to mass evacuation and/or retirement vis-à-vis physician in California. Commenter agrees with the comments made by Dr. Gabor Vari regarding this proposed fee schedule.  Commenter notes issues of complexity. When performing a complete hand examination there will be 94-plus measurements, as always from neck to fingertips. It’s profoundly complex. Every single little angle, sensibility in all the nerves, cervical brachial plexus, all possible entrapment neuropathies, every possible tendinopathy. People who have no access to care for breast cancer now recurring, their lymphedema, follow no deceptions. People with hypothyroidism. People with Vitamin D deficiency; 10 percent increases in body mass index consequence to overeating during the shutdown. All of these factor are a constellation of thoughts spell complexity. When there is a reexamination, one often has a patient wo may have worsening inter-current back pain and other functionally limiting conditions. Commenter states that complexity is increasing as there is a shrinking population of expert level, still in the trenches working medical professionals. Commenter cautions to think very carefully about the past, present and potential future populations of med-legal evaluators who know what they are doing and in his case, can put their knife behind it. Commenter requests that the DWC think very quickly before rushing into things because, historically it not worked out. | Robert Markinson, MD  December 14, 2020  Oral Comment | Noted. This comment does not specifically address the content of this rulemaking that is amenable to change to make the regulations more clear or effective. | None. |
| 9793(n)  9795(c) | Commenter opines that the proposed fee schedule is a good step in the right direction, but there are some issues that could lead to friction between the providers and payors, and he wants to bring up some concerns around the pages of record review and how that is going to be interpreted.  In regard to the declaration, commenter is not certain what will happen when there is a discrepancy between the number of pages provided for review and the number of pages on the declaration itself. Commenter opines that there needs to be a clear way to resolve any potential dispute that is likely to occur. Commenter opines that it is easy to see 4,000 pages may be received but by accident, 400 pages are declared. A clear method to resolve this type of potential dispute would be helpful.  Commenter also questions what will happen when duplicate records are sent for reevaluations or supplemental reports. The QME is supposed to spend the time indexing and cross-checking these records; however they are not really getting paid to do that. Commenter opines that the way the regulation is currently worded, it seems that a payor could send 2000 pages, with 500 duplicates, and this would be a lot of unpaid administrative work that the QME would be expected to perform. Commenter hopes that this can be resolved as we move forward. | Joseph Tichio, MD  Medical-Legal Experts  December 14, 2020  Oral Comment | Verification of pages of records reviewed is a tool added simply to provide for accountability.  The letter of attestation is intended to be mandatory. Disputes over page count are subject to current billing dispute resolution methods. | This section has been amended, please see update. |
| General Comment | Commenter states that it’s been almost a year since the DWC task force has concluded its discussions and this proposal is largely the work of that task force. This fee schedule has not been updated for over 14 years and commenter and her organization is supportive of DWC’s efforts to move forward with this flat rate proposal.  Commenter opines that nothing in the workers’ compensation arena is ever perfect and when changes are enacted in the workers’ compensation system, many of the issues discussed during this hearing will be ongoing – primarily around duplicate records and the records review and as brought up by an earlier speaker, the task force did assume that the more complex cases would have more medical records. Commenter opines that if that ends up not being the case with professional athletes and things, she is certain that the task force or the DWC would be open to revisiting that issue because there is no doubt the complex cases really need some thoughtful time and attention.  Commenter notes that the task force did recommend that the records be send to the evaluator 15 days prior to the evaluation and that this did not make it into this proposed fee schedule. Commenter states that this sets the stage for the evaluator, not only having the records ahead of time, which is important, but knowing what issues need to be addressed.  Commenter requests that the DWC move forward with this much needed update to the Med-Legal Fee Schedule. Commenter opines that no one can deny that there is severe issues in the system for the injured workers getting access to QMEs and AMEs. Commenter and her organization are committed to the payors and others who have expressed concerns with the record review and pledge to work with them on the solution. | Diane Przepiorski  California Orthopaedic Association  December 14, 2020  Oral Comment | Receipt of records by the physician prior to an evaluation is not the subject of this rule making. | None. |
| General Comment | Commenter states that he has been a QME since 1990 and continues perform evaluations but that it is getting more difficult. Commenter states that a few years ago, because of all the problems with complexity factors, the fraud, certain physicians being prosecuted, et cetera, it was decided that complexity factors were way too difficult and a simpler system was needed. Commenter had a meeting with Administrative Director George Parisotto at the COA meeting three years ago and started discussing this. As a result they came up with the idea of a flat rate fee schedule with a charge for medical records. Commenter states that he continues to believe that this is the best way to go.  Commenter acknowledges there are problems and that some cases are more complex than others; however, he states that typically complexity goes along with the medical records. Commenter opines that in sports injuries that may not be the case, but it’s been three years and this fee schedule needs to be adopted because the system is losing QMEs like crazy. Commenters states it is a difficult situation with fraud and things like that but he encourages the DWC to continue to do what it is doing as the system is needed.  Commenter states that they need to be able to get records in advance, along with the attestation show exactly what records are going to be reviewed because there is a page count - $3.00 per page – and multiply that, then add it to the basic fee and you arrive at a number that nobody can dispute. It is right there in front of everyone.  Commenter states that it does take some work by the defense to provide the records in advance and already marked up so that the provider knows exactly what to review.  Commenter states that of course there will be duplicates, and all of the other little problems that have been discussed today, but he opines that these can be overcome with enough time and effort. Commenter states that this fee schedule is the starting point and he also recommends that there be a COLA so that this does not happen again as their last rate increase was in 2006.  Commenter would like to know the date that this fee schedule will take effect. | Ron Perelman, MD, QME  December 14, 2020  Oral Comment | Receipt of records by the physician prior to an evaluation is not the subject of this rule making.  Existing empirical studies yield conflicting conclusions with respect to appropriate increases in QME reimbursement. As a result, any increase should only be instituted after careful study of all factors related to QME reimbursement. This set of circumstances precludes an automatic adjustment to the rates.  The effective date will be April 1, 2021. | None. |
| General Comment | Commenter states that he has been a QME since 1981 and he opines that the only fair way to pay people is by the hour. Commenter realizes it is a dead end, but he wanted to say his piece.  Commenter opines, like any other profession, paying by the hour is the way to go and that is could be done in a very simple fashion. Commenter proposes getting rid of the complexity factors as people were playing games with that. Commenter does not see why causation is that complex because it is part of the game. Commenter opines that review of literature is a waste of time with today’s search engines. Commenter opines that there is no reason to do research for more than two hours and if you need to do more than that you shouldn’t be talking about it.  Commenter recommend that the Applicant verify the amount of face-to-face time spent with the evaluator and should be included at the end of the report.  Commenter finds $3.00 per page to review medical records hilariously ridiculous. Commenter states that 4000 pages might time him just two hours while sometime 200 pages might take hours to go through due to the complexity so he opines that $3.00 per page makes no sense. Again commenter makes a plug for an hourly rate.  Commenter recommends that the DWC simply grant an increase based on the cost of living and move on. | Jonathan Ng, MD, QME  December 14, 2020  Oral Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system. | None. |
| General Comment | Commenter agrees with Dr. Johnathan Ng, that evaluators should be paid an hourly rate for their reports. | Diane J. Weiss, MD, MPH Diplomate, American Board of Psychiatry and Neurology  Assistant Clinical Professor  UCLA School of Medicine, AME, QME  December 7, 2020  Written Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system. | None. |
| General Comment | Commenter has been a QME for eight year and has enjoyed the process.  Commenter practices in the field of psychiatry and this is very different as they do not focus on a body part but on the brain and the mood. Commenter states that the issue with psychiatry is that everything affect the mood. It could be orthopedic injuries, neurological injuries, harassment, abuse, stress, so on and so forth. Commenter states every case is very different even if they have the same diagnosis, for instance depression. What leads that individual to become depressed and subsequently file a workers’ compensation claim can vary substantially. Because of this, there is a lot of additional complexity to each case and the commenter simply as no idea what to expect when seeing the Applicant.  Commenter notes that some cases are surprisingly easy and other are much more complex than anticipated. Because of this, the amount of time necessary to do a full history of present illness and do a proper bio-psycho-social breakdown of the individual can vary substantially. Commenter opines that in the field of mental health it is impossible to have a one size fits all because of how much information that they have to collect. Because of this commenter is opposed to the flat rate fee schedule.  Commenter agrees with Dr. Ng that records vary in complexity and some take a longer than others to review. Commenter states that when reviewing records he needs to identify all the potential factors that could be affecting an individual’s mood, right them down and cross reference them with the Applicant, that is, if he has the opportunity to review the records prior to interviewing the individual. Commenter state that all of this is critical when it comes down to apportionment because he needs to address every one of those factors. | Sanjay Agarwal, MD, QME  December 14, 2020  Oral Comment | The AD disagrees and finds that for stability and predictability in the workers compensation system which is largely a fixed fee system that this fee schedule reflects that system. The medical record per page review and the modifier for psyche evaluations take into account the relative complexity. | None. |