

Medical-Legal Independent Bill Review Regulations

Title 8, California Code of Regulations Chapter 4.5 Division of Workers' Compensation Subchapter 1 Administrative Director – Administrative Rules

Article 5.6 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

§9793. Definitions.

As used in this article:

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

(b) "Contested claim" means any of the following:

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

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

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

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

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

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

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

(d) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority.

(e) "Disputed medical fact" means an issue in dispute, including an objection to a medical determination made by a treating physician under Section 4062 of the Labor Code, concerning (1) the employee's medical condition, (2) the cause of the employee's medical condition, (3) For dates of injury before December 31, 2012, where the evaluation occurs on or before June 30, 2013, treatment for the employee's medical condition, (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition, or (5) the employee's medical eligibility for rehabilitation services.

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

(g) "Follow-up medical-legal evaluation" means an evaluation which includes an examination of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606, (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 in a comprehensive medical-legal evaluation and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive medical-legal evaluation.

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

evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:

- (1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.
 - (2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.
 - (3) The report is capable of proving or disproving a disputed medical fact essential to the resolution of a contested claim, considering the substance as well as the form of the report, as required by applicable statutes, regulations, and case law.
 - (4) The medical-legal examination is performed prior to receipt of notice by the physician, the employee, or the employee's attorney, that the disputed medical fact or facts for which the report was requested have been resolved.
 - (5) In the event the comprehensive medical-legal evaluation is served on the claims administrator after the disputed medical fact or facts for which the report was requested have been resolved, the report is served within the time frame specified in Section 139.2(j)(1) of the Labor Code.
- (i) "Medical-legal testimony" means expert testimony provided by a physician at a deposition or workers' compensation appeals board hearing, regarding the medical opinion submitted by the physician.
- (j) "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.
- (k) "Primary treating physician" is the treating physician primarily responsible for managing the care of the injured worker in accordance with subdivision (a) of Section 9785.
- (l) "Reports and documents required by the administrative director" means an itemized billing, a copy of the medical-legal evaluation report, and any verification required under Section 9795(c).

(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 at the time of the initial examination, or a request for factual correction pursuant to Labor Code section 4061(d), (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

Authority: Sections 133, 4622, 4627, 5307.3 and 5307.6, Labor Code.

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

§9794. Reimbursement of Medical-Legal Expenses.

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

(1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the official medical fee schedule adopted pursuant to Labor Code Section 5307.1. In no event shall the claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report. Additionally, the claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the claims administrator, if adequate medical information is already in the medical record provided to the physician.

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

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

(c) A claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative director using an explanation of review. Any notice of objection shall include or be accompanied by all of the following:

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

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

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

(4) A statement pursuant to Labor Code section 4622(b)(1) that the physician may seek a second review by the claims administrator of the reduction of billing of the medical-legal expense. The statement shall also state the request for second review by the physician and completion of the second review process of the medical-legal expense by the claims administrator is a prerequisite to seeking independent bill review provided in Labor Code section 4603.6. If the provider does not seek a second review and the only issue in dispute is the amount of payment, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any additional payment.

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

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

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

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

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

(e) If the claims administrator receives a written objection to the denial of the medical-legal expense under subdivision (d) within ninety (90) days of the service of the explanation of review, the claims administrator shall file a petition to review of the denial of medical-legal expense and

a declaration of readiness to proceed pursuant to section 10228 et. seq., of title 8 of the California Code of Regulation.

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

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

(h) A physician may not charge, nor be paid, any fees for services in violation of Section 139.3 of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;

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

(1) name and specialty of medical evaluator;

(2) name of the employee evaluated;

(3) date of examination;

(4) the amount billed for the evaluation;

(5) the date of the bill;

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

(7) the date payment was made.

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

Authority: Sections 133, 4622, 4627, 5307.3 and 5307.6, Labor Code.

Reference: Sections 4620, 4621, 4622, 4625, 4626, 4628 and 5307.6, Labor Code.

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

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

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

(b) The fee for each evaluation is calculated by multiplying the relative value by \$12.50, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.

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

<i>CODE</i>	<i>B.R.</i>	<i>PROCEDURE DESCRIPTION</i>
ML100		<i>Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation.</i> This code is designed for communication purposes. It does not imply that compensation is necessarily owed.

<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML101	5	<i>Follow-up Medical-Legal Evaluation.</i> Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall

be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour.

<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML102	50	<i>Basic Comprehensive Medical-Legal Evaluation.</i> Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.

<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML103	75	<i>Complex Comprehensive Medical-Legal Evaluation.</i> Includes evaluations which require three of the complexity factors set forth below. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon: (1) Two or more hours of face-to-face time by the physician with the injured worker; (2) Two or more hours of record review by the physician; (3) Two or more hours of medical research by the physician; (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor; (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors; (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation; (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference. (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical

monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances;

(9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

(10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML104	5	<p><i>Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances.</i> The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:</p> <p>(1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon.</p> <p>(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;</p> <p>(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.</p>

<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML105	5	Fees for medical-legal testimony. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour,

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

<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML106	5	Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

(d) The services described by Procedure Codes ML101 through ML106 may be modified under the circumstances described in this subdivision. The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

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

-93 Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML 102 and ML 103.

-94 Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. If modifier -93 is also applicable for an ML-102 or ML-103, then the value of the procedure is modified by multiplying the normal value by 1.35.

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

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

(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments; (2) medical-legal testimony provided on or after the effective date of the 2006 amendments; and (3) supplemental medical legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.

Authority: Sections 133, 4627, 5307.3 and 5307.6, Labor Code.

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