Working Paper

California Workers' Compensation Medical-Legal Fee Schedule

Analysis and Recommendations

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1. Introduction and Background

The California Department of Industrial Relations (DIR) Division of Workers Compensation (DWC) requested that RAND review the California workers' compensation Medical-Legal (ML) fee schedule, which has not been revised since 2007. Because evaluation and management maximum allowable fees were increased as a result of Resource-based Relative Value Scale (RBRVS) reforms introduced in Senate Bill (SB) 863, DWC inquired whether comparable ML fee schedule changes might also be appropriate.

This section provides a background of ML services in California, and describes the data and methods employed in exploring ML fee schedule issues and the factors that contribute to the ML process. It includes a discussion of common themes from stakeholder interviews and our review of other state fee schedules for ML evaluations. Please refer to the RAND Report, "Medical Care provided to California's Injured Workers, Monitoring System Performance Using Administrative Data" (Medical Treatment Evaluation Study) to examine trends in the utilization and cost of medical services provided to injured workers.

Background

ML Services

In workers' compensation cases where there is disagreement over the primary physician's opinion on work-related issues, a medical expert is invited to provide an independent evaluation of the injured worker's condition to determine entitlement to WC benefits. "ML services" refers to disability evaluations and expert testimony by independent medical experts. The types of issues that ML examiners evaluate include:

- Whether the injury is work-related
- Whether the injured worker is able to return-to-work
- Whether the injured worker's condition is permanent and stationary and, if so:
    - the worker's permanent disability rating
    - the worker's likely future medical needs
- Whether the patient's disability is new or should be apportioned among multiple employers.
- Whether part or all of any permanent disability can be apportioned to non-industrial cause(s).

Prior to July 1, 2013, ML evaluations could also be used to assess the medical necessity of medical treatments when there was a dispute between the treating physician and the claims

administrator.[1] However, if the only issues involved medical necessity, the injured worker could have requested an expedited administrative hearing on the medical necessity dispute. Therefore, it is likely most ML evaluations during 2007-2012 involved at least one work-related issue and may have also involved one or more medical necessity disputes.

ML expenses are incurred whenever a medical expert evaluates an injured worker's condition to determine entitlement to WC benefits but does not provide medical treatment. While the ML examiner does not provide medical treatment, the examiner may order relevant diagnostic testing to clarify the injured worker's condition in order to complete the ML evaluation.

The ML examiner may be either a qualified medical examiners (QME) and an agreed medical examiner (AME). QMEs are individuals who are certified by DWC to evaluate disability and develop ML reports, which are used to determine an injured worker's eligibility for WC benefits. QMEs may be a licensed allopathic or osteopathic physician, chiropractor, psychologist, dentist, optometrist, podiatrist or acupuncturist. AMEs are individuals who have been selected by agreement between the defense and applicant's attorneys to perform the ML evaluation. DWC does not certify AMEs, although many individuals who are asked to perform AME evaluations are also certified QMEs.

If the employer or injured worker disagree over work-related medical issues in the claim, either party may request a panel of three QMEs in a designated specialty from DWC. DWC randomly generates the panel from the list of certified QMEs in the requested specialty. An unrepresented injured worker may select a QME from a QME panel provided by DWC. For represented workers, the defense and applicant's attorneys may each remove one individual from the QME panel; the remaining individual is selected as the QME for the injured worker. An important stipulation of using a QME panel is that once a QME is chosen for the WC case, most disputes must go to that QME, unless there are multiple injuries that require evaluations by different specialties. Alternatively, if a worker is represented, the applicant's attorney and claims administrator may agree upon an examiner. Legal representation on behalf of the injured worker is required to select an AME for a ML evaluation.

ML Fee Schedule

Table 1 lists the fee schedule codes that are used in the California WC program to describe and pay for ML evaluations and testimony. Two codes – ML102 and ML103 – are paid on a per-evaluation basis. Providers must document at least three complexity factors that are specified in the fee schedule to justify payment for ML103. The remaining four codes are billed in 15-minute increments. A follow-up evaluation is an examination and report that occurs within nine months of an initial ML evaluation. A supplemental evaluation does not include an examination;

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[1] Effective January 1, 2013 for all injuries occurring on or after that date and effective for all disputes occurring on or after July 1, 2013 regardless of date of injury, SB 863 established an independent medical review process to resolve medical necessity disputes.

rather, it is a report based on the physician's review of records, test results or other information that was not available to the physician at the time of the initial evaluation. The criteria that are used to distinguish between ML102-ML104 evaluations take into account the complexity of the issues and the time required for the evaluation and report (see Appendix Table 1).

Table 1 also lists maximum allowable amounts for each ML code expressed in relative value units. Current maximum allowable amounts are $12.50 per RVU. The time-based codes value the physician's service at $62.50 per 15 minutes ($12.50 x 5), or $250 per hour. Providers may bill a ML code with one or more modifiers, some of which affect the maximum allowable amount. For example, the fee schedule maximum allowable amount for an evaluation performed by an AME is 25 percent higher than the allowable amounts when a QME or primary treating physician performs the evaluation. The allowances are increased 10 percent if an interpreter is involved in the evaluation.

Table 1: California WC ML Codes

Code	Description	Payment (RVUs)	Unit of Service	Allowances per hr. or evaluation
ML101	Follow-up ML evaluation	5	15 minutes	$250
ML102	Basic comprehensive ML evaluation	50	1 evaluation	$625 (2.5 hrs.)
ML103	Complex comprehensive ML evaluation	75	1 evaluation	$938 (3.75 hrs.)
ML104	Comprehensive ML evaluation involving extraordinary circumstances	5	15 minutes	$250
ML105	Fees for ML testimony	5	15 minutes	$250
ML106	Fees for supplemental ML evaluations	5	15 minutes	$250

Note: ML 100 is used to describe a missed appointment for a comprehensive or follow-up ML evaluation. The code is intended for communication purposes only and does not imply that compensation is necessarily owed.

Management organizations provide administrative and support services to a significant percentage of physicians performing ML examinations. Typically, these organizations provide office space, scheduling, and transcription services, obtain the medical records pertinent to the examination, submit the required ML reports, bill for the services, and pay the physician performing the evaluation. The physicians under contract to these organizations are listed as individuals on DWC's listing of qualified QMEs but the practice locations and phone numbers are those supported by the management company. Some management organizations do not require an exclusive contract, so that the listings for an individual (limited to ten locations by SB 863) may be associated with more than one management organization and/or their private practice location.

ML Payment Trends

In the Medical Treatment Evaluation Study, we analyzed WCIS data from 2007-2014 to explore trends in billing and payment structure for ML services in California. Despite the lack of fee schedule changes and a reduction in the number of WC claims, WCIS aggregate spending for ML expenses increased 46 percent. When we decomposed the spending increases relative to 2007, we found that the major cost drivers were an increase in the volume of follow-up evaluations and, most importantly, an increase in the proportion of evaluations that were billed based on 15 minute increments and in the average number of units billed per evaluation. Time-based initial evaluations (ML 104) increased from 44 to 54 percent of initial evaluations and the average number of units billed for ML104 increased from 30.6 to 45.0, which represents an increase of 216 minutes or more than 3.5 hours in the average length of time reported to conduct an examination. In 2007, the ratio of follow-up evaluations to initial evaluations was 0.43; by 2012, the ratio increased to 0.55.

In addition, there was steady increase in the percentage of claims with ML codes within the first 36 months following dates of injury. The proportion of injured workers receiving ML services in a given service year is considerably higher in Los Angeles than in other regions in the state.

According to the Workers' Compensation Research Institute's multistate benchmarking data, 31 percent of California claims with at least seven days lost from work at 36 months experience had ML expenses compared to a median of 27 percent for the 18 states included in the data. California's average ML expenses per claim with ML expenses was $3,681, the highest among the 18 states. The median for the 18 states was $2,192.[2]

[2] Belton, et al., 2017, Measures are based on claims arising from October 1,2012 through September 30, 2012, evaluated as of March 31, 2016,

2. Data and Methods

Our approach to evaluating the ML fee schedule consisted of three basic activities: interviews with individuals with different roles in ML evaluations, a systematic review of other state WC program policies for ML evaluations, and a comparison of ML allowances for comparable services under the RBRVS. We followed these activities with a discussion with members of the technical advisory group convened at the outset of the SB 863 evaluation concerning our findings and potential fee schedule refinements.

First, we conducted 11 exploratory semi-structured interviews with ML stakeholders (QMEs, AMEs, defense and applicant's attorneys, and claims administrators) to understand the factors that affect the ML evaluation process. Our interview protocol was constructed to identify the characteristics of a high-quality ML evaluation and report. We also obtained information on the factors that contribute to the decision to select a QME versus an AME. Our protocol included several inquiries on the factors that affect whether the examination is a basic comprehensive examination or a complex examination, and whether the pricing structure could be modified to encourage the efficient production of high quality exams and reports.

Next, we conducted an environmental scan of other states to explore the comparability of the rates and fees for independent medical exams, reports, and other ML services. Fee schedule payment amounts for ML services were systematically pulled from state WC sites. States that employ independent medical examiners or provide for negotiated or partially negotiated rates were excluded. Under these exclusionary criteria, we examined the fee schedule structure and policies for 29 states. We categorized each ML service by state, CPT code, payment structure (hourly vs. flat rate), fee schedule allowable amount, AMA Guide edition,[3] and type of evaluation. We compared the rates across states and by type of ML service to California's ML allowances.

We also compared the allowances for ML services with allowances for selected services under the OMFS for services provided by physicians and other practitioners. After a four-year transition period, effective March 1, 2017 the OMFS allowances are based on 120 percent of the amounts paid under Medicare's resource-based relative value scale fee schedule.

We also held a meeting with 15 members of the technical advisory group with stakeholder interests in the ML process to discuss our findings. Attendees represented different stakeholder perspectives, including provider, defense and applicant's attorney, claims administrator and self-insured employer. Our evaluation did not include an assessment of the quality of the ML reports.

[3] The *AMA Guides* contains detailed guidelines that emphasize objective medical findings reflecting the physical impairment, as opposed to potentially more subjective evaluations of the patient's functional status or capacity for work.

3. Findings

Interviews with Stakeholders

Characteristics of High Quality ML Evaluations & Reports

Our interviews with stakeholders revealed several important factors affecting the production of a high-quality ML evaluation and report. First, the ML examiner should conduct a thorough medical history and document the injured worker's prior history and current issues. The ML examiner must then conduct a thorough examination, focusing on objective findings and documenting any relevant test results. The ML examiner should focus on providing an appropriate analysis of the issues described in the cover letter received with the request for a ML evaluation, which often outlines the scope of the evaluation and defines the questions that need to be addressed. The ML examiner report should demonstrate a thorough review of the relevant medical records and describe the ML examiner's formulation of the issues. When the worker has reached permanent and stationary status, the ML examiner should provide a well-reasoned permanent disability explanation. The explanation should include appropriate references to the AMA Guides or provide a thorough explanation of the rating in cases where the Almarez/Guzman decisions are used to rebut the AMA Guides.

Factors to consider in deciding whether to seek an AME or use the QME panel process

Our interviews with users of ML reports disclosed several factors that are considered in deciding whether to seek an AME or to use the QME panel process for represented claims. An important factor is the complexity of the injury. Respondents explained that various types of injuries and diagnoses are so unique that it would be more appropriate to go through an AME, as often panel QMEs are not sufficiently qualified to address the injury or illness. Another factor is whether there is an issue regarding whether the injury is work-related. Since both parties agree upon an AME, an AME's determination tends to be more final [permanent]. From an employer's viewpoint, it can be riskier for defense to use the QME panel process because some QMEs are more flexible and less predictable in their decisions. For less complex cases, the added cost of an AME evaluation is also a factor for the employer.

Actions taken to assure the examining physician has the information needed for a complete exam (cover letter, medical records, testing)

ML stakeholders identified several actions that can be taken to assure the examiner has the information necessary to complete an exam and ML report. First, it is important for the claims administrator (and applicant's attorney if applicable) to send a customized letter describing the

injury and the accepted body parts and outlining the issues that should be addressed by the ML examiner. Second, it is important to ensure that all subpoenaed records from prior records and all relevant medical records are sent to the examining physician in advance of the scheduled evaluation.

Frequency of supplemental reports

Users of ML reports indicated that 10-20% of initial evaluations involve supplemental reports that result from the lack of coordination between the ML examiners and the primary treating physicians over diagnostic tests needed for an evaluation and delays in obtaining the medical records in sufficient time for review before the scheduled examination. DWC rules provide that diagnostic tests required in connection with a ML evaluation must be warranted by the subjective complaints and physical findings in the report and that prior authorization is required if adequate medical information is already included in the medical record. The rules governing utilization review of medical treatment do not apply to tests ordered for ML evaluations. If the primary treating physician submits a request for authorization under the utilization process for the diagnostic tests, unnecessary delays may be encountered before the testing is performed. If the examiner receives the needed diagnostic tests results after the examination is conducted, a supplemental report is required. Untimely receipt of medical records also forces the examiner to decide whether to postpone the examination until the medical documentation is received or proceed with the examination and file a supplemental report after the documentation is received. If the tests are ordered by the examiner at the time of the evaluation, no additional payment is allowable for a supplemental report.

Several claims administrators noted the tendency of some examiners to file initial evaluation reports that are incomplete with regard to one or more findings. This forces the claims administrator to either ask for a supplemental report or withhold payment until a complete report is filed. The latter action does not happen often because it could harm the claims administrator's relationship with the examiner and potentially risks less favorable permanent disability ratings.

Changes in complexity of ML exams & factors that contribute

Several factors contribute to the change in complexity of ML exams. Respondents indicated that the AMA Guides for impairment ratings, which are effective for injuries occurring on or after January 2005, require more documentation for ML reports. An increasing proportion of evaluations over the study period (2007-2011) were based on either the AMA Guides or a rebuttal based on the Almarez/Guzman decisions. Several users pointed towards the need to address apportionment more thoroughly as a contributing factor in the increase of complex ML evaluations. They noted that the rules on apportionment have evolved. and now the examiner must determine for all cases the proportion of a permanent disability attributable to the injury

and to other causes, including other injuries and pre-existing conditions.[4] In terms of the types of claims, cumulative trauma, long term exposure, and psychiatric cases are historically more complex than other claims and the proportion of claims that are for cumulative trauma has been increasing.

Familiarity with factors used to determine basic vs. complex comprehensive examination for payment purposes (Users of ML reports familiarity with factors)

All interviewees were familiar with the various factors used to determine whether an initial ML evaluation qualifies as a basic, complex comprehensive or comprehensive evaluation involving extraordinary circumstances (see Appendix Table 1). A combination of complexity factors and the time required for each factor determine the type of evaluation that has been performed. Concerns were expressed by interviewees representing employers over several factors: medical record review, medical research, causation and apportionment.

Interviewees representing employers indicated a willingness to pay a reasonable amount for record review but expressed concern that there needs to be an objective way to measure and pay for that record review. From provider representatives, we learned that while it is the responsibility of the claims administrator to send and demarcate the relevant records, this is not always done and the physician must spend time going through the entire file or there are often additional records that the physician deems relevant and must spend time reviewing.

Medical research is another factor that can be problematic for claims administrators to assess. According to the fee schedule rules, it includes investigating medical and scientific journals and texts but does not including reading the AMA Guides, the ACOEM guidelines, the Labor Code, or other legal materials. As with medical record review, interviews representing employer perspectives indicated a willingness to pay a reasonable amount for medical research that is relevant to the issue being evaluated but expressed concerned it is not always be necessary. Provider representatives indicated that research may be necessary to support a rebuttal of the AMA Guide impairment rating as well as apportionment and causation issues.

The complexity factors considered in determining the type of evaluation performed include apportionment and causation. These factors are not time-based. The consideration of apportionment often raises the number of complexity factors from three to four (thereby qualifying a comprehensive evaluation as involving "extraordinary" circumstances) and as discussed earlier, the issue is contributing to the complexity of the evaluations.

DWC rules provide that the examiner will address causation upon the written request of one or both parties. Several ML professionals reported that reexamination of medical causation

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[4] Senate Bill 899 amended Labor Code Section 4663 in 2004 to require any physician who prepares a report addressing permanent disability to determine the approximate percentage of the permanent disability that was caused as a direct result of the work-related injury. While this change in apportionment rules likely increased the complexity of permanent disability ratings, it was effective for all ratings performed during the study period and is unlikely to account for the increase in the complexity of the evaluations over the study period.

occurs infrequently, but if there is a reason to dispute causation or if the physician has uncovered new medical evidence, the issue can become a particularly problematic.

Recommended changes in pricing structure to encourage production of high quality reports:

At the conclusion of each of our interviews, we asked whether the interviewee had any recommended changes in pricing structure to encourage the timely submission of high quality reports. Some suggested increasing the payment for high quality reports while others suggested reducing the payment for untimely or incomplete reports. One interviewee suggested the incentives could be implemented more easily if the payment for the examination were separated from the payment for the report while another thought that the combined payment should be continued, but that the payment could be increased for an initial examination and report that completely addressed the issues and did not require a supplemental report. Several claims administrators argued for more oversight and discipline for QME reports that are deficient or defective and that these reports should not be paid the same amount as high quality reports.

Discussion with Technical Advisory Group

For the most part, our discussion with the technical advisory group confirmed our findings from our stakeholder interviews. Below, we summarize additional points that were made by the group.

Increase in "extraordinary circumstances" reports and time units

The technical advisory group members provided several explanations for the increase:

- The AMA Guides increased the documentation requirements. For example, the guides require documentation for the impairment ratings and independent objective diagnostic testing.
- The lack of a cap on the number of hours that can be billed under ML 104 has created incentives to qualify an examination as involving "extraordinary circumstances" and maximize the number of hours spent in performing the evaluation.
- The elimination of increases in impairment ratings for psychiatric impairments has led to some applicant attorneys to explore more complicated theories for documenting impairments.
- The increase in cumulative trauma cases has also led to more complex evaluations.

Increase in supplemental reports

- Payer failure to provide medical records in a timely manner means that examiners are unable to produce the evaluation report within the specified 30 days. Either the initial evaluation report will be late or a supplemental report will be required.

- A disconnect between the MTUS and the AMA Guides leads to delays in testing. Some diagnostic tests are not medically necessary under the MTUS (and therefore aren't approved by UR) but are required for a ML evaluation.

Quality of Reports

- Quality of reports might be improved by reverting to the pre-899 "dueling docs" scenario when ex parte communication was permitted and attorneys could provide feedback to the examiner on the quality of the report.
- There is a need for more "nuts and bolts" training for QMEs regarding how to write a quality report.
- Any linking of payment to report quality should rely on objective measures, e.g., whether the report is timely and addressed all required elements, rather than a subjective determination of whether the report is of "good" quality.

Other Points

- Billings by ML management companies should be reviewed to assess whether they are associated with the increase in ML 104s and supplemental reports.
- Low fee schedule allowances may be encouraging evaluators to do more complex reports.
- Claims adjustors are hesitant to challenge overbilling because it may antagonize the examiner and affect impairment ratings.
- Despite the incentives of hourly billings, moving to all flat rate billing was a concern because it would not account for the time needed to deal with the most complex cases. The incentive should be on the examiner to write a high-quality report.

Comparison of State Fee Schedules for ML Evaluations

We reviewed fee schedules across the states to explore how other states pay for ML evaluations. We eliminated states that employ independent medical examiners (IMEs) or provide for negotiated rates between the payer and the provider. Based on these criteria, we examined the fee schedule structure and policies in 24 states. Documenting each state's policies and procedures for independent medical exams, we categorized ML fee schedule payments according to: state, type of service and/or report, hourly vs. flat rate fee, and the maximum allowable amount (per unit or hour for hourly rates) in the fee schedule (see Appendix Table 2).

IME Evaluations

We found considerable variation among the states in their fee schedule policies for IME evaluations. Most states use CPT 99456 for work-related or medical disability examinations and services to pay for IME evaluations. This code includes the following activities: completion of

medical history, patient examination, assessment of capabilities and stability, calculation of impairment, development of future medical treatment plan, and completion of necessary documentation, certification, and report. However, some states have state-specific codes tailored to how they pay for IME evaluations and reports. Except for Minnesota and North Carolina, all states bundle the payment for the IME examination and report. Minnesota has separate fee schedule payments for each component of an IME evaluation: medical record review, history and examination, interpretation of diagnostic images, and written report and treatment recommendations. North Carolina uses time-based rates for medical record review and the evaluation (capped at $400) and a flat rate for the patient examination.

Thirteen other states use time-based rates to pay for initial IME examinations and reports. The rates for the initial hour range from $200 (Nebraska) to $600 (Georgia). The hourly rate for additional time is set at a lower rate in South Dakota ($289.20 versus $576.90) and Wyoming ($250 versus $500) but most states using time-based codes pay the equivalent hourly rate for subsequent hours. Three states have a limit on the maximum number of billed hours or allowable fee. Maine allows up to five hours while Nebraska sets a maximum of four hours but, based on a court order, allows up to an additional two hours for complex cases. Oklahoma, which has an hourly rate of $300, sets a maximum allowable fee of $1,600 including medical record review.

Nine states have flat rate fees for initial IME evaluations. As discussed below, the policies differ regarding whether medical record review is separately payable or is bundled into the payment for the IME examination and report. Moreover, most states vary the rates based on characteristics of the evaluation, such as level of complexity, number of body parts involved, and/or whether the evaluation is for a mental health condition. For example,

- Washington pays a flat rate of $498 for an impairment rating determined by an IME exam for 1-3 body parts or organ systems and $622 for a complex exam consisting of 4 or more body parts or organ systems. Nevada, New York, and Ohio also have higher allowances for multiple body parts. Instead of a higher flat rate, Colorado, Connecticut and Vermont have exceptions policies for unusually extensive or complex exams.
- Texas fee schedule policies distinguish between the type of evaluation being conducted. There are separate rates for a maximum medical improvement evaluation and the impairment rating. The impairment rating fee varies based on the type and number of affected body parts and whether range of motion testing is required but the evaluation fee does not. There is also a separate rate ($500) for evaluations of the extent of the compensable injury (apportionment), causation, and the employee's ability to return to work.
- Rhode Island pays a flat fee of $350 to psychologists, $475 to chiropractors, and up to $700 to medical physicians completing the exam.
- Tennessee's flat rate payment varies based on the timeliness of the evaluation and report. Complete and accepted reports received within 30 days of scheduling the

report are paid $1,000, with lower rates for reports received between 31-45 calendar days ($850) and 46-60 days ($500). No payment is made for reports received later than 60 days of the scheduling of the appointment.

Record Review

For IME evaluations and reports, most states include the payment for medical record review in the hourly or flat rate payment for the evaluation and report.[5] However, there are some exceptions. Minnesota (which pays separately for each component of the evaluation) pays $285.89 for review of the first 50 pages of medical records and $163.37 for each additional 50 pages. Kansas, which uses a time-based payment based on $300 per hour for the evaluation and report, pays $100 for first 50 pages of record review, and $75 for each additional 50 pages. Maryland's $750 flat rate for an IME evaluation includes 30 minutes of record review; additional time spent on record review may be billed using the CPT code for prolonged non-face-to-face codes at $140.30 per hour.

Supplemental reports

Several California payers expressed concern in their interviews over the increase in supplemental reports. California's time-based allowance for supplemental reports is $62.50 per 15 minutes. We identified five states with fee schedule allowances for supplemental reports. Maryland was the only other state that provided an hourly rate ($400) for these reports. The other states use a flat rate ranging from $114.31 to $252. Two states limit the circumstances under which a supplemental report can be billed. Nevada does not allow a separate charge if an addendum is necessary to clarify the original report but allows $252 if an addendum is filed after review of additional medical records. Washington does not pay for a supplemental report if the rating report did not contain all the required elements. If requested and authorized by the claims manager, $114.31 is paid for an addendum report for additional information which necessitates review of new records.

Documentation requirements

California providers noted in their interviews that medical records and other documentation are sometimes not received in sufficient time for review prior to the evaluation and may not be organized to permit efficient review. Several states have policies that establish timelines for submission of medical records, but as is the case in California, there is typically no penalty for not submitting the records timely. Colorado's policy is an exception. The failure of an insurer to submit medical documentation at least 14 days before an IME examination allows the claimant to request that the IME examination be canceled or to submit all medical records he/she has

[5] Some states have separate fee schedule rates for record review and evaluation without a patient examination. Because the California ML fee schedule does not contemplate this circumstance, we do not report on these values.

available. Any supplemental documentation must be submitted at least 7 days before the examination.

Colorado also requires that medical documentation be organized in a specific format. The records are to be listed in chronological order and tabbed by year and should include a written summary of medical providers with the range of treatment dates. Maine and Massachusetts have similar requirements that the medical records be submitted in chronological order, tabbed, and indexed. Nevada does not require that the medical records be ordered chronologically but pays $42.50 to the IME examiner for the organization of medical records in chronological order.

Cancellations /no-shows

California providers also noted the burden of scheduling appointments and obtaining the medical records and the costs of potential cancellations or "no-shows", particularly after the examiner had expended effort on reviewing medical documentation. The majority of other states have flat rate allowances in their fee schedules for cancellations and/or no shows. Payment rates typically range from $100-250 for cancellations within 3 business days; however, some states pay a much higher rate. New York pays $350 for less than 24-hour notice of cancellation, and Minnesota, which pays $650 for cancellations within 3 days and no-shows.

Comparison with RBRVS Allowances

In this section, we examine the assumptions used to establish selected RBRVS values and benchmark the ML allowances to the OMFS allowances for comparable services and to the allowances for Permanent and Stationary reports filed by primary treating physicians. The comparisons provide a basis for assessing the reasonableness of the current allowances.

The OMFS pays for physician services based on 120 percent of the amounts payable under the Medicare's RBRVS fee schedule for similar services. The Medicare fee schedule file does not have relative values for the work-related or medical disability evaluation services (CPT 99456) performed by an independent medical examiner. The activities involved in providing an IME evaluation include both face-to-face time with the injured worker during the examination and prolonged non-face to face time for medical record review, any necessary research, and, as appropriate, evaluating causation, apportionment and impairment.

The ML fee schedule implicitly uses $250 per hour to value all services. Under the RBRVS, the hourly allowance for time spent with the patient is typically higher than the time spent in non-face to face activities. Using the prolonged service codes as an example, the OMFS allowance for the first hour of prolonged service with patient contact (CPT 99354) is $173.90 compared to $149.40 without patient contact (CPT 99358). The value for either code is substantially less than the $250 used to value ML services. Also, the hourly rate for additional prolonged services is lower than the rate for the initial hour.

There are two additional benchmarks for the examination component only of a ML evaluation. The first is CPT 99245 Office Consultation for a new or established patient requiring a comprehensive history, comprehensive examination and medical decision making of high complexity with typically 80 minutes spent in patient care. This code is not used by Medicare or the California WC program. If it were priced using the OMFS fee schedule policies applicable to other evaluation and management services, the examination allowance would be $301.36, or an hourly rate of $226 assuming 80 minutes of fact to-face-contact. If the examination portion of the evaluation were benchmarked to this code, additional allowances would be needed for the portions of the evaluation that do not involve patient contact.

The second potential benchmark is the amount paid to the primary treating physician for a permanent and stationary report (PR-4) when the patient has reached maximum medical improvement with permanent impairment. Effective March 1, 2017, a combined allowance will be allowed based on the sum of the allowances for the office visit, any prolonged services, and the PR-4 report. Before taking into consideration any prolonged services, the estimated combined allowance is $301.87,[6] considerably less than the allowance for a ML102 ($625) or ML103 ($938). Presumably, because the primary treating physician is familiar with the injured worker's medical history, the resources required to complete the examination, determine the impairment rating and document the findings should take less time than an independent medical evaluator would require. However, the substantial differences suggest that the ML codes are relatively overvalued and/or the allowances for the primary treating physician's examination and PR-4 report are relatively undervalued.

Limitations

Our evaluation of the Official Medical Fee Schedule (OMFS) for ML services provided under California's workers compensation (WC) program was shaped by the data that was available to us. While we employed various methods to evaluate the OMFS and to deepen our understanding of the ML processes involved in conducting independent medical exams and producing high quality reports, these methods contain several important limitations.

Our selection of stakeholders for ML interview respondents was taken from a convenience sample of physicians and representatives from different stakeholder groups. As such, our cohort of interview respondents may not be representative of the experiences and/or opinions of all AMEs and QMEs that actively conduct independent medical examinations, produce ML reports, and are paid according to the fee schedule for ML services. Our selection of respondents was comprised of a group of stakeholders that have provided feedback in a concurrent study

[6] Assuming a CPT 99215 for a complex established patient office visit is reported, the allowance for the examination would be $197.13. Using WCIS data, we estimate the average allowance for a PR-4 in 2017 will be $105.74. Combining the two allowances results in an estimated allowance of $302.87 before consideration of any additional allowances for prolonged services.

exploring reporting requirements in California's WC system. Additionally, the majority of our convenience sample practice medicine in Northern California, which may have had an effect on responses due to regional differences in California's WC system, such as different volumes of patients, patient demographics, and different types of practices and available support staff.

To explore the characteristics that are critical to the production of a high-quality ML examination and report, we relied on anecdotal evidence as described by our interview respondents and did not examine the quality of actual physical reports. Therefore, while we learned the theoretical composition of a high-quality report, we did not include examination of ML reports as part of our analysis.

Last, our comparison of state fee schedules for ML evaluations and med-legal services may be limited as fee schedules rates might not be comparable across states due to different state reporting requirements. While we excluded states that negotiate rates or make partial payments for ML services from our comparison, we did not conduct a comprehensive comparison of state regulations or reporting requirements, and so may be limited in our cross-state comparisons.

4. Discussion and Recommendations

At the outset of our assessment of the ML fee schedule, we anticipated that we would find that the ML fee schedule was undervalued relative to evaluation and management services. The ML fee schedule has not been updated since 2007 while estimated payments for evaluation and management services were projected to increase when the RBRVS was fully implemented before further adjustments for inflation. Instead, we found that the $250 per hour used to determine the ML allowances is significantly higher than the fully-transitioned 2017 allowances for evaluation and management services that consist of similar activities. While this might lead one to conclude that no changes are needed in the ML fee schedules, we have concluded that this would not be appropriate in light of the increase in the number of ML 104 evaluations and the number of units per evaluation. Despite these increases, the number of subsequent follow-up evaluations has also increased significantly. Taken together, the trends suggest that consideration should be given to restructuring the allowances for extraordinarily complex evaluations. An hourly rate for complex ML evaluations assures that the evaluator is fully compensated for the time spent in evaluations; however, it also creates incentives for prolonging the time spent on all aspects of the evaluation. The objective should be to create incentives for the efficient completion of high quality evaluations. A combination of strategies should be considered to accomplish this objective.

First, consideration should be given to converting the allowance for an extraordinarily complex evaluation into a flat rate based on the complexity of the issues that need to be addressed by the evaluator. Nine states have a flat rate payment, most of which vary by the type or number of body parts. Texas has separate rates for the type of evaluation and the issues that are being considered. A potential next step would be to identify the factors that affect the payment level for the ML 104 evaluations. Based on our interviews and discussions with members of the technical advisory group, these might include the number and type of affected body parts, the age of the claim, whether causation is an issue, and whether the AMA Guides are being rebutted. The factors could be used to establish non-time-based allowances that would replace the current criteria. Implicit in this approach is an assumption that the actual time spent on an individual evaluation might vary, but that on average the allowance provides reasonable remuneration for a ML evaluation and incentives for conducting the evaluation efficiently. The structure of the ML 102 and ML 103 as well as the payment for the primary treating physician's permanent and stationary report should be reviewed at the same time.

Second, consideration should be given to establishing policies that provide incentives for completing high quality reports that address the issues outlined in the cover letter(s) from the parties requesting the evaluation. Timely completion of reports could be incentivized by establishing a higher payment for timely submissions. In addition to incentivizing complete

reporting, the policies for the supplemental evaluations should create incentives for both payers and applicant's attorneys to fully outline the issues from the outset and for the payer to ensure that necessary diagnostic testing is completed prior to the evaluation. Comprehensive reporting could be incentivized by not paying for an initial evaluation unless the issues have been addressed and limiting payment for supplemental evaluations to specific issues: for example, review of diagnostic test results or other medical documentation that were not available before the evaluation or review of an issue that was not identified in the cover letters.

To be effective, claims administrators would need to be willing to enforce any policies that relate fee schedule payments to the timeliness and quality of the reports. The policies would need to be carefully constructed to make the fee schedule determinations as objective as possible so as to not create frictions between the claims administrators and providers. Some claims administrators indicated reluctance to challenge unreasonable billings for ML evaluations out of fear that it could adversely influence the evaluator's impairment rating. This perception- whether justified or not- might also apply to application of any financial incentives. Post SB-863, ML fee schedule disputes are appealed using the Independent Bill Review process. As of April 27, 2017, 443 IBR decisions involving the ML fee schedule had been posted on the DWC website. Of these, 279 or 63 percent of the decisions overturned the claims administrator's fee schedule determination. However, some of these overturned decisions actually lowered the claims administrator's determination. For example, the provider may have billed a ML 104, the claims administrator may have allowed a ML 103, and IBR review may have determined a ML 102 was payable. A review of the 2017 decisions indicates most disputes involve either whether the evaluation is payable as a ML 104 or whether a supplemental report is payable under ML 106. The IBR reviewer does not review the reasonableness of the hours that are reported for each activity but rather applies the criteria for determining the fee schedule allowance in a straightforward manner (for example, assessing whether each of the relevant complexity criteria for a ML 104 apply based on submitted documentation). The same type of checklist review could be used to determine whether any incentives for timeliness and completeness of the report are payable. The assessment could be done by the claims administrator or an independent party. While it would represent a major departure from current practice, having an independent party who has no vested interest in the outcome of the evaluation make the initial determination of the ML allowances might be considered. This would also allow the possibility of feedback on the quality of reporting and reasonableness of reported hours.

Third, consideration should be given to policies that would facilitate conducting evaluations more efficiently. Physicians raised several issues that make the evaluations more resource-intensive. In their experience, needed medical documentation is sometimes not received in sufficient time to allow for review before the evaluation and may not be organized, which means the physician spends time getting the records organized as well as reviewing them. The evaluator's staff also needs to spend considerable time scheduling the evaluation and following up on outstanding documentation and any needed diagnostic tests. The evaluator is at risk for not

recovering these costs if the evaluation is subsequently canceled. We believe that the "hassle" of undertaking these activities is a contributing factor to the growth of the ML management companies. Several states have adopted policies that address untimely submission of medical documentation and cancellations of evaluations.

Regardless of whether a flat rate or hourly rate is used for the ML 104, consideration should also be given to valuing selected components of the evaluation differently. In this regard, Labor Code Section 4628 does not require the physician to personally perform the research or to summarize prior medical records as long as the evaluating physician reviews the excerpts and entire outline to determine the relevant medical issues and any individuals assisting in these functions are identified. The $250 hourly allowance for research and medical record review is the same as the time the physician spends examining the patient and writing the report. When a physician personally performs similar activities as a primary treating physician or consulting physician, the hourly allowance for the prolonged services without the patient (after the first 30 minutes) is $149.40.

If the ML rates are realigned to be more consistent with the RBRVS values for comparable services, the allowances should be regularly using the same update factors that are used to update the OMFS physician fee schedule.

Appendix Tables

ML102-ML104 evaluations are defined to take into account the complexity of the issues and the time required for the evaluation and report. Appendix Table 1 describes the criteria that are used to determine which code should be reported for an evaluation. Appendix Table 2 summarizes the fee schedule policies used in other states for independent medical evaluations. States that use negotiated rates or employ independent examiners are not listed.

Appendix Table 1: Criteria for Determining Type of Medical Legal Evaluation

CODE	*RV*	*PROCEDURE DESCRIPTION*
ML102	50	*Basic Comprehensive ML Evaluation*. Includes all comprehensive ML evaluations other than those included under ML 103 or ML 104.
ML103	75	*Complex Comprehensive ML Evaluation*. Includes evaluations which require three of the complexity factors set forth below.
		In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were 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;
		(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) A psychiatric or psychological evaluation which is the primary focus of the ML evaluation.
		(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.
ML104	5	*Comprehensive ML Evaluation Involving Extraordinary Circumstances*. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:
		(1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were 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.
		(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;
		(3) A comprehensive ML 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.
CODE	*RV*	*PROCEDURE DESCRIPTION*
ML105	5	Fees for ML 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.

Source: https://www.dir.ca.gov/t8/9795.html

Appendix Table 2: Fee Schedule Policies Used for Independent Medical Evaluations in Other WC Programs

State	Exam and Report Description	Payment Type	Payment	Record Review?
California	ML102- Basic Comprehensive	Flat rate	$625.00	Included
	ML103-Complex Comprehensive*	Flat rate	$937.50	Included
	ML104-Comprehensive-Extraordinary Circumstances	Time based	$62.50 per 15 minutes	Included
Alabama	99245 Office Consultation for the first eighty (80) minutes of time	Time-based	$256.88	Included
	99354 Prolonged Physician Service for the next 30 - 74 minutes of time	Time-based	$240.16	Included
	99355 Prolonged Physician Service for each additional 30 minutes or fraction thereof	Time-based	$115.78	Included
Colorado	Z0768 Division Independent Medical Exam; May request addiitonal payment if unusually extensive or complex or multiple body parts requiring more than one hour.	Flat rate	$675.00	Included
	Impairment Rating	Flat rate (assume 2.5 hours)	$660.75	Included
	Z0756 IME/Report W Patient Exam (billed in 15 minute increments) if not division requested	Time-based	$325.00	Included

State	Exam and Report Description	Payment Type	Payment	Record Review?
Connecticut	Employer/Respondent Examiner Fee or Commissioner Exam	Flat rate; prior authorization for unusual circumstances	$750.00	Included
Georgia	IME 01 First Hour		$600.00	Included
	IME01 Each additional 15 minutes	Time-based	$150	Included
Hawaii	99456A - First hour	Time-based	$201.24	Included
	99456B - Each addl 30 minute	Time-based	$100.62	Included
Kansas	CPT 99456 - Medical Disability Evaluation	Time-based	$300.00 for first hour/$75.00 for each additional 15-minute increment	Included
Maine	99456 - IME	Time-based	$300 Hr./max 5 hours	Included
Minnesota	B - obtain history and examine employee	Flat rate	$449.26	Separate
	C - read, interpret, and analysis of x rays, diagnostic images	Flat rate	$122.53	Separate
	D - written report, diagnosis, analysis, treatment recommendations	Flat rate	$408.42	Separate
Mississippi	IME Ordered by Commission or Administrative Judge	By Report	Rate negotiated; in absence of agreement, service is billed using appropriate consultation code	Included
Nebraska	99456 - Independent Medical Evaluation	Time-based	$200 hour/nte four hours. In a complex case an additional fee of up to $200 per hour for up to two additional hours may be allowed.	Included

State	Exam and Report Description	Payment Type	Payment	Record Review?
Nevada	NV01000 - Review records, testing, evaluation, and report for up to 2 body parts	Flat rate	$754.62	Included
	NV01004 - Review of medical records and evaluation for each additional body part	Flat rate	$252.02	Included
New York	Issues related to causation or ongoing disability for injuries of the extremities; Level of impairment for PPD schedule loss of use	Flat rate	$750	Included
	Issues related to causation or ongoing disability for non-scheduled injuries (e.g., neck, back or other body systems); Level of impairment for nonscheduled permanent partial disability;	Flat rate	$1,250	Included
	Other complex medical issues including injuries/conditions involving more than one body part	Flat rate	$1,250	Included
North Carolina	IME01 One hour record review and evaluation	Time-based	$100	Included
	IME02-Two hours record review and evaluation	Time-based	$200	Included
	IME03 Three or more hours record review and evaluation	Time-based	$400	Included
	99456- Disability Exam	Flat rate	$300.00	Separate payment
Ohio	One body part or organ system	Flat rate	$500	Included
	Two or three body parts or organ systems	Flat rate	$600	Included
	Mental and behavioral health	Flat rate	$600	Included
	Four or more body parts or organ systems	Flat rate	$700	Included
Oklahoma	Medical evaluation; medical reports; patient examination; record review. CPT code 99456	Time-based	$300.00 Hour NTE $1,600.00 per case	Included

State	Exam and Report Description	Payment Type	Payment	Record Review?
Rhode Island	Medical Doctor	Flat rate	$700.00	Included
	Chiropractor	Flat rate	$475.00	Included
	Psychologist	Flat rate	$350.00	Included
South Dakota	The IME is typically billed under CPT 99456	Time-based	Maximum rate of $576.90 for the first hour, and $72.30 each additional 15 minutes	Included
Tennessee	Completed reports received and accepted by the Program Coordinator within thirty (30) calendar days of scheduling the appointment	Flat rate	$1,000	Included
	Completed reports received and accepted by the Program Coordinator between thirty one (31) and forty-five (45) calendar days of the scheduling the appointment	Flat rate	$850	Included
	Completed reports received and accepted by the Program Coordinator between forty six (46) and sixty (60) calendar days of the scheduling of the appointment	Flat rate	$500	Included
	Completed reports received and accepted by the Program Coordinator later than sixty (60) calendar days of scheduling the appointment	Flat rate	No fee paid	
Texas	99456-W5 MMI Evaluation	Flat rate	$350.00	Included

State	Exam and Report Description	Payment Type	Payment	Record Review?
	99456 W5 Impairment Rating	Flat rate	Rate varies based on type and number of affected body parts and whether full range of motion testing is performed for musculoskeletal injuries. Without testing, rate is $150 for first body part plus $50 for each additional body part.	Included
	99456-W6-Extent of Compensable Injury 99456-W7-Examination for Disability (causation) 99456-W8-Employees ability to RTW	Flat rate	$500	Included
Utah	CPT code 99456	Time-based	132.5 per 30 minutes	Included
Vermont	99456 IME Non Treating Physician	Flat rate	NTE $450.00 for an examination. Exceptions may be made.	Included
Washington	Impairment rating by consultant, standard, 1-3 body areas or organ systems.	Flat rate	$497.51	Included
	Impairment rating by consultant, complex, 4 or more body areas or organ systems.	Flat rate	$621.87	Included
Wyoming	99456 - Independent Medical Evaluations or Impairment Ratings	Time-based	$500.00 1st hour, each additional 15 minutes $62.50	Included

References

Belton, Sharon E., Rebecca (Rui) Yang, Carol A. Telles, Evelina Radeva, Bogdan Savych, Karen Rothkin, Roman Dolinschi, William Monnin-Browder. Compscope™ Benchmarks, 17th Edition: The Databook. Workers' Compensation Research Institute, 2017.

Wynn, Barbara O., Andrew W. Mulcahy, Harry H. Liu, Rosalie Malsberger, and Edward N. Okeke. "Medical Care Provided to California's Injured Workers: Monitoring System Performance Using Administrative Data." RAND RR-1344. Available at: https://www.rand.org/pubs/research_reports/RR1344.html.