December 14, 2020

The California Applicants' Attorneys Association ("CAAA") offers the following comments regarding the proposed revisions to the Medical Legal Fee Schedule regulations which are currently posted on the DWC website for a public rulemaking hearing on December 14,2020.

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 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.

Unfortunately, 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.

All parties will be negatively impacted by an inadequate fee schedule, although injured workers the most.

Most importantly, 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.

Adequate QME/AME compensation is critical to the ability to obtain substantial medical evidence required to prove a claim.

With these issues in mind, the following are our general comments about some of the more problematic revisions in this most recent proposal.

§ 9793. Definitions.

(g) "Follow-up medical-legal evaluation"

This subsection has been amended to extend the time from nine months to <u>eighteen months</u> 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.

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.

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.

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.

(n) "Record Review"

This subsection has been added to define record review and includes the following:

<u>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.</u>

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. 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?

Furthermore, 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? And 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.

This new sub-section language is unnecessary and likely to slow down the entire medical legal process with needless procedural red tape. Frankly, 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.

Additionally, what about the unrepresented injured worker who doesn't know they must provide a declaration. Under this language, it is unlikely they will get an evaluation as the evaluator can't bill for it.

What if you get the page count wrong? Off to jail?

The defendant is primarily responsible for providing records to the evaluating physician, but this seems to shift the burden.

This subdivision is extremely impractical.

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?

This 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.

As stated before this section is poorly drafted and extremely impractical.

CAAA's recommendation is that this language simply be eliminated from the proposed revisions to avoid unnecessary friction and disputes.

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

ML 202 sets forth the "new" eighteen month time period for a "follow up" medical legal evaluation. For the reasons set forth in the comments above for § 9793 (g) the existing nine month time period for a follow up evaluation should not be changed.

ML 206 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." 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.

Circumstances under which a reduced payment is owed for a supplemental medical legal evaluation should 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.

ML 201 through 203 modifiers should include record review. 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.

Lastly, as repeatedly asserted in our comments over the last two years regarding changes to the medical legal fee schedule, a Cost of Living Adjustment ("COLA") is needed in these regulations.

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)

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.