MedLegal Billing while the DWC is on the Prowl

Law Offices of
TRACI M. HINDEN
Protecting your Interests

www.hindenlaw.com
1 Sansome Street, Suite 3500
San Francisco, California 94104
415-781-3030

What does FACE to FACE include?

- Does it include time interviewing? Depends.
  - If YOU the QME are interviewing, yes.
  - If your staff is doing the history/interviewing, NO
- Does it include time spent doing Diagnostic testing? NO
- Does it include time the Applicant is in your waiting room? NO
- Note, when doing a 101 or 104- you do not bill for an Interpreter Modifier, as you bill for your actual face to face time, whereas you do not get Face to Face time with a 102 or a 103, so that is why you can get a Interpreter modifier for those visits.

Medical Research- the When, the How & the Why

- If you are doing this, which is a VERY, VERY RARELY needed issue, you are not doing this to educate the parties, you are doing this to educate YOU on an issue that is new, or cutting edge, or one you have not seen before that is within your specialty.
- The parties are coming to you to resolve their medical disputes because YOU went to medical school.

Medical Research- the When, the How & the Why

- So you did research on something you have not seen that you needed to educate yourself on to resolve their dispute, now what?
- You need to either (1) attach the research, or (2) put the citations & include an excerpt in the report.
  - Presenter Comment- I recommend the second option as the first is a Copyright violation. Unless you receive permission from the author/publisher.
- AND- the DWC wants you to explain WHY you needed to research what you researched. ******

Causation. When is it actually requested?

- What if any, preexisting conditions have contributed to or caused the employee's current condition?
- Do your findings support the Applicant's subjective complaints?

Causation. When is it actually requested?

- Are your medical findings consistent with the mechanism of the injury alleged by the applicant?
- Is there a connection between the applicant’s alleged injury & work? if so, what is the connection (actually said "Causation" in front of this question but let's not tell them that)
- Please discuss within reasonable medical probability, whether the injured worker’s employment caused the injury. Please also discuss whether the employment contributed to, aggravated, accelerated, triggered or lit up any condition that also caused the injury? The appeals board in Escobedo made a distinction between cause of injury and cause of permanent disability. Apportionment does not apply to the cause of an injury, since only one of the potentially many factors contributing to the cause of an injury need be work-related. Regarding causation of the injury, if there is any pathology separate from the trauma which is the contributing cause of the injury, please consider whether it is medically probable that a contributing cause of the pathological condition was either (1) cumulative trauma from working (this may include a period of time over and up to one's entire work life) and/or (2) a lighting up by the work injury of a previously asymptomatic and non disabling pathological condition. Please give reasons for your opinion.

Causation. When is it actually requested?

- Is any permanent disability the result of result of the May 28, 2013 injury, non-industrial injuries/conditions, prior injuries/conditions, subsequent injuries, and/or some other cause?
- Are any of the above-mentioned medical problems, assuming they exist, related in any way to the applicant's employment and claimed injures listed above? If so, please set forth the relationship and the reasons therefore. Please be sure that your causation discussion comports to the current state of the law. If medical condition was not caused by the applicant's employment, but in fact was "lit up" , aggravated or accelerated by applicant's employment, please so state and discuss.
- Is there a connection between applicant's alleged injury and his work? If so, what is the connection?

What is the DWC's position on Causation?

- The DWC is taking a "new" hardline on Causation.
- Now, even if causation is "requested" and a QME/AME responds to it, the DWC says that is not enough to ensure you get a complexity factor point.
- They want the QME/AME to do some "investigation" even though nothing in the regulations require this action.
- They want the evaluator to discern if causation is really "in dispute".

How do you know if Causation is “in dispute”?

- The DWC claims these steps will help the evaluator to discern if its in dispute:
  - (1) the applicant tells the physician the case was admitted or denied.
  - (2) The medical records show treatment was provided. (DWC was not buying the argument that the treatment could have been Self-procured or done on a lien.)
  - (3) the Cover letter tells you it is admitted or denied.

So apparently a QME is now Sherlock Holmes.

- That was my actual response to the DWC at a face to face meeting with the Administrative Director, the Chief Of Enforcement, the attorney Prosecuting the claims and Medical Director.

They did not find humor in that.

Apportionment- When do we bill for this?

The Code Says: 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.

- What does that mean?

The “Rule of Threes”

- The Rule of threes refers to the three options, of three items of when you can bill for apportionment found in the billing code:
  1. Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment *by three or more employers, or*
  2. Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment *by 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
  3. Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by *two or more or more injuries involving two or more body systems or body regions* as delineated in that Table of Contents.

DWC's positions on Apportionment

- You must only do this when the Applicant is P&S. So never bill for this if the Applicant is not P&S/MMI.
- You must evaluate all of the items of the rule of threes in your apportionment analysis. For example, you must mention all 3 employers, or mention all 3 injuries by date to that body part, regardless of whether you are apportioning to them all and same with the 2 or more injuries to 2 or more body systems or regions.

Report Writing

- According to the DWC's "CURRENT" position. This is only allowed under the following circumstances and they are denying QMEs reappointments on OLD reports for having billed otherwise.
  - 101s
  - 106s
  - 104 (3) After the parties have given permission for you to bill the report as a 104

If you billed or bill for report writing on any other 104s, they will come after you for billing "fraud".

Factor 4 vs. Factor 5, what's the difference?

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.

On Factor 4 you need only 2 of the first 3 factors. Whereas, on Factor 5, you need all 3. You cannot combine all 3 to get you factor 4.

How do I get the parties to agree to a 104 ahead of time?

- 8 CCR Section 9795, Section (C) Code 104, Subsection (3) states:
  - (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.

How do I get the parties to agree to a 104 ahead of time?

- This means you must obtain approval BEFORE YOU BEGIN the EVALUATION, which includes before you review the records.
- You may have to explain to the parties why you need a 104. Technically the code says you do it in the report, but I've seen the DWC have a problem when they look at your facts later and it seems you're telling the parties you won't do it unless it's a 104 and the facts do not support it.
  - Example was 150 pages of record review.
  - A good example is 2000 pages on a disk. Or if you get boxes still, 2 boxes of records.

ML 105- You have a deposition coming up, how do you bill?

- This is a hotbed issue for the DWC right now.
  - They are going after Physicians who refuse to schedule a deposition until payment is received, or
  - Who will not schedule another part until payment is received, or
  - Who will not be deposed if all the funds are not present.

- In Response, the DWC is making the QMEs know the rules. The following is a list of the rules.

List of Rules of what you can bill for related to a deposition & when you can do it.

- Payment for medical legal testimony is governed by 8 CCR §9795 (ML-105) at the rate of $250 an hour, for a QME and $325 per hour for an AME. Reasonable preparation in anticipation of the deposition is also allowed under that section.
- DWC does recognize the provisions of California Code of Civil Procedure §2034.450 that allows for payment for the deposition at the commencement of the deposition.
- A reading of the statutes and regulations taken together means the QME cannot demand prepayment for the deposition as a condition of scheduling and attending the deposition.
- It is acceptable as a QME to request payment of the minimum hour for the deposition plus an hour for preparation time totaling $500.
- The QME cannot technically demand the fee up front per CCP 2030.450. Payment at time of notice; or **at the start of the depo.** Asking for one hour ($250.00) prep time is customary.

Other Deposition items you should Know

- Pursuant to 8 CCR §35.5(f) the QME must make himself or herself available for a deposition within at least 120 days of the notice of deposition.
- It is a good practice to send out a letter confirming the deposition and explaining you expect $500 at the start of the deposition, but that would only cover one hour of your preparation and one hour of the deposition. And that if your preparation exceeds the one hour which is the customary payment, you will advise them at the deposition, they can issue a payment later on for the remaining “reasonable” amount of preparation time.
  - Be ready to explain why it took more than 1 hour to prepare though.

What is Billing Fraud?

- Technically, to commit fraud, you need to have a specific intent. Meaning, you need to have intended to defraud the person(s).
- Usually ignorance of the law is no defense to the law, but here, it can be as you cannot prove specific intent if the actor did not have the request knowledge to defraud someone.
- When can intent be impugned? In theory (as this is delves into criminal law which is beyond my area) they can argue you had the requisite intent if you've been in trouble for billing before, you've taught on it, or otherwise been previously warned and disregarded it.

So what's the big deal with "Billing Fraud?"

1. In California, any amount of money "stolen" or "defrauded" over $400 is a Felony. (so that's mandatory prison time, if district attorney, city attorney or other prosecutor with Jurisdiction comes after you.)

2. In the QME World, if proven, it's a mandatory 5 year probation per the Sanction Guidelines, as well has possible 6 months actual suspension.

If you are put on Probation what happens?

If are put on probation all of the following happens-

1. Your licensing board is notified- for Chiros, Psyches, their boards always respond;
2. You are put on the “wall of shame” for the next 10 years- http://www.dir.ca.gov/dwc/medicalunit/DisciplineList.html
3. Every panel while you are on probation (not suspended though) with your name issued on it, will say “on probation” next to it.
4. Every Presiding Judge in the State will get a copy of your settlement agreement.
5. President of Both the Defense and Applicant Lawyer Associations will also receive a copy of your settlement agreements.

Final Don’ts

- Don’t bill as an APQME, meaning as an AME when you see “Thank you for agreeing to be the Panel QME.” There are no APQMEs anymore and most of the ones in the past that you thought you were an APQME you weren’t, you were the last one standing, which is the normal QME process.
- Don’t bill your diagnostic tests as face to face, or as Med-legal, they are billed only under the OMFS.
- Do not believe you will be paid for diagnostic tests just because the Applicant gave you permission! The carrier/defense is paying for it, and they do not have to pay for unreasonable testing, which can include testing that has just been done. So rather than ordering a test if it has just been done, ask for it to be sent to you.
- Don’t respond to a request for your last 10 reports without calling an attorney.
- Don’t upcode because “everyone is doing it.”
- Don’t bill for review of tests ordered at initial under a 106.

8 CCR Section 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.

8 CCR Section 9795- Con’d

(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.

8 CCR Section 9795- Con’d.

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

- ML 100: Description: Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation. This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.
- ML 101: Description: Follow-up Medical-Legal Evaluation. 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.

8 CCR Section 9795-Con'd

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

- ML 102: RV: 50: Basic Comprehensive Medical-Legal Evaluation. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
- ML 103: RV 75: ML 103: Complex Comprehensive Medical-Legal 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*:

8 CCR Section 9795-Con'd- ML 103

(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;

8 CCR Section 9795-Con’d- ML 103

(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 CCR Section 9795-Con’d- ML 103

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

8 CCR Section 9795- Con’d ML 104

Comprehensive Medical-legal 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 forany 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.

8 CCR Section 9795- Con’d ML 104

(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 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.

8 CCR Section 9795- ML 105

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.

8 CCR Section 9795 Con’d ML 106

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.

8 CCR 9795- Con’d

(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.

8 CCR 9795- Con’d

-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.

8 CCR 9795 Con’d final

(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.

MedLegal Billing while the DWC is on the Prowl

Law Offices of
TRACI M. HINDEN
Protecting your Interests

www.hindenlaw.com
1 Sansome Street, Suite 3500
San Francisco, California 94104
415-781-3030