<u>Thoughts from the Bench on the Medical-Legal Dispute Process</u>

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Of the many and vast changes brought about by passage of SB 863, one of the least understood and least utilized procedures relates to resolution of medical-legal disputes, both as to the amount payable and as to the compensability of such charges. Before going into these procedures in detail, I'd like to begin with a mini refresher course that I'll entitle "Medical-Legal 101."

Medical-legal expenses are defined at Labor Code 4620 and are further defined at 8 CCR 9793 as:

> "…any costs and expenses incurred by or on behalf of any party, the administrative director, or the board, which expenses may include x-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter's fees… for the purpose of proving or disproving a contested claim."

A "contested claim" includes any of the following:

- Where liability for claimed benefit has been rejected;
- Where claim has become presumptively compensable per LC 5402;
- Where there has been failure to respond to demand for payment of compensation after expiration of statutory time periods; or
- **Where a disputed medical fact exists on an accepted claim.**

A "disputed medical fact," pursuant to 8 CCR 9793, is an issue in dispute, including objections to a primary treating physician (PTP) determination concerning:

- The employee's medical condition;
- The cause of the employee's medical condition;
- For dates of injury prior to 1/1/13, a dispute over a UR decision regarding treatment communicated to the physician on or before 6/30/13;
- The existence, nature, duration or extent of TD or PD caused by the employee's medical condition; or
- The employee's medical eligibility for rehabilitation services.

Medical-legal charges cannot be incurred prior to there being a contested claim. Period. That means no defense liability for copy service charges before an application has been filed. That means no defense liability for purported medical-legal reports and other purported med-legal charges before an application has been filed. In fact, except pursuant to LC 4061(c) and 4062, no comprehensive medical-legal evaluations, except those at the request of an employer (i.e. pursuant to LC 4060), may be

performed during the first 60 days after the notice of claim has been filed, ***unless*** the claim has already been rejected by the employer [LC 4621(b) & (c)].

Medical-legal charges can include x-rays, lab services, and diagnostic tests, which are to be billed and reimbursed per the Official Medical Fee Schedule (OMFS) [8 CCR 9794(a)(1)]. There is no liability for the cost of any diagnostic test unless the subjective complaints and physical findings that justify the test are included in the report. Duplicative testing is not permitted unless there is prior authorization by the claims examiner [8 CCR 9794(a)(1)]. The cost of comprehensive, follow-up and supplemental med-legal evaluations and med-legal testimony must be billed and reimbursed per the Medical-Legal Fee Schedule (8 CCR 9795, Table 12 in the Index of the blue "Workers' Compensation Laws of California" book) [8 CCR 9794(a)(2)].

All medical-legal reports must comply with LC 4628, LC 139.2 and 8 CCR 10606, and must contain all the disclosures and declarations required under those sections [8 CCR 9793(c)]. Remember, form and substance count when it comes to medical-legal reports and reports must be substantial evidence (capable of proving or disproving a dispute) before there is compensability for the charge [LC 4620(c)]. While treating physician reports are usually admissible (except as otherwise provided by LC 4628 and 5703 and the Rules of Practice and Procedure), and failure to comply with 8 CCR 10606 goes to the weight to be given the report, failure to comply with LC 4628, LC 139.2, and 8 CCR 10606 makes medical-legal reports both inadmissible and non-reimbursable [8 CCR 9793].

Medical-legal reports may be performed by a QME, an AME, or by the primary treating physician [8 CCR 9793(c)]. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all the conditions of 8 CCR 9793(h)(1)-(5) are met. These include:

- The report must be prepared by a physician as defined by LC 3209.3;
- The report must be obtained at the request of a party or parties, the AD, or the WCAB for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the requestor (but nothing prohibits the physician from addressing additional related medical issues);
- The report must be capable of proving or disproving a disputed medical fact essential to the resolution of a contested claim, considering the substance as well as the form of the report;
- The med-legal exam must be performed prior to receipt of notice by the physician, the employee or the employee's attorney, that the disputed medical fact or facts for which the report was requested have been resolved;
- If the med-legal report is served on the claims administrator after the disputed medical fact or facts for which the report was requested have been resolved, the report must be served within the 30 day period (to 45 days, if good cause is shown) set forth in LC 139.2(j).

Of course, per LC 4622 and 8 CCR 9793(l), all medical-legal reports must be transmitted to the claims administrator with an itemized billing and any verification required under 8 CCR 9795(c).

Pursuant to LC 4622(a), all medical-legal expenses must be paid within 60 days of **receipt** of the report and billing, unless the claims examiner, within this period of time, contests liability. If all or any part of a med-legal bill is contested, or if the bill is contested on the basis that it doesn't constitute a med-legal expense, the claims examiner must pay the uncontested amount and notify the provider of the

objection within 60 days after **receipt** of the report and bill using an **explanation of review (EOR)** [LC 4622(a)]**.**

For purposes of medical-legal disputes, the definition of an "Explanation of Review" (EOR), per 8 CCR 9793(f), means the document described in LC 4603.3(a) and 4622 that is provided to a QME, AME or the primary treating physician (PTP) when the claims administrator has objected to the cost of a medical-legal expense. Per LC 4603.3, the EOR **must** include all of the following:

- A statement of the items or procedures billed and the amounts requested by provider to be paid;
- The amount paid;
- The basis for any adjustment, change or denial of the item or procedure billed;
- The additional information required to make a decision for an incomplete itemization;
- If a denial of payment is for some reason other than a fee dispute, the reason for the denial;
- Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing; and
- The time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill per LC 4603.6.

Rule 9794(c)(1)-(6) also sets forth specific requirements for the objection and EOR, some of which overlap those listed in LC 4603.3. The requirements include:

- The basis for the objection to each contested procedure or charge;
- A clear description of any information required as a prerequisite to payment;
- The name, address and phone number of who to contact for additional information regarding the objection;
- The statement required by LC 4622(b)(1) regarding the right to seek second review and the procedures set forth in Rule 9792.5.5; and
- A statement that a request for 2nd review is a prerequisite to seeking Independent Bill Review (IBR) per LC 4603.6;
- A statement that if the provider doesn't seek 2nd review and the only issue in dispute is the amount of payment, the bill is deemed satisfied and there is no liability for any additional payment.

You may ask, "Why is the judge talking about the required content of an EOR?" Because it is VERY important in resolving medical-legal disputes, that's why. The new procedure for adjudicating medical-legal disputes mandates that ALL objections to the medical-legal charges, whether based upon a dispute as to the amount to be paid or a dispute as to whether liability for any payment at all exists, must be fully set forth in the **EOR** [LC 4622(a) and 8 CCR 9794(c)].

It is stated in 8 CCR 9794(f) that if the claims administrator denies liability for the medical-legal charge in whole or in part for any reason other than the amount to be paid per fee schedule, the denial must set forth the legal, medical, or factual basis for the decision in the EOR. This section also requires the EOR to state that the provider may object to the denial by notifying the claims administrator in writing of their objection within 90 days of the **service** of the EOR and that if the provider does not file a written objection with the claims administrator challenging the denial, neither the employer nor the employee are liable for the amount of the denied expense.

If an objection is not contained in the EOR, it is deemed waived (with very few exceptions) [8 CCR 10451.1(f)(1)(A), LC 4622(a) and 8 CCR 9794(c)]. A defense attorney's letter of objection to a medical-

legal report or medical-legal charge after an EOR has issued is useless to dispute liability for payment of charges. A form objection that does not identify the specific deficiencies of the report is not valid [8 CCR 9794(c)]. So, as a practice point, since claims administrators have 60 days within which to pay or object to medical-legal charges, they would be wise to carefully review the reports or refer them to their counsel for a determination as to whether there is some other basis to dispute the charges, other than just what is payable under the fee schedule.

Medical-legal expenses, per 8 CCR 10451.1(b), may include any cost or expense incurred by or on behalf of any party for the purpose of proving or disproving a contested claim, including but not limited to:

- Goods or services expressly specified by LC 4620(a);
- Services rendered by a non-medical expert witness (i.e., vocational expert, accident reconstruction expert, handwriting analysis, etc.)
- Services rendered by a certified interpreter during a medical-legal examination; and
- All costs or expenses for copying and related services.

Per 8 CCR 10451.1(c), the types of disputes that can arise with medical-legal charges include:

- The amount charged. These disputes are typically resolved via IBR procedures, unless there is no fee schedule for the goods supplied and/or services rendered.
- Whether there is a threshold issue that would entirely defeat a medical-legal expense claim. These disputes include employment, statute of limitations, insurance coverage, personal or subject matter jurisdiction. However, for the purposes of this section, a “threshold issue” shall not include a dispute over whether the employee sustained industrial injury or injury to a particular part of the body.
- Whether the claimed expense was actually incurred for the purpose of proving or disproving a contested claim, including a disputed medical fact.
- Whether the claimed expense was reasonably, actually, and necessarily incurred.
- Whether there has been waiver of any objection to the amount of the bill because defendant failed to comply with the relevant requirements, timelines, and procedures set forth in LC 4622 (pay or object within 60 days via EOR), 4603.3 (requirements for EOR), and 4603.6 (notification of IMR procedures) and the related AD Rules (Rule 10451.1).
- Whether the provider has waived any claim to further payment because of failure to comply with the relevant requirements, timelines, and procedures set forth in LC 4622 (timely object and request 2nd review of disputed charges per fee schedule) and 4603.6 (IBR procedures) and the related AD Rules (Rule 10451.1).
- Whether an interpreter who rendered services at a medical-legal exam did not meet the criteria established by LC 4620(d) and 5811(b)(2) and the Rules of the AD (Rule 9795.1 et seq.).
- If defendant contends an interpreter was not reasonably required at a medical-legal examination because the employee proficiently speaks and understands English.

Medical-Legal Dispute Procedures

Medical-legal expenses filed as liens before 1/1/13 remain liens and are handled as they have always been handled, per LC 4903.06(a). They are also subject to the requirement of paying the activation fee before 1/1/16 or else they are deemed dismissed by operation of law. This means, the medical-legal provider who filed a lien prior to 1/1/13 and paid their activation fee, may have to wait until the case-in-chief is finished before their disputes can be heard [8 CCR 10451.1(e)].

Per 8 CCR 10451.1(c)(3)(D), after 1/1/13, medical-legal providers are not required to file a lien. However, if they do decide to file a lien, they must pay the lien filing fee. The method of adjudicating medical-legal disputes on and after 1/1/13 is vastly different than in years past. Two important things to remember about medical-legal disputes: 1) if the dispute is just the amount to be paid under a fee schedule, all disputes are required to go through the IBR process set forth in LC 9794; 2) if the dispute is not about just the amount to be paid under a fee schedule, or if there is no fee schedule for the goods or services in issue, all disputes are considered non-IBR disputes and are required to go through the non-IBR medical-legal dispute procedures set forth in LC 9794 and 8 CCR 10451.1(c).

For the most part, most people are familiar with the regular IBR procedures, and I will merely touch on the basics, which are:

1. Provider sends fully-itemized and compliant billing to claims administrator attaching all information justifying the bill (such as medical report and testing results, photocopy order form and proof of efforts to get records directly from defense, proof of interpreter services used at med-legal exam with interpreter's qualifications/certification number, vocational expert report, etc.) [LC 4622 and 8 CCR 9793(l)].
2. Defendant must either pay the undisputed charges and object to disputed charges/services within 60 days of receipt or must pay the charges together with a 10% penalty and 7% interest [LC 4622].
3. ALL OBJECTIONS must be on defendant's initial fully-compliant EOR, which must be served within the 60-day period after receipt of the billing and itemization [LC 4622 and 8 CCR 9794(c)].
4. Provider has 90 days from date of service of the EOR to object to the EOR and request 2nd review [8 CCR 9792.5.5 and 9794].
5. Within 14 days of the request for 2nd review, defendant must respond with a final written determination on each of the items or amounts in dispute, including whether additional payment will be made [8 CCR 9792.5.5(g)].
6. Provider has 30 days after receipt of 2nd review to contest the amount paid and request IBR per LC 4603.6 (and pay the IBR fee).
7. If additional amounts are found payable after IBR, then defendant must reimburse the IBR fee. If no additional amounts are found payable, the IBR fee is not reimbursed [LC 4603.6(c)].
8. If defense fails to comply with time deadlines (and the requirement for a valid EOR to address all objections), they are considered to have waived their objections and must pay the bill in full, together with any penalties (10%) and interest (7%) [LC 4622(a) and 8 CCR 10451.1(f)].
9. If the provider fails to comply with time deadlines for initial objection or for 2nd review, they are deemed to have waived any objection based on the amount payable and the bill is deemed satisfied and neither the employee or employer is liable for any further payment [8 CCR 9792.5.5(e) and 10451.1(f)].

If defendant objects to the medical-legal charge in whole or in part for any reason **other** than the amount to be paid per any applicable fee schedule, the following is the basic non-IBR medical-legal dispute procedure:

1. Provider sends a fully itemized and compliant billing with all information justifying the bill.
2. Defendant has 60 days from date of receipt to pay undisputed amounts and object to disputed charges/services or must pay the charges with 10% penalty and 7% interest [LC 4622(a)].
3. ALL OBJECTIONS must be on defendant's initial fully-compliant EOR, which must be served within the 60-day period after receipt of the billing and itemization [LC 4622(e) and 8 CCR 9794(f)].

4. Provider has 90 days from date of service of the EOR to object to the EOR (NOTE: There is no requirement to request a 2nd review if it is a non-IBR dispute) [8 CCR 9794(f) and 10451.1(c)].
5. If provider timely objects to denial of their charges for any reason other than the amount to be paid per a fee schedule in effect on the date services were provided, DEFENDANT is required to file a Petition for Determination of Non-IBR Medical-Legal Dispute ***and*** a Declaration of Readiness to Proceed (DOR) within 60 days of service of the provider's objection [8 CCR 10451.1(c)(2)]. A copy of the provider's objection and proof of service (POS) must be appended to the petition (and remember that all petitions are required to be verified, per 8 CCR 10450). The petition must be concurrently served on the provider, the employee/dependent, any other defendants, and any attorneys or representatives for these persons.
6. Failure by defendant to file the petition and DOR after provider timely objects to defendant's EOR regarding a non-IBR med-legal dispute means that defendant has waived all objections relating to a medical-legal provider's billing, other than any amount to be paid per a fee schedule in effect [8 CCR 10451.1(f)].
7. If defendant does not comply with the requirement to file a petition and DOR within 60 days of service of provider's objection to the EOR, then the provider may file a Petition for Determination of Non-IBR Medical-Legal Dispute. The provider petitioner is not required to file a DOR, but they may [8 CCR 10451.1(c)(3)].
   NOTE: It is strongly encouraged that when a med-legal provider sends a notice of objection to defendant's EOR in a non-IBR med-legal dispute, that they file a Notice of Representation or Notice of Self Representation with the board (as a "biller" or "Non-IBR Medical-Legal Provider" and NOT as a "lien claimant") so that they can be added to the Official Participants List (Official Address Record) and receive service of any notices of hearing that may issue in response to any filing of a DOR or may receive any pertinent orders or dispositions from the board.

Failure to follow these procedures has potentially-serious negative ramifications to both defendant and to the medical-legal provider. Rule 10451.1 (g) provides for the payment of sanctions, attorney's fees and costs for bad faith actions or tactics. Listed actions that may be construed as "bad faith" include, but are not limited to the following:

- Failing to timely pay any uncontested portion of a medical-legal provider's billing.
- Failing to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures.
- Contesting liability for the medical-legal provider's billing based on a dispute over injury or injury to a particular body part.
- A provider inappropriately asserts that a defendant failed to comply with the requirements, timelines and procedures.

These sanctions, fees and costs are in addition to any penalties and interest that may apply. The Rule also states that sanctions after the effective date of this section (10/23/13) shall not be less than $500.00.

A judge can defer hearing and determination of non-IBR medical-legal disputes **only** if there is a "threshold issue" within the meaning of 8 CCR 10451.1(c)(1)(a) (see definition above). Remember, a "threshold issue" **shall not** include a dispute over whether the employee sustained industrial injury or injury to a particular body part.

Keep in mind, if there is a problem with the admissibility of a medical-legal report, or if there is a dispute over whether or not a report actually meets the definition of a medical-legal report (for example, that of

a treating physician), that dispute should be determined and decided ***before*** the case is submitted, so that the record can be further developed, if necessary, to accomplish due process and substantial justice. If there is a basis to strike a Panel QME report for not meeting a requirement under the QME regulations or a claim that the report is not valid under LC 4628, and a new PQME is required, doesn't it make sense to get that issue decided and obtain a new evaluation and report before the case is submitted? Parties need to remember that failure to raise ALL objections in the **EOR** is construed as waiver (with very few exceptions), so unless parties want to be stuck with reports for which objections have been waived, either intentionally or unintentionally, these disputes need to be timely and appropriately raised and adjudicated so that the ultimate record is not a complete mess when brought to a judge at trial.

Frankly, speaking for myself and for no other judge, it is easier to decide multiple limited disputed issues earlier in the litigation process than it is to try to "make silk purses out of sows' ears" (to use a hackneyed, but all-too-true cliché), after the record is an absolute mess. No judge appreciates a horrible record and, in my experience, the earlier such disputes are addressed and the "cleaner" the record, the more likely the case is to settle. Even if the case doesn't settle, the issues will be narrowed and the record more complete and less messy.

In closing, I would like to offer some "pearls of wisdom" or practice points when addressing medical-legal disputes:

- Any time-sensitive document, for which the timing of service is of critical importance, should be served via Proof of Service. A valid Proof of Service is the cheapest insurance I know to prove service of a document. It shifts the burden to the opposition to prove it wasn't served, which is VERY difficult, if not impossible, to do. Keep in mind the requirements of 8 CCR 10505(d) regarding documents served by a party or lien claimant by mail and how proof of mail service may be made.
- All petitions must be verified (Rule 10450) and have a proof of service showing service on all necessary participants.
- If a medical-legal provider wants to get on the Official Participants Listing, they must file a Notice of Representation or Notice of Self Representation as soon as the dispute arises, otherwise they may not get notice of any hearing set pursuant to any petition for non-IBR med-legal dispute. They should clearly identify themselves as a "biller" or "Non-IBR Medical-Legal Provider" (whichever applies). They should NOT identify themselves as a "lien claimant."
- I have NEVER seen a defendant file a petition for determination of non-IBR med-legal dispute and we see only a few of these types of petitions and DORs filed by providers. I don't know whether this is because defendants don't know the rules or whether medical-legal providers don't know the rules (or both). What I do know, however, is that the negative ramifications for not engaging in the appropriate process to resolve medical legal disputes can be quite serious and costly to both defendant and the medical-legal provider. The workers' compensation community needs more education to recognize and appropriately address these disputes.
- Many DWC employees (i.e., clerks who process petitions and DORs, and even judges who get tasks or hearings set pursuant to such petitions and DORs) do not all fully understand that these disputes are not lien disputes and that there is a procedure to address them before the case-in-chief is concluded. More education is needed. If you are a medical-legal provider and are pursuing this method of dispute resolution and a judge wants to defer the issue and the issue is NOT a threshold issue (per 8 CCR 10451.1(c)(1)(a)) and says that it is a

lien issue and must wait until the case-in-chief resolves (and orders the matter off calendar or inappropriately defers a non-threshold issue), you have two options. You can either diplomatically ask the judge to review Rule 10451.1(c)(4) (and read this article) or you can consider filing a Petition for Removal. Per this rule, only threshold issues, specifically defined (see above), are supposed to be deferred.

NOTE: Remember, a Petition for Removal is the appropriate appeal of an interim, non-final order, and one must show substantial prejudice or irreparable harm for which reconsideration will not be an adequate remedy after the issuance of a final order, decision or award.

- Lastly, think of the reasons why we want non-IBR medical-legal issues resolved sooner, rather than later in the claim. In addition to the reasons stated earlier in the article, we all want to keep good quality medical-legal evaluators in our system, whether AMEs, QMEs or PTPs. Prompt payment of their appropriate charges and expedient adjudication of disputes over their charges or services is one way to do that. Judges are supposed to report to the Medical Unit when QMEs are not complying with the QME regulations or their reports are stricken for not being substantial evidence or for not complying with appropriate laws or rules. This is because the Medical Unit has a vested interest in ensuring that physicians who achieve QME status continue to meet the standards to maintain their qualification to evaluate California's injured workers. Thus, it is important that problems with QMEs be discovered early and reported to the Medical Unit as they arise so that appropriate steps can be taken by the Administrative Director and/or Medical Unit to notify the physician of problems, suggest needed re-training, or pursue discipline (up to and including suspension or revocation of their QME status) if the physician cannot meet required standards.

We all need to do our part to work within the Labor Code, Regulations and Rules to accomplish our universal goal, which is to efficiently and expeditiously deliver appropriate benefits to injured workers and to quickly resolve disputes.