

2018 DWC PRIORITIES



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PROPOSED CHANGES TO THE MEDICAL- LEGAL FEE SCHEDULE

<http://oak01web/dwc/DWCWCABForum/Reimbursement-of-Medical-Legal-Expenses.htm>

8 C.C.R. section 9794 - Reimbursement of Medical-Legal Expenses.

(a) (3) No other charges shall be billed under the Official Medical Fee Schedule in connection with a medical-legal evaluation or report.

New regulatory text. No prior regulation.

8 C.C.R. section 9795 - Reasonable Level of Fees

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. If prior agreement of the parties is required under any provision of this regulation, the physician may not condition performance of the evaluation on receipt of prior agreement of the parties.

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.

ML 101 - Follow-Up Medical-Legal Evaluation:

No more than 3 hours may be billed for report preparation under this code.

New regulatory text. Addition to prior regulation

ML 103 - Complex Comprehensive Medical Legal Evaluation

In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed which made these complexity factors applicable to the evaluation.

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.

ML 103(2) - Record Review

2) Two or more hours of record review by the physician. An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;

2) Two or more hours of record review by the physician;

ML 103(3) - Medical Research

(3) Two or more hours of medical research by the physician, using sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon this complexity factor. An evaluator who specifies this complexity factor must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;

(3) Two or more hours of medical research by the physician;

ML 103(4) - Combining Complexity Factors

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. Any complexity factor used as a stand-alone may not be used in combination under this subdivision

(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;

ML 103(5) - Combining Complexity Factors:

Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, provided that some portion of time has been devoted to each of the three factors. Any complexity factor used as a stand-alone may not be used in combination under this subdivision;

5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;

ML-103(6) - Addressing the Issue of Medical Causation

Addressing and providing an analysis of the issue of medical causation, provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation;

(6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report;

ML 103(7) - Addressing the Issue of Apportionment

7) Addressing the issue of apportionment, when items (A) and (B) below both apply:

(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the claimant's employment by three or more employers, (ii) three or more dates of injury to the same body system or body region as delineated in the chapter headings of the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference], or (iii) two or more dates of injury involving two or more body systems or body regions as delineated in that Table of Contents.

(B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.

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.

ML 104(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 actually and necessarily incurred for the production of the medical-legal report and required for the evaluation, and the circumstances which made these complexity factors uniquely and specifically applicable to the actual evaluation being performed. The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be billed for report preparation.

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.

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. The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be billed for report preparation;

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;

ML 104(3) - Extraordinary Circumstances

A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the start of the evaluation, that the evaluation involves extraordinary circumstances. Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request. When billing under this subdivision of the 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.

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.

ML 106 - Supplemental Medical Legal Evaluations

...(B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation. No more than three hours may be billed for report preparation under this code. No more than two hours may be billed for medical research under this code. In order to bill for medical research under this code, the physician must use sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon medical research in billing. An evaluator who bills for medical research under this code must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon.

...(B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

Anti-Fraud Measures

Automatic Stay of Liens

- Labor Code section 4615
- Liens filed by physicians or providers who are criminally charged with workers' compensation fraud, medical billing fraud, insurance fraud, and Medicare or MediCal fraud automatically stayed pending the disposition of criminal case.

Provider Suspension

- Labor Code section 139.21
- California Code of Regulations, title 8, sections 9788.1 – 9788.4
- Convicted of any felony or misdemeanor that involves fraud or abuse of Medi-Cal, Medicare, or workers' compensation system, or fraud or abuse of any patient; license revoked or suspended; suspended, due to fraud or abuse, from Medicare or Medicaid programs

Anti-Fraud Measures

Lien Consolidation Proceedings

- If the disposition of the criminal proceedings provides for dismissal of liens, the liens will be dismissed with prejudice by operation of law.
- If the disposition of the criminal proceedings doesn't address the disposition to be made of the liens pending in the workers' compensation system, the liens will be identified, consolidated and subjected to special lien adjudication proceedings.
- Presumption that liens connected with criminal activity

Lien Declaration

- Labor Code section 4903.05
- <http://www.dir.ca.gov/dwc/SB1160-AB1244/SB1160.htm>
- All liens for medical treatment subject to the filing fee, must be accompanied by a declaration signed under penalty of perjury affirming that the dispute is not subject to independent bill review and verifying that the lien claimant is eligible to file that lien.

Anti-Fraud Measures

Lien Declaration (cont.)

- The declaration requires that the entity filing the lien indicate on what basis they are eligible to file the lien.
- The failure to file the declaration will result in the dismissal of the lien with prejudice. The filing of a false declaration will serve as grounds for dismissal of the lien with prejudice.

Labor Code section 4603.2

- An employer may object to any bill submitted by or on behalf of a provider who has been suspended under section 139.21 and may defer objecting to or paying any bill for a provider whose liens are stayed pursuant to section 4615.

MTUS Update

- The MTUS is a set of regulations found within the California Code of Regulations.
- Contains definitions, establishes the primary role of the **treatment guidelines** in the MTUS, provides a **Medical Evidence Search Sequence** and a **Methodology for Evaluating Medical Evidence** when there are conflicting recommendations.
- Is based on the principles of evidence-based medicine (EBM).
- Adopts and incorporates by reference the treatment guidelines of the American College of Occupational and Environmental Medicine

Evidence-Based Updates to the MTUS

ACOEM Treatment Guidelines (Adopted effective December 1, 2017)

Cervical and Thoracic Spine Disorders Guideline

Shoulder Disorders Guideline

Elbow Disorders Chapter

Hand, Wrist, and Forearm Disorders Guideline

Low Back Disorders Guideline

Knee Disorders Guideline

Ankle and Foot Disorders Guideline

Eye Disorders Chapter

Chronic Pain Medical Treatment Guideline

Opioids Treatment Guideline

Initial Approaches to Treatment

Hip and Groin Guideline

Occupational/Work Related Asthma Guideline

Occupational Interstitial Lung Disease Guideline

Evidence-Based Updates to the MTUS

These Guidelines have been added:

Hip and Groin Guideline

Occupational/Work Related Asthma Guideline

Occupational Interstitial Lung Disease Guideline

These Guidelines have been deleted because these treatments are addressed in the other guidelines:

Acupuncture Medical Treatment Guidelines

Postsurgical Treatment Guidelines

NOTE: Stress Related Conditions Guideline has no replacement. ACOEM's updated guideline is not yet ready, but psychological treatment and evaluation related to chronic pain is addressed in the Chronic Pain Guideline.

MTUS Drug Formulary

MTUS Drug Formulary applies to drugs dispensed on or after January 1, 2018

Applies to all DOIs (except as specified for ongoing course of treatment)

For DOIs before 1/1/2018, if injured worker is on an ongoing course of treatment with Non-Exempt drug, unlisted drug, or compounded drug, the treatment is subject to the phased implementation rule

MTUS Drug Formulary applies only to drugs *dispensed* for *outpatient use* at home or outside a clinical setting

Not applicable to physician-administered drugs

Not applicable to drugs self-administered within a facility, e.g. hospital

MTUS rules other than formulary rules apply to physician-administered drugs

MTUS Drug Formulary

ACOEM Treatment Guidelines – The Backbone

Presumed correct on scope of medically necessary treatment

MTUS Drug List – guides the prospective review requirements

“Exempt” drugs – No Prospective Review if in accord with MTUS

“Non-Exempt” & Unlisted Drugs – Prospective Review required

“Special Fill” & “Perioperative Fill” of specified Non-Preferred drugs

Ancillary Formulary Rules

Special Fill policy

Perioperative Fill policy

Physician dispensed drugs

Generic/Brand selection

Compounded drugs

Off-label use of drugs

Utilization Review

- **Reporting UR Data to DWC**
 - Mandatory electronic reporting of UR data by claims administrators to DWC.
- **Electronic Medical Reporting**
 - Labor Code section 6409.1
 - The current Doctor's First Report to be submitted electronically to both the DWC and the employer's claim administrator
- **Combined RFA and PR-2: PR-1**

Utilization Review

- **Limited UR Within First 30 Days of DOI**
- Effective 1/1/2018, prospective UR would not be required for emergency services, medications as designated under the new formulary, and services provided by a predesignated physician, MPN or HCO providers, or employer-selected physicians or facilities within 30 days of the initial date of injury.
- The services must relate to an accepted body part or condition that is addressed by the MTUS, and the treatment plan must be outlined in the report required by Section 6409 and accompanying request for authorization. All treatment rendered must be consistent with the MTUS.

Utilization Review

- Specific services, such as surgery, psychological treatment, home health care, MRIs, and DMEs over a total expenditure of \$250 based on OMFS pricing, would require prospective UR
- Bills for treatment rendered under this provision must be submitted within 30 days of the treatment date
- Providers who fail to timely submit the report and request for authorization outlining the treatment plan may lose their ability to provide treatment to that injured employee that is exempt from prospective UR during the remainder of the 30-day period.

Utilization Review

- An employer may conduct retrospective UR for any treatment provided solely for the purpose of determining if the provider is prescribing treatment consistent with the MTUS.
- If providers have a pattern and practice of providing treatment inconsistent with the MTUS, they could lose their ability to provide UR-exempt treatment for any employees or be removed from the MPN. Additionally an employer has the option to file a petition requesting a change of physician.

Utilization Review

- **UR Process Changes**
- Formulary treatment requests are subject to expedited UR and IMR, requiring a decision within five days from receipt of the treatment request.
- Decisions denying treatment due to lack of sufficient information to make a medical necessity determination must include a specific description of the information needed and document details regarding the attempt to obtain the information.

Utilization Review

- A UR decision to modify or deny treatment remains in effect for 12 months with no action needed on similar request by the same physician or another physician within the requesting physician's practice group, unless there is a documented change in material facts.
- Employers and Utilization Review Organizations (UROs) are prohibited from offering financial incentives to physicians based on the number of UR denial or modification decisions they issue.

Utilization Review

- Claims administrators cannot refer matters to a UR entity in which the claims administrator has a financial interest unless there is a prior written disclosure to the employer and AD of the name of the UR entity and the financial interest in the UR entity.
- The AD has authority to review contracts between the UR physician and the claims administrator or employer for purposes of enforcing these provisions.
- URAC and DWC approval for UR plans. Certain nonprofit, public sector internal UR programs may be exempted from the accreditation requirement.

Interpreter Regulations

- Labor Code section 5811
- Fixed fee structure except by mutual agreement
- Billing Codes and Detailed Invoices
- Uniform Fee Rates – one for certified, one for provisional
- IBR for medical treatment and medical-legal bills
- Emphasis on certified interpreters over provisionally certified. Rule of 3. Exhaustion of alternative ways to obtain certified interpreters
- Restriction on claims for multiple double billing
- Verification of interpreter credential