

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION**

**INITIAL STATEMENT OF REASONS**

**Subject Matter of Regulations: Workers' Compensation –  
Medical-Legal Fee Schedule**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS  
SECTIONS 9793, 9795**

Section 9793	Definitions
Section 9795	Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

**BACKGROUND TO REGULATORY PROCEEDING:**

The adjudication of workers' compensation claims requires the use of written reports of Qualified Medical Evaluators (QME's). The fees for preparing the written reports and the rules for determining the fees have been established by Title 8, California Code of Regulations, §§ 9793 and 9795. The fees were last changed in August, 1993.

Pursuant to Labor Code §§ 4060, 4061, 4062, 4062.01, 4062.1, 4062.1, 4062.2, 4062.3, as amended by Chapter 34, Stats. 2004, (SB 899), for evaluations made after January 1, 2005, unless the injured employee and the employer agree upon an Agreed Medical Evaluator (AME), both the injured employee and the employer, if the employee is represented, are to select a QME from a panel of three chosen at random by the Administrative Director. An unrepresented employee is to select one QME from a panel of three. Previously, only the unrepresented employee had to select a QME from an Administrative Director's panel of three. If the employee were represented, neither the employee nor the employer selected a QME from an Administrative Director's panel of three. QME's are now required to resolve every disputed case.

Before the enactment of SB 899, physicians evaluated permanent disability (upon which permanent disability indemnity is based) by describing the existing disabilities of the employee under guidelines of the Administrative Director, and evaluated apportionment of the permanent disability to other disabilities generally only if the other disabilities had already manifested themselves as labor-disabling as of the date of injury. SB 899 required physicians, instead of evaluating permanent disability, to evaluate impairment using the Guidelines of the American Medical Association. Physicians are now required to apportion disability not only to existing labor-disabling permanent disability, but also to any other pathology which is an impairment,

even if not then labor-disabling. These evaluations and reports take more time to complete than those required in 2004.

The Administrative Director (formerly the Industrial Medical Council) appoints QME's from physician applicants who successfully pass a QME examination administered periodically by the Administrative Director. Since the enactment of SB 899, the number of physician applicants for the examination has decreased by 64%. The number of QME's has decreased by 11.6%. (Statistics of the office of the Manager, Medical Unit, Division of Workers' Compensation.)

## **Section 9793                    Definitions**

### Specific Purpose of amendments to Section 9793:

Section 9793 lists the terms used in the regulations and defines the terms as they are used in the regulations. The purpose of the definitions is to ensure that the meaning of the terms is clearly understood by the regulated community. The definition of *Claim* is changed to correct a typographical error in the text. Paragraph (3) of the definition of *Contested claim* is changed to correct a typographical error in the text. *Claims administrator*, is changed to make it identical to the definition used in other regulations of the Division of Workers' Compensation. *Primary treating physician* is changed to correct an error – it now refers to a repealed regulations. It is changed to refer to a term in a current regulation.

### Necessity:

It is necessary to define the key terms used to ensure that the content and meaning of the regulations are clearly understood by the regulated community. It is necessary that the definition of *Claim* be changed to use the coordinating conjunction *or* instead of the proposition *of*, so that it correctly mirrors the language of Labor Code sections 5400 and 5402. It is necessary that paragraph (3) of the definition of *Contested claim* be changed to correct the typographical error which referred to an injury of an *employer*, when it was intended to refer to an injury of an *employee*. It is necessary for efficient administration of workers' compensation programs, that different subject areas of regulations have the same definition for the commonly used term, *claims administrator*. It is necessary that the definition of *primary treating physician* be changed so that it no longer will refer to a non-existent regulation.

### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted drafts of the proposed regulations on its website to allow for pre-notice public comment.

### Business Impact:

The changes to this regulation will have no impact on business, because these changes to the definitions will not have any substantive effect.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The present rulemaking process solicits alternatives to be considered.

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

Specific Purpose of amendments to Section 9795:

The purpose of Section 9795 is to set forth the parameters for different types of medical-legal evaluation, and the fees to be allowed for the evaluations. The purpose of changing the multiplier from \$10.00 to \$12.50 is to increase the fees for the evaluations by 25%.

The section is partially rewritten and renumbered, without regulatory effect, for clarity. In two places, the computation of hourly fees now requires rounding to the nearest quarter hour. The purpose of this change is have a more uniform system of computing the fees for hourly work.

If an evaluator is billing for two or more hours of research, the evaluator must now list the references consulted. This is to provide a means of assuring that the research was appropriate and the time spent reasonable.

*Extraordinary circumstances* and consideration of a *complex issue of medical causation* were deleted as reasons for an evaluation being classified as an ML 104 because the terms are too vague and are susceptible of different interpretations.

Evaluators are now required to state at the beginning of the report what the four factors of complexity are, so that the reports may be more speedily processed by claims administrators.

Two new categories of evaluation are created, the ML 105 and ML 106, for clarity. The functions of medical testimony and supplemental evaluations were moved into these two new categories from their status in the current regulation as modifiers. The new categories make clear that these activities are reimbursed at the RV 5 rate, which does not represent a change from the previous treatment.

Fees for duplicate copies of reports were changed from a prescribed rate, to the rate prescribed for duplicate copies in the Official Medical Fee Schedule, to make the charges more equitable, since now all requests for duplicate copies would be charged at the same rate.

Necessity:

Labor Code §5307.6 requires the Administrative Director to adopt and revise a medical-legal fee schedule. In the twelve years since the multiplier was set at \$10.00, there has been substantial inflation, and the medical-legal fees no longer represent reasonable compensation for the services performed. The change to include rounding to the nearest quarter hour for hourly fees is necessary to ensure uniformity in payment for similar amounts of time.

It was necessary to require the evaluator to list the research references consulted to allow payers to be assured of the reasonableness of the research and the time spent.

It was necessary to delete *extraordinary circumstances* and consideration of a *complex issue of medical causation* from the reasons for an evaluation being classified as an ML 104, to make more objective the determination of whether an evaluation qualifies as ML 104.

It was necessary to require evaluators to list the four factors of complexity at the beginning of the report, to make it easy for readers of the report quickly to determine that the evaluation qualified for ML 104 status.

It was necessary to create the two new categories of evaluation, ML 105 and ML 106, for clarity.

It was necessary to change the means for determining the fee for duplicate copies of reports in order to make it more consistent with charges for duplicate reports in the Official Medical Fee Schedule.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

*2005 Legislative Cost Monitoring Report*, Workers' Compensation Insurance Rating Bureau, September 15, 2005.

E-Mail of 10-11-05 from Sue Honor to Richard Starkeson, re: Number of QME's

E-Mail of 10-12-05, from Sue Honor to Richard Starkeson, re: current number of QME's

E-Mail of 10-12-05 from Joanne Van Raam to Richard Starkeson, re: QME Exam statistics

The Division of Workers' Compensation posted drafts of the proposed section on its website to allow for pre-notice public comment.

Business Impact:

This regulation increases the fees for medical-legal evaluations by 25%. Workers' compensation insurance companies and self-insured employers will have their costs for medical-legal evaluations increased by 25%. California physicians who perform workers' compensation evaluations, will receive 25% more for performing these evaluations.

The changes to this regulation will not have a significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states, because the fees apply only to insurance companies, which are very large businesses, and to self-insured employers, which are businesses large enough to qualify for self-insurance by making large security deposits, and because although the fees for medical-legal evaluations will generally increase by 25%, the total cost of these evaluations in California is only four per cent of total workers' compensation costs.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

Labor Code §5307.6 directs the Administrative Director to adopt and revise a medical-legal fee schedule.