Division of Workers' Compensation
Administrative Director - Administrative Rules
Title 8 California Code of Regulations
Chapter 4.5, Subchapter 1
Article 5.5, Article 5.6

§9791.1 Medical fee Schedule

The Official Medical Fee Schedule shall include the procedures, procedure numbers, descriptions, instructions, and unit values adopted by the Administrative Director, effective January 1, 1994; as revised for services on or after January 1, 1996; and as thereafter revised and adopted. The Official California Workers' Compensation Medical Fee Schedule (Revised April 1, 1999, and as amended for dates of service on or after July 12, 2002) is hereby incorporated by reference. An order form for purchasing a copy of the Schedule can be obtained by contacting the Division of Workers' Compensation at the following address:

DIVISION OF WORKERS' COMPENSATION
(ATTENTION: OMFS ORDER)
P.O. BOX 420603
SAN FRANCISCO, CALIFORNIA 94142

The amendments to the OMFS for dates of service on or after July 12, 2002 may be obtained either by purchasing them from the Division or they may be downloaded at no charge from the Division's website at (http://www.dir.ca.gov/workers'_comp.html).

Note: Authority cited: Sections 133, 4603.5, 5307.1 and 5307.3, Labor Code. Reference: Sections 4600, 4603.2 and 5307.1, Labor Code.

§9792.5. Payment for Medical Treatment.

(a) As used in this section:

(1) "Claims Administrator" has the same meaning specified in Section 9785(a)(3).

(2) "Medical treatment" means the treatment to which an employee is entitled under Labor Code Section 4600.

(3) "Physician" has the same meaning specified in Labor Code Section 3209.3.

(4) "Required report" means a report which must be submitted pursuant to Section 9785.

(5) "Treating physician" means the "primary treating physician" as that term is defined by Section 9785(a)(1).

(b) Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator within sixty days from receipt of each separate itemized bill and any required reports, unless the bill is contested, as specified in subdivisions (d), and (e), within thirty working days of receipt of the bill. Any amount not contested within the thirty working days or not paid within the sixty day period shall be increased 10%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill.

For purposes of this Section, treatment which is provided or authorized by the treating physician includes but is not limited to treatment provided by a "secondary physician" as that term is defined by Section 9785(a)(2).

(c) To be properly documented, a bill for medical treatment which exceeds the amount presumed reasonable in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1, must be accompanied by an itemization and explanation for the excess charge.

(d) A claims administrator who objects to all or any part of a bill for medical treatment shall notify the physician or other authorized provider of the objection within thirty working days after receipt of the bill and any required report and shall pay any uncontested amount within sixty days after receipt of the bill. If a required report is not received with the bill, the periods to object or pay shall commence on the date of receipt of the bill or report, whichever is received later. If the claims administrator receives a bill and believes that it has not received a required report to support the bill, the claims administrator shall so inform the medical provider within thirty working days of receipt of the bill. An objection will be deemed timely if sent by first class mail and postmarked on or before the thirtieth working day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth working day after receipt. Any notice of objection shall include or be accompanied by all of the following:

(1) An explanation of the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or authorized provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation shall include both the code reported by the provider and the code believed reasonable by the claims administrator.

(2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.

(3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.

(4) A statement that the treating physician or authorized provider may adjudicate the issue of the contested charges before the Workers' Compensation Appeals Board.

(e) An objection to charges from a hospital, outpatient surgery center, or independent diagnostic facility shall be deemed sufficient if the provider is advised, within the thirty working day period specified in subdivision (d), that a request has been made for an audit of the billing, when the results of the audit are expected, and contains the name, address, and telephone number of the person or office to contact for additional information concerning the audit.

(f) Any contested charge for medical treatment provided or authorized by the treating physician which is determined by the appeals board to be payable shall carry interest at the same rate as judgments in civil actions from the date the amount was due until it is paid.

NOTE: Authority cited: Sections 133, 4603.5, and 5307.3, Labor Code. Reference: Sections 4603.2, and 5307.1, Labor Code.

§9793. Definitions

As used in this article:

(a) "Claim" means a claim for compensation as evidenced by either the filing of a claim form pursuant to Section 5401 of the Labor Code or notice of knowledge of an injury under Section 5400 or 5402 of the Labor Code.

(b) "Contested claim" means any of the following:

(1) Where the claims administrator has rejected liability for a claimed benefit.

(2) Where the claims administrator has failed to accept liability for a claim and the claim has become presumptively compensable under Section 5402 of the Labor Code.

(3) Where the claims administrator has failed to respond to a demand for the payment of compensation after the expiration of any time period fixed by statute for the payment of indemnity benefits, including where the claims administrator has failed to either commence the payment of temporary disability indemnity or issue a notice of delay within 14 days after knowledge of an employer's injury and disability as provided in Section 4650 of the Labor Code.

(4) Where the claims administrator has accepted liability for a claim and a disputed medical fact exists.

(c) "Comprehensive medical-legal evaluation" means an evaluation of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (B) is either:

(1) performed by a Qualified Medical Evaluator pursuant to subdivision (h) of Section 139.2 of the Labor Code, or

(2) performed by a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician for the purpose of proving or disproving a contested claim, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (g).

(d) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, a group self-insurer, or a third-party claims administrator for a self-insured employer, insurer, legally uninsured employer, group self-insurer, or joint powers authority.

(e) "Disputed medical fact" means an issue in dispute, including an objection to a medical determination made by a treating physician under Section 4062 of the Labor Code, concerning (1) the employee's medical condition, (2) the cause of the employee's medical condition, (3) treatment for the employee's medical condition, (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition, or (5) the employee's medical eligibility for rehabilitation services.

(f) "Follow-up medical-legal evaluation" means an evaluation which includes an examination of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606, (B) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician within nine months following the evaluator's examination of the employee in a comprehensive medical-legal evaluation and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive medical- legal evaluation.

(g) "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for 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. 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 of the following conditions exist:

(1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.

(2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive

medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.

(3) The report is 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, as required by applicable statutes, regulations, and case law.

(4) The medical-legal examination is 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.

(5) In the event the comprehensive medical-legal evaluation is served on the claims administrator after the disputed medical fact or facts for which the report was requested have been resolved, the report is served within the time frame specified in Section 139.2(j)(1) of the Labor Code.

(h) "Medical-legal testimony" means expert testimony provided by a physician at a deposition or workers' compensation appeals board hearing, regarding the medical opinion submitted by the physician.

(i) "Primary treating physician" is the treating physician primarily responsible for managing the care of the injured worker in accordance with Section 9785(a)(1).

(j) "Reports and documents required by the administrative director" means an itemized billing, a copy of the medical-legal evaluation report, and any verification required under Section 9795(c).

(k) "Supplemental medical-legal evaluation" means an evaluation which (A) does not involve an examination of the patient, (B) is based on the physician's review of records, test results or other medically relevant information which was not available to the physician at the time of the initial examination, (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

NOTE: Authority cited: Sections 133, 4627, 5307.3 and 5307.6, Labor Code. Reference: Sections 4061, 4061.5, 4062, 4620, 4621, 4622, 4625, 4628, 4650, 5307.6 and 5402, Labor Code.

§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.

(b) The fee for each evaluation is calculated by multiplying the relative value by $10.00, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure is all inclusive, and includes reimbursement for the examination, review of records, preparation of a medical-legal report, including 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.

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

CODE	B.R.	PROCEDURE DESCRIPTION
ML100		*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.

CODE	RV	PROCEDURE DESCRIPTION
ML101	**5**	*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. 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.

CODE	RV	PROCEDURE DESCRIPTION

ML102	**50**	*Basic Comprehensive Medical-Legal Evaluation*. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
CODE	**RV**	**PROCEDURE DESCRIPTION**
ML103	**75**	*Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the following complexity factors: The physician shall, in a separate section at the beginning of the report, clearly and concisely specify three or more of the complexity factors listed below which were required for the evaluation and the circumstances which made these complexity factors applicable to the evaluation. (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, or if a bona fide issue of medical causation is discovered in the evaluation; (7) addressing the issue of apportionment, upon written request of the party or parties requesting the report, or if a bona fide issue of apportionment is discovered in the evaluation. (8) addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances; (9) a psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

CODE	RV	PROCEDURE DESCRIPTION
ML104	5	Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances; Medical-Legal Testimony; Supplemental Medical-Legal Evaluations. 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 spent by the physician for any of the following: (1) Fees for comprehensive medical-legal evaluations where there are extraordinary circumstances relating to the medical condition being evaluated. Evaluations which typically involve extraordinary circumstances include the following examples as well as evaluations of comparable complexity: a. An evaluation which requires four or more of the complexity factors listed under ML 103; b. An evaluation involving prior multiple injuries to the same body part or parts being evaluated, or a complex issue of medical causation, 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; c. An agreed medical evaluation which is obtained after each party has obtained its own evaluation, which involves complex issues of medical causation or apportionment; d. An agreed medical 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. (2) Fees for medical-legal testimony. 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.

(3) Fees for supplemental medical-legal evaluations. 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.

(d) The services described by Procedure Codes ML101 through ML104 may be modified under the circumstances described in this subdivision. When applicable, the modifying circumstances should 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. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by .80, except where services are performed under ML 104.

-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 not be applicable to ML 101 or ML104.

-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, 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 for an uncontested claim. This modifier should be added to the code reflecting the appropriate level of evaluation performed. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

-96 Modifier for medical-legal testimony. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-97 Modifier for supplemental medical-legal evaluations. This modifier is added solely for identification purposes, and does not change the normal value of the procedure.

(e) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable. Where the payer requests an additional copy of the report, the payer shall reimburse for the duplicate report at $10.00 for up to the first 15 pages. Pages in excess of 15 pages shall be reimbursed at $0.25 per page.

(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. Amendments to this section shall apply to medical-legal evaluation reports where the examination to which the report refers occurs on or after the effective date of the amendments and to medical-legal testimony where such testimony occurs on or after the effective date of the amendments. The 1999 amendments to this section shall apply to medical-legal evaluation reports where the medical examination to which the report refers occurs on or after April 1, 1999, and to medical-legal testimony on or after April 1, 1999.

NOTE

Authority cited: Sections 133, 4627, 5307.3 and 5307.6, Labor Code. Reference: Sections 139.2, 4061, 4061.5, 4620, 4621, 4622, 4625, 4626, 4628 and 5307.6, Labor Code.