# Introduction

The transcript that appears below is an unofficial transcript that may have been edited for clarity. This DWC hosted Question and Answer meeting was for informational purposes only.

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Jurisdiction over fee disputes lies with the WCAB pursuant to the Labor Code and regulations addressing Independent Bill Review.

George Parisotto: Good afternoon, and thank you for joining us today on our Q&A session regarding the new medical legal fee schedule which went into effect on April 1st, just about a week or so ago. Generally I'd say, well let's give everybody a minute, wait for the audience to quiet down since we have mute buttons, you know it works really well, so we can just jump into it. I am George Parisotto. I'm the Administrative Director of the Division of Workers’ Compensation. I'm joined here today by our Executive Medical Director, Dr. Raymond Meister, and two of our attorneys from our division’s legal unit, Winslow West and Nicole Richardson, who many of you probably know. We are joined by Dr. Steven Feinberg, an AME and QME in our system and a real valuable stakeholder to us. And so we'd like to just jump in. I don't think I need to provide much of a background because probably everybody on this call is familiar with our fee schedule and probably has a lot of questions about that. So, with that I will turn it over to our attorneys, Winslow and Nicole.

Nicole Richardson: Hello, we would like to do a quick disclaimer here that this presentation and any opinions expressed are solely those of the presenters and not necessarily the positions of the State of California, Department of Industrial Relations, Division of Workers Compensation or any other entity or individual. This information is intended to be a reference tool only and is not meant to be relied upon as legal advice. Also, we want to point out that jurisdiction over fee disputes lies with the Workers’ Compensation Appeals Board (WCAB) pursuant to the Labor Code and regulations addressing independent bill review.

**Nicole Richardson:** If you'd like to share a question or ask a question, please send in the chat to Nicole Richardson, the host. Questions will be read and then answered by this panel. Questions or comments related to debating the reasons or the utility of the new fee schedule will not be addressed. If, after this session, you have additional questions you may email the med-legal fee schedule at MLFSProposals@dir.ca.gov. So with that, we'll get into some questions that we've previously received. And that is, what is the effective date of the fee schedule?

Winslow West: I'm going to provide the initial answer, then turn it over to the panel. The effective date is April one. Evaluations that occur on or after April one are under the new schedule. With respect to supplementals, it's the date of the request, so look at the date on the letter. One thing we should let you know at the outset is that this session may be recorded for educational purposes in the future, so your opinions, as expressed, or your questions, as expressed, are subject to being recorded. So that is the effective date of the schedule.

Nicole Richardson: And the attestation - what happens if I receive records with no attestation? Do I still review the records?

Winslow West: This is probably the overriding question all of you have given how the schedule was finally amended and how close it was in time to the implementation and the actual approval by the Office of Administrative Law (OAL). So, the medical records have been sent to the QME. It would be best practice for the parties to get the physician a declaration of the number of pages provided prior to the evaluation itself. If no declaration is provided prior to the evaluation, we recommend proceeding with the evaluation, and depending on the nature of the case, a supplemental report might be needed for the record review after the evaluator receives a proper attestation for those records. Additionally, as with all things, the parties can come to an agreement on number of pages and records sent, and if that agreement has been stated in writing ahead of an evaluation, that would appear to be reasonable. Try to communicate and make the schedule work.

Nicole Richardson: Is there a difference if it is less than or more than 200 pages?

Winslow West: No. The attestation is needed no matter the amount of pages that are received. I’ve not been good about this, but anyone on the panel, if you want to jump in with regard to anything I say – if I did it wrong, just let me know, and jump in.

Steven Feinberg: I'm going to jump in from a practical standpoint. You know I've actually had a few of these already. I think at some level, I want to give people the benefit of the doubt and try to get reports done for our injured workers. So, certainly if it's under 50 or 200 pages for a new evaluation, I'm inclined to personally do it. Maybe I'm taking a risk, and that may not comply with the regulations, but it is one approach. But, also, understand that legally as a QME, or provider, that you can choose to just see the patient, write a report, and await getting records, an authorization with the attestation.

Winslow West: We’re hoping against hope that practicality will prevail in this interim time period. So, if a QME, in good faith, does an evaluation, we’re hoping that agreement can be reached, even at a later date, as to the actual number of pages that were involved in that evaluation. It's not rocket science. There's an amount sent and then there’s a page count. I don't know how there could be substantial disagreement over that. I’m hoping that there won’t be.

Nicole Richardson: What if there is a declaration that does not match the number of pages received?

Winslow West:Well, at that point you should document the number of pages received by the QME. The QME may want to hang on to the actual physical copy, so that if there is an IBR determination in the future they can prove the amount of pages sent. Once again, you should try to seek some agreement with respect to the actual amount of pages. Hopefully it will be viewed by a workers’ compensation judge that contact between QMEs, employers, or carriers, or applicants’ attorneys with regard to page count should be deemed an administrative matter and, hopefully, not ex parte. The way to guard against that is to probably have your staff contact them or, if you have to, to contact both parties in writing with respect to the page count discrepancy.

Nicole Richardson: Would it be acceptable for a claims administrator that is in communication with the page counter, for the declaration to be signed using information and belief language, in your opinion?

Winslow West: I’m not allowed to offer legal opinions to anyone who doesn't work for the State of California.

Nicole Richardson: Can we just remind everyone to mute. I’m trying to mute everyone but I’m having a hard time. There's a lot of people on the call. I remind everyone to mute their phones.

Winslow West: It looks like there was a contrary opinion coming. To me it would seem that the ultimate question of an information and belief declaration would be up to a WCAB judge or the IBR fact determiner. Information and belief is not actually the same, but it might do for initial purposes.

Nicole Richardson: Is there a cap after 200 pages, $3.00 per page, is there a cap?

Winslow West: The current fee schedule has no cap on the amount paid for pages reviewed.

Nicole Richardson:I think I just muted you.

Electronic Voice: All participants are now in listen only mode.

Steven Feinberg: I think that we're good to go ahead, Nicole.

Nicole Richardson: Yeah, I’m trying to get Winslow to unmute.

Winslow West: I’m unmuted now, aren’t I?

Nicole Richardson: There you go.

Winslow West: I usually do what I’m told!

Nicole Richardson: On that note, what is a billable page? Is it cover letters and proof of service as well?

Winslow West: OK, so the advocacy letters I believe are billable pages. Proof of service, I believe, is not a page that can be counted. Cover and non-medical record pages, between the cover pages, I don't think that those are actually countable records. When I look at 9793(n) which describes the record review, it says it means the review by a physician of documents sent to the physician in connection with a medical legal evaluation or request for report. The documents may consist of medical records, legal transcripts, medical test results and other relevant documents. And in that sentence, relevant is the deciding term. The key here is relevance. Ask yourself the question, do I need to review this document in order to resolve the medical issues in dispute. Does it help me resolve the medical issues in dispute? If the answer to that question is yes, then it should be a document that is billable. If the answer to that question is no, then it's probably a document that should not be counted. So, I would say, a subpoena probably doesn't help you, but it's clear that the cover letters do. I hope that AMEs and QMEs will agree that cover letters count in the counting pages.

Steven Feinberg: So let me chime in here regarding the practical problems with this. When we get records, they are scanned. So that's going to include those six or seven pages at the beginning of subpoenaed records which are irrelevant. And so, my approach, and this is just very personal, is that, if there's a small discrepancy between myself and the claims examiner, I'm just going to not fuss about it. But, I think the problem is going to be when there's a 100 page difference, and you need to then negotiate that. I don't see any other way to do that. It does create extra work as we are finding, in my practice, with having to remove pages that should not be counted. Winslow, let me give you one more example. There are sometimes blank pages in a set of subpoenaed records and, you know, there's no way to know how many there are sometimes. So, I think that if it's a piece of paper, we're going to probably count it as one of the pieces of paper we've gotten.

Winslow West: If it’s in the attestation as one of the pages that they’ve counted, then I don't think you have a problem. The problem will arise when there's a discrepancy between your page count and theirs, and that discrepancy might be as to documents they show as not relevant. I like your practical approach. If it's less than 100 pages, why sweat it? If it is more than 100 pages, then you have to have some discussions with the provider of records and, hopefully, you'll come to an agreement.

Nicole Richardson: Can I always bill for records that are sent, even if previously reviewed?

Winslow West: The way I read the schedule, if it’s an ML201 you can bill for all records sent if they were sent related to that evaluation. You cannot go back and charge for reviews of records previously reviewed, but not sent at that time. If it's an ML202, you can only bill for review of records that you have not previously reviewed, regardless of what was sent. If it's an ML203 you can only bill for review of records that you have not previously reviewed, even if they are sent again. That's my interpretation of the wording in the schedule.

Nicole Richardson: And on that note, when can I bill for a 201 again?

Winslow West:The way that I read all of the definitions, either in 9793 or in 9795, with the actual billing codes itself, it seems like you can bill for an ML201 a second time, 18 months and one day after the last 201 billing. In other words, if you have a an initial comprehensive, 18 months after that initial comprehensive, the clock sets again, and you can bill for a 201. It doesn't seem to matter if there are 202s in between that time. The time setting event seems to be the comprehensive evaluation.

Steven Feinberg: Winslow, how about all these 102s, 103s and104s we did in the past? I may have done an ML102 a year ago, but that's not listed. It's called a basic report, it's not a comprehensive report. I thought in our discussion earlier today that what you were saying, and I may have misinterpreted, was that you can use the ML202 going back to the original initial evaluation, but not a follow up, even if it was… go ahead.

Winslow West: The way I look at this, and it’s an interplay between the old schedule and the new schedule, if you did something under the old schedule that was not a follow up, an ML101, and it was not a supplemental, an ML106, then that would count as the 18 month start. So, a 102, 103 or 104 would actually be a comprehensive medical legal evaluation for purposes of this new schedule. If you had an ML101 in between, or if it's not 18 months since you last did a 102, 103 or 104, then you're going bill an ML202, it's going to be follow-up. So, the counting actually starts with the last comprehensive. And I believe that under the old schedule, 102, 103 and 104s were comprehensives because they didn't qualify under the definition of a follow up or a supplemental. If I'm wrong a judge somewhere will correct me on that. A good WCALJ will correct me. Does that make any sense, Dr. Feinberg?

Steven Feinberg: Well, I understand what you're saying.

Winslow West: That's a good first step.

Nicole Richardson: Next question, and I'll just go ahead and answer it. Will there be a specific attestation form? At this time, there is not a specific form. You can create your own. And what about depositions scheduled prior to April one? If it was scheduled prior to April one, but the deposition happens on or after April 1, 2021, then this schedule would apply. Moving on, what do the modifiers apply to?

Winslow West: When I read the new schedule, I believe that the modifiers apply to 201s, 202s, and 203s. If you actually read the words, there are more descriptions of each one of those individually in the individual modifiers, but it deals with anomalies like when an interpreter is used, or when you're using an interpreter and acting as an AME. The defining terms, I believe, are in the beginning sentences when they say the modifiers will apply to ML201 through 203.

Nicole Richardson: And, just to be clear, the modifiers only apply to the base rate?

Winslow West: That's correct. That's stated in the definition for the modifiers.

Nicole Richardson: When can a PTP bill under the medical legal fee schedule?

Winslow West: That was not addressed in this regulatory package, so nothing has changed. The determination is based on statute, regulation and on case law. That’s a very murky area right now, but this schedule does not affect it.

Nicole Richardson: So, I do have a question. I think you answered it, but we're going to go ahead and ask it anyways. Are AME fees no longer increased by the modifier for testimony? So the deposition fee of an AME is no longer modified, correct?

Winslow West: I don't think so. I think that was one of the changes, when that was made, with respect to the increase in the AME modifier.

Nicole Richardson: Correct. If the applicants’ attorney summits records that are duplicative of the records submitted by the carrier, can the panel QME then bill for the total number of records, including the duplicate records?

Winslow West: I would hope that the panel QME will not bill for duplicate records. That is not contemplated by this schedule.

Nicole Richardson: And there is a requirement that the parties meet and confer ahead of time, so hopefully duplicate records, if they do exist, will become less.

Winslow West: That’s an interesting point to point out, that the attestation is twofold. The attestation is saying that you have complied with 4062.3, meaning that you've met and conferred, and you are attesting to the amount of records that you are sending. So, hopefully, the community will go forth in good faith using the schedule. When I talk about the community, I’m saying QMEs and the participants, the lawyers, the claims adjusters, etc.

Steven Feinberg:I can just tell you that physicians are under the impression that, if we're sent records that both sides attest to for pages that it's 800 pages, even if they're duplicates, I don't personally think it's reasonable to expect us to have to sort and choose which ones are duplicates and which ones are not.

Winslow West: That's an open question, but I hope the community will resolve it. Or, in the final analysis, IBR or a judge will.

Steven Feinberg: Well, I understand you when you say that. I don't want to argue with you, but it really adds friction to the system, you know, in that scenario where the doctor has to start -- so what if the claims examiner sends you duplicates within the 400 they send you? Those are included as billable records. I was under the impression the burden was on the payer and the applicant attorney to work together, and if they want to get rid of duplicates, God bless them, I hope they do. It'll be to their benefit. But I don't think that burden should be on the physicians, and I really felt that in these regulations, and in chatting with you folks, that we were not being put in a position where we had to be the judge of deciding which records were which.

Winslow West: I don't think it's entirely fair to bill for duplicates, because I don't think it takes as much time to review a medical record if it's a duplicate. Because, given the intellectual level of our QMEs, you're going to recognize it is a duplicate right away. A lot of people send their records out to services who do just what you're saying, so this issue of duplicates is one that's going to probably be with us; but I’m hoping that common sense will prevail.

Nicole Richardson:Maybe Dr. Feinberg can answer how he handles this. What do you do when you get an attestation that's not correct?

Steven Feinberg: Well, this is just a week old, for me, because I was gone last week. My staff is spending hours every day calling people, emailing people, and we've been reasonably successful, I call it doing the right thing, in communicating with people. But, I got a phone call from one of our esteemed physician members today who told me that the claims examiner was not going to pay for letters from the attorneys. They weren't going to -- they sent her 900 pages and instead there were only 300. So there's lots of room for problems. It gets down to people because we're dealing with human beings here. You know, many claims examiners are wonderful, some of them are stressed and overworked, and you know, I think we're going to have a few months of chaos.

Nicole Richardson: Yeah, and then it should settle out and hopefully the parties can work together to come to an agreement on a page count and reduce that agreement into writing -- would be the best option. Where are you, Dr. Feinberg, going to put your attestation with regards to the number of pages? The question submitted is, can we expect that to be with the physicians bill?

Steven Feinberg: Well, so far, at the bottom of my report I have an extra attestation for this. You know, I have been working with some of my colleagues and we don't have a specific agreement, but I know I have developed the form in my office to send to people ahead of time when there's a disagreement and we've had moderately good success. The frustration for me is, I like to, I mean, I insist on reviewing the records ahead of time. When the injured worker comes into my office I pretty much have spent hours going over the records and get my report ready. So it's very stressful to even think about not reviewing the records ahead of time because there is no attestation. I'm going to probably do it anyway, but I don't believe many of my colleagues will because that's not what the law says.

Nicole Richardson: You're going to go forward with the evaluation, even if the attestation’s not there?

Steven Feinberg: In most cases. But that's not, I think what's going to happen in general.

Nicole Richardson: Well, do you want to comment on that Winslow? Isn’t there a requirement that the physician not cancel the evaluation based on records not being available?

Winslow West: Yeah, there is a regulation section on it.

Steven Feinberg: Yeah, but I'm not talking about canceling. I mean I’ll go ahead and see the person, and you know, bill for an ML201. But I'm going to be forced into a supplemental report. Practically, I'm at my best on the day I see the injured worker, or within two or two or three days, in terms of getting my report done. That's when it's fresh in my mind. You know, when you do it a week or a month later, you can’t ask a question. This happens under the old system. You see someone, you talk to them and then you get records a week later that contradict what the injured worker told you or isn't consistent, and you're kind of in a strange place of what do you do now? So it's always best that we all work together, that the payers and the applicant attorneys work together, and we give the physicians a clean set of records. I mean, I've been advocating this all along. There are services available that will get rid of duplicates. Why don't we give the physicians records that are already in order? I mean, it's not that expensive, and it will save the payers money to do that.

Winslow West:That is the best of all possible worlds and what we hope the community is working towards. Hopefully this schedule will alleviate friction points, not cause new ones. Hopefully if it's not a lot of duplicate records were talking about, it's not going to be worth the friction involved to dispute them heavily. But yes, there is a regulation section that says that you're not supposed to cancel simply because you haven't received the record. It’s 34(g).

Steven Feinberg: Yeah, you go ahead and you do the exam. You do the best job you can, and you know you may end up doing a supplemental.

Nicole Richardson: Is there is a requirement for the attestation for sub rosa? Do they have to disclose the time on the sub rosa film?

Winslow West: Apparently, in the regulations there's no requirement of an attestation for a sub rosa.

Nicole Richardson: The requirement to send copies of all correspondence received when submitting bills and reports is very broad. Does the DWC expect a doctor to send back earlier correspondence received for previous evaluations every time there is either a follow up or supplemental evaluation, or just the correspondence specifically related to the current evaluation?

Winslow West: Correspondence related to the current evaluation would be what would be indicated, in terms of service. So, if you're serving the report you want to serve the correspondence that goes with that report, not prior reports.

Nicole Richardson: Does the DWC consider Labor Code 4062.3 declaration with page count a communication, non-medical information that must be sent to the opposing side 20 days in advance of the evaluation?

Winslow West: That would be the hoped for result, yes. That would be the best of all possible worlds.

Nicole Richardson: Is it okay to send excerpts from the subpoenaed records, or does the QME have to review all of the pages of subpoenaed records? Also does the number of pages include everything from the cover letter, proof of service, etcetera? I think we addressed the second question, but people have fallen in and out so you might want to re-address it.

Winslow West: So, if you send excerpts, then you are subjecting your report to collateral attack as not being substantial medical evidence because the QME didn't review all of the medical records. We've already gone over the fact that we consider countable pages the relevant pages of medical records and other materials sent. And we kind of use the standard of does it help the QME to resolve the medical issues in dispute? If so, it should be a countable page. If not, it shouldn't be. So hopefully you can use that as a guide.

Steven Feinberg: I would think the applicant attorney would be very concerned about a claims examiner redacting certain pages. I mean, you know, there's a scenario, you know, medical records today, an 8 or 10 page report is 90% duplicate of prior reports. But we haven't gotten to that point yet where we're redacting that information that's duplicative. I think this system basically says if it's a page, it's a page, if it's got information on it.

Winslow West: I believe that's correct. If it’s 8 and 1/2 by 11 with information, it’s a page.

Nicole Richardson: If a panel QME has a staff member prepare the written summary of the records, can they still bill the $3 per page?

Winslow West: The $3.00 per page has nothing to do with who prepares the summary. The $3.00 per page has to do with the QME’s responsibility to review all of the medical records sent to them, no matter who does the summary. So you're being paid for the review, not the summary.

Steven Feinberg: You know I want to add in, I personally have a lot of trepidation about this new system. But, I have to tell you it's been a sigh of relief this week not having to deal with complexity factors. Just to do the report, whatever the pages are, they are. I’ve got to tell you, at least for me so far, it's kind of a breath of fresh air. We'll see how it goes in the next few weeks.

Nicole Richardson: Can a missed appointment bill be included with a sub rosa billing code? Can you combine those two?

Winslow West: That's an interesting question. So the evaluation doesn't take place, but you do a report on the sub rosa? Is that the question?

Nicole Richardson: Yes.

Winslow West: I guess there is no prohibition against it. I guess so. If it's a legitimate sub rosa report and a legitimate missed appointment, then I guess that would be alright. Subject to IBR and a judge’s review, yeah.

Steven Feinberg: Well, Winslow, I think the question has more to do with if you get sub rosa all by itself you can bill a supplemental report fee, but you can't bill it if the sub rosa is part of an evaluation. So, to me the question is, if the patient doesn't show up and you bill a no show, and you bill the supplemental, I don't think you can bill a supplemental report fee as well. That’s just my interpretation. Am I making sense?

Winslow West: Yeah, I see what you're saying but I honestly don't know if there's a prohibition against it in the regulations. Because we have a separate -- I'm just looking at the regulations for sub rosa.

Steven Feinberg: So in other words, if it's a no show, and you review the records and you also review sub rosa, you can bill for the records and the no show fee? I just don't see how you could bill another 650 supplemental report fee.

Winslow West: Well, when I look at the left paragraph of the sub rosa description, it says if the sub rosa recordings are received by a physician prior to the issuance of a pending report related to a medical legal evaluation, a physician may not also bill a supplemental report fee in connection with review of the sub rosa material. So, I think your interpretation is correct, Dr. Feinberg. I think you bill the no show fees and you legitimately wait until the evaluation is complete to review the sub rosa, and then bill for it.

Nicole Richardson: So we're not sure if we got you the answer. But that's where we are at. It is our opinion. It is only our opinion. We're not sure what the WCAB will eventually do with this, but there is potential that you can bill, both for the missed appointment fee, as well as for the review of the sub rosa. We'll see what happens. There is no PowerPoint that goes along with this presentation. Potentially after this presentation we will create one but, at this time, there is no PowerPoint that goes along with this presentation. But I will remind everyone that this presentation is being recorded -- if I turned that on correctly, which I think I did. Okay.

If a defense attorney objects to the applicants’ attorneys pages being sent as irrelevant, it could go either way there, would the parties need a discovery order prior to the QME exam?

Winslow West: An interesting question and it's one that's going to be answered ultimately by the courts. If there is a legitimate dispute and it's over a huge amount of records, the dispute is probably going to be one of relevancy and that's probably going to be something that will have to be dealt with by the courts.

Nicole Richardson: And this goes along the same lines. If I have 1000 pages of hospital records obtained by medical release, but only 10 are related to the injury, can I pull out the 10 pages and only send those, or do I have to send all of the records?

Winslow West: What I’ve heard some defense lawyers posit is that they're going to send the applicants attorney what they feel are the relevant records and what they feel are not relevant records. Hopefully you will have this discussion way ahead of the QME evaluation and reach an agreement as to what goes to the QME. But yeah, you’re supposed to, by regulation, and always have been supposed to by statute and regulation, to only send relevant documents to a QME. So, I would think that part and parcel of sending relevant documents, is culling out documents that are irrelevant.

Nicole Richardson: And from the physicians perspective, Dr. Feinberg, do you see a gap there? Would you want to get the full thing or do you really only want the records related to the injury?

Steven Feinberg:Well, I think what most of us are going to be nervous about is, you know, there may be gynecological records having to do, where there's mention of back pain or prior injuries or a past medical history. So, I think if I were an applicant attorney, or defense person, I want to send all the records. I just don't think you could have non-medical people deciding what's appropriate and what's not appropriate. In general, my preference is always to have the applicant and the defense attorney. I love them to write strong advocacy letters. It helps me knowing where they're coming from, but frankly I'd like them to take care of all this before it gets to me.

Winslow West: Then we agree.

Nicole Richardson: This is along the same lines, again. Can we redact the records to delete the blank pages for those that do not appear to be relevant, with the agreement of the opposing party to show actual records being sent? I do think that's the whole intention. To come to an agreement as to the records being sent, and send the relevant records to the physician.

Steven Feinberg: You know the duplicates are not the big problem. The real problem is that I’d be very nervous about someone else deciding what's relevant and what isn't relevant. I can tell you that when you're talking about hospital records from a large institution, in a lot of cases 80 or 90% of them are not relevant, you know. For instance, orders for a musculoskeletal spine surgery, I really don't need to see the orders in the medical records. But, they're part of the subpoenaed records, so there may need to be more legislation or more consideration about this. But certainly, physicians would like to get as many pages as possible that are not relevant, because your bill for them. That's just common sense. But from the payer side, the fewer records they send the better in terms of their ultimate cost for the system. I don't think any of us benefit, frankly, from huge $40 or $50,000 medical bills. I mean, the system will just collapse it that becomes the norm.

Winslow West: And there will be a push for a new fee schedule.

Steven Feinberg: Not one we’ll be happy with, maybe.

Nicole Richardson: Disputes over what documents are relevant or not should go to the WCAB, correct? That is correct. If there is a dispute, you are requesting meet and confer try to come to an agreement, and if you're unable to reach an agreement, the WCAB would have jurisdiction over what is to be sent to the QME.

Winslow West: That is correct.

Nicole Richardson: And again, this question is asked again. I think people are logging in and out. If someone other than the physician does the review is it still $3 a page? Yes, it is still $3 a page. The physician does have an obligation to review the records, even if they use an outside vendor. The records are made available to them to review and then you still charge $3 per page for record review. And this is a repeat again, but I'm going to go ahead and ask it. Regulation 9794 requires any correspondence received by the physician from the parties, is a declaration and attestation considered correspondence? Also, this instruction requires a physician to repeatedly send the same correspondence, again and again, when there are different MLs submitted?

Winslow West: You are not required to repeatedly send the same correspondence. As we said before, you want to send the correspondence received related to the report that you're doing, with the service of that report. A declaration and attestation could be considered correspondence, but it's probably part of the records received. So I don't think you have to send the medical records. We do not intend for you to send the medical records. We only intend for you to send correspondence, i.e. the charge letters.

Steven Feinberg: Let's be real clear about that. You need to send your report, any forms you're filling out, or the patient, injured worker fills out, and the letters from the attorneys or the claims examiner.

Winslow West: That's correct. The letters received for that report.

Steven Feinberg: Yes.

Nicole Richardson: And again, I think you answered this, but we'll go over it again. The next 201 starts another 18 months, is that correct?

Winslow West: Correct. 18 months and one day from the initial comprehensive you start billing a 201 if it's a face to face evaluation.18 months and one day from that second comprehensive, you start billing a 201 again if it’s a face to face evaluation.

Steven Feinberg: That includes if it's a zoom telemedicine.

Nicole Richardson: Can providers bill for records reviewed at the $3 per page rate for evaluation appointments? For example, the 99205 code. We do provide for a code in the medical fee schedule for the page count and the code is MLPRR. So that is the billing code for the $3 per page. Can a physician bill an ML200 and a ML205? I think we answered that one earlier. That we believe that you can, but it will be left to the WCAB to enforce.

Winslow West: And it’s going to be left to the interpretation of the last sentence of ML205. Is there a pending report related to a medical legal evaluation? If it's a missed appointment there is an argument to be made that there is a pending report.

Steven Feinberg: Well, Winslow, if you're actually summarizing the records, so you get paid for them, because you've done it ahead of time that is a report.

Winslow West: Yeah.

Steven Feinberg: Now, if all you got was sub rosa and nothing else, then, that seems to be questionable.

Nicole Richardson: What replaces the ML106? That is the ML203.

Winslow West: Correct.

Nicole Richardson: The supplemental report billed at $650 plus per page count over 50 pages.

Steven Feinberg: Let me interject a question here that I've seen repeatedly, you know that can be a real boon if it's a yes or no answer. And sometimes it's that simple, where you can finish it in 5 or 10 minutes. But what if it's a supplement report when they say that we decided after all that we really do want a P&S report, and you end up spending eight or 10 hours, particularly your psychiatrist or mental health practitioner. I mean, 650? I mean no one's going to do that. What are your expectations about if there's unusual complexity, but no records of significance?

Winslow West: Well, first of all, if it's a psychiatric report, it's not $650, its $1,300 because of the modifier. And second of all, who asks for a non P&S report? If you're going over the elements in 10682, status is one of them. If you've submitted a report prior to this and did not find the applicant P&S, and there are no intervening records, the question is why weren't they P&S when you did the first report?

Steven Feinberg: Winslow, it happens all the time where I get a letter from both sides saying it's been over two years and the claimant wants to settle their case. Please send a report based on your findings of your last physical examination. That's the reality of what happens.

Winslow West: And there are no intervening records?

Steven Feinberg: Well, it’s going to be less than 50 pages, let’s say.

Winslow West: Well that's quite an anomaly. I don't understand that. But, in that instance, you're right, you'd be limited to the $650 for the supplemental. Plus any records you have to review.

Nicole Richardson: When asked to do a supplemental, can the previous report, like the previous evaluation or supplemental report be counted in the number of pages to review? So can the physician review their prior reports and charge per page count for those? That's not provided for in this fee schedule. My answer would be no, you cannot go back and search for pages, including your own reports and bill for them. And that's the same thing under an ML201. If you're getting that 18 months and one day and you're able to bill an ML201 again, and the parties send you a limited number of records, but you know previously you had received 1000 pages of records. You can't go back and look for those records and bill for those.

Steven Feinberg: Unless they send them to you again.

Nicole Richardson: Unless they send them to you again. So it's the same thing. You can't go back and bill for review of your own report.

Steven Feinberg: Nicole, I think the issue here is that some doctors write 930 page reports and they actually do spend hours reviewing their own report, but there's no reimbursement for that.

Nicole Richardson:There is not. That was discussed when we developed this fee schedule and there were actually some physicians that said they did not want to get paid to review their own report, so I don't know.

Can the physician submit ML203 for diagnostic testing ordered at the evaluation?

Winslow West: There is nothing that prohibits that under the definition of an ML203. However, best practice would be to get that diagnostic test approved by the carrier and wait for a request for the supplemental report. Then I think you would bill for a supplemental.

Nicole Richardson: And if you had multiple tests that you are waiting for, would you issue a report for each test as it came back?

Winslow West: If you want to get a denial of all of those charges from the carrier, sure. The more practical approach would be to wait for all of the tests to come in and write one complete supplemental.

Nicole Richardson: If there is a dispute with regards to duplicate records, or number of pages sent, would that be an IBR issue?

Winslow West: Initially, it would be an IBR. No, actually that would probably be a WCAB issue because it's not actually the proper application of the schedule, it's the actual underlying facts related to the application of the schedule. So that would probably be a petition for determination issue.

Steven Feinberg: While we're waiting, there was a question that I saw that maybe is on your list, but what about SIBTF evaluations? My understanding is that the SIBTF will be using the new MLFS.

Winslow West: That is correct. At the time we expect that it will apply to SIBTF and you're welcome.

Nicole Richardson: Have a question here about multiple attestations. Is it permissible to have one attestation form that everyone signs?

Winslow West: I don't see any problem with it.

Nicole Richardson: Is it permissible to have separate attestations from each source of records? So this goes to the copy service sending records, probably.

Winslow West: That's probably correct. I think the attestation reads that whoever's providing the records sign it. So if a copy service is providing the records, then an attestation from them would probably suffice. And if there are multiple, then there are multiple.

Steven Feinberg:You’d think that a smart payor would want to get those records directly and remove duplicates.

Winslow West: You’d think that a smart attorney, on either side, would want to remove non-relevant records out off a fear of a faulty apportionment and non-relevant records out of a fear of overpaying for non-relevant items. Hopefully all of this will work itself out as this schedule is put to actual use.

Nicole Richardson: If there is a face to face evaluation and there are no declarations or attestations, and the report goes out, so they saw the injured worker - they didn't get the records or that they didn't get the attestation, anyways, then after this, the declaration and attestation is received -- can they then bill an ML203 for a supplemental report?

Winslow West: If that supplemental report contains a review of the records received, then that would probably be appropriate. But, if you look at ML203 it's at the request of a party, so you would want to wait for them to ask you for that record review report. Obviously that report that you forwarded without records is not going to be substantial medical evidence, so you can rely on a request from one of the parties for that supplemental.

Steven Feinberg: I think the practical way to handle this is and, in fact, because of the system I use, I get my reports out within a day or two because I’ve done them ahead of time and then I finished them up after I see the injured worker. But I think if records come in a few days or a week later, my reports out. My staff will just send out an email saying we just want to confirm that you'd like us to review these and provide a supplemental report.

Winslow West: Sounds like a common sense solution.

Nicole Richardson:Is there any requirement that a physician that's doing a face to face evaluation wait a certain period of time before serving their report? The question is, do they need to wait 10 days to serve the report? I'm not aware of any requirement that says you can't serve it the same day as the evaluation.

Winslow West: I’m not aware of anything other than regulation 36 that deals with service of a report. I’m unaware of anything in that regulation that details that you have to have a waiting period before serving a report. But you would look to that regulation to see, 36 and 36.5, for the psychiatric report that should not be shown to the injured worker.

Nicole Richardson: And there are a lot of questions out there. There are some that we're not going to be able to get to today. But again, there is an email address, MLFSProposals@dir.ca.gov. We understand this is a work in progress. There's going to be some things that come up in the next couple weeks, but hopefully over time, a lot of these issues will resolve and the parties will be able to come to some sort of agreement with regards to some of these issues. We are hosting this again next week, so if you know someone that was not able to log on because we did hit our capacity, please encourage them to log on next week. A lot of this has to do with attestation and the page count, I've noticed. I think what Winslow said at the beginning, the DWC is encouraging parties to come to an agreement if they can, if you have an evaluation coming forward. What we're recommending is that the QME contact the parties to try to come to an agreement, get a declaration if you can, and move forward with the evaluation.

Steven Feinberg: Can you publish these answers we've given or the ones that are going to come to you at this website at this email address because you're going to keep getting the same questions. If you publish them then maybe it will cut down on the number of repeat queries.

Nicole Richardson: Yes. I can work with my IT department to see if we can get out some sort of educational material onto our website. Is there any other question that you're seeing that you want to answer, Dr. Feinberg, or anyone else on the panel? I've got one. If the applicants’ attorney and the defense attorney submit advocacy letters with no records, but the copy service submits records with the attestations, would the records be reviewed?

Winslow West: I would say that records received with an attestation are received for purposes of the regulations, so you should probably review them. But, do you also have in that attestation, a declaration that the party has complied with 4062.3? That's a complete attestation. So there's that wrinkle to think of too.

Steven Feinberg: There's a question here. Can the paralegal sign instead of the attorney? That’s a legal question. The attestation, I mean, I would assume so.

Winslow West: There is no delineation of who the party is signing the attestation. If they're the person who can verify the records that have been sent in compliance with 4062.3. I don't see any prohibition against a paralegal signing. Of course, I hope that they would make it clear that they are the paralegal in the signature space.

From Steve Cattolica, thank you, Steve. He says try to index the question by topic and searchable with keyword search. I concur. We'll do our best to try and answer them. And here's one from Albert saying that the copy company is not a party to the case and would not be serving the records on all parties, so should not be able to provide a declaration and attestation. I think it's a preview of the court action we’ll see in the future and it's a good point. So, take that into consideration.

Steven Feinberg: Diane Weiss has a question. If you are sent your previous report with the new records to review before a re-evaluation or before a supplemental with the previous report as part of the attestation, can you review and bill for those records? Well let's just say that the claims examiner sends you your report, or the defense attorney. That happens all the time and they include that in the number of records sent to you in their attestation. I suppose you could subtract them if you want, but, most people won't. Is there a different answer?

Winslow West: Was it reviewed before or available?

Steven Feinberg: Well it's your report.

Winslow West: I understand.

Steven Feinberg: They're sending it to you again.

Winslow West: I understand, and there was no intent for the physician to be able to bill for reviewing the prior reports. I think Nicole went over that we discussed that in the stakeholder meeting. To the extent that as we go through this, that amendments to the schedule are indicated, we will take those issues up at the time.

Steven Feinberg: I don't expect that the claims examiner says they sent you 500 records and that your count is for 90, that you're going to subtract any pages. That’s just a reality.

Winslow West: I've got my fingers crossed and I’m hoping I’m not unreasonably optimistic that these page count disputes won’t amount to much once we actually get up and running.

Steven Feinberg:Well let's hope you're right.

Nicole Richardson: We're going to wrap this up. Thank you all for being here. Again we are hosting this again next week on Tuesday. If you need the link, let us know. You can send an email to that email account. Again, that’s MLFSProposals@dir.ca.gov. And good luck to you all.

Winslow West: Thank you.

George Parisotto: Thank you.