



# Research Note

## The Changing Nature and Cost of the Medical-Legal Process in California Workers' Compensation

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### Executive Summary

Medical-legal services have historically represented less than 10 percent of California workers' compensation medical services,<sup>1</sup> but they are an important component of the process for resolving disputes in indemnity claims. This study provides a quantitative analysis of paid medical-legal services. Key findings include:

- The percent of indemnity claims with medical-legal services dropped from 24 percent in accident year (AY) 2004 to 17 percent in AY 2005, after implementation of SB 899 reforms, and has remained near that level.
- The average payment for an individual medical-legal service rendered in 2014 was \$1,628 -- 66.3 percent more than the average paid for services rendered in 2007.
- The increase in the average medical-legal payment from 2007 to 2014 reflects a continuing shift from services with flat fees to the following time-based services:
  - Follow-up evaluations within nine months of a prior evaluation (billing code ML 101), where the average payment increased 136.4 percent;
  - Comprehensive evaluations involving extraordinary circumstances (ML 104), where the average payment increased 66.2 percent; and
  - Supplemental evaluations (ML 106) where the average payment rose 86.1 percent.
- Among AY 2004 – AY 2011 claims with medical-legal services at 36 months post injury, more than 80 percent had the initial medical-legal evaluation in the first 24 months of claim development.
- At three years post injury, AY 2007–AY 2012 claims with medical-legal services averaged between 1.2 and 1.4 ML 101 follow-up services and between 1.6 and 1.7 ML106 supplemental reports.
- Invalid charges for supplemental reports have increased. The proportion of supplemental (ML 106) medical reports billed within 24 months of the injury absent an initial medical-legal evaluation increased from one in seven in AY 2007 to one in five in AY 2013.

1. Ireland, J. California Workers' Comp Medical & Indemnity Benefit Trends AY 2002-14. CWCI, August 2015.

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## Background

Medical-legal evaluations are used to resolve various claim issues in California workers' compensation, including the extent of an injured worker's impairment. Over the past quarter century, state lawmakers and regulators have implemented a number of reforms that have altered the medical-legal process, which in turn has led to changes in the volume and cost of medical-legal services. The initial catalysts for many of those changes included:

- **AB 276**, signed in 1989, which restricted the number of medical-legal evaluations needed to determine the extent of an injured worker's permanent disability (PD); and
- **SB 31**, enacted four years later, which mandated the adoption of a fee schedule to establish set prices for medical-legal reports and instituted a more restrictive definition of what constitutes a compensable medical-legal evaluation, while making employers liable for the cost of each reasonable and necessary comprehensive medical-legal report.

Prior to these legislative changes, California workers' compensation claims often involved multiple reports from forensic physicians, and because medical-legal report reimbursement rates were not subject to a fee schedule, medical-legal fees had become a significant cost driver in the system. In addition to SB 31, other legislative reforms enacted in 1993 included the following changes:

- no medical-legal reports could be obtained until 60 days after the employer was notified of the claim;
- the primary treating physician's (PTP's) opinion was given a rebuttable presumption of correctness for the purpose of calculating permanent disability;
- employees or employers in medical disputes were allowed to obtain only one additional medical-legal report;
- the workers' compensation judge was required to approve the permanent disability rating proposed by one side or the other (the so-called "baseball arbitration" rule);
- physicians who wanted to be appointed qualified medical evaluators (QMEs) were required to pass a QME exam; and
- medical-legal reports issued by QMEs were required to meet certain quality standards, and QMEs had to meet continuing-education requirements in order to be reappointed.

Following the implementation of SB 31, the medical-legal fee schedule, and the 1993 rule changes, the volume and cost of medical-legal reports plummeted, with total medical-legal costs on insured permanent partial disability claims falling from \$394.1 million in 1991 to \$51.2 million in 2002 – an 87 percent decline.<sup>2</sup>

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2. WCIRB Medical Legal Costs on Insured PPD Claims, Commission on Health and Safety and Workers' Compensation 2010 Annual Report.

Despite the steep drop in medical-legal payments following the adoption of the fee schedule and the other reforms, average treatment costs and medical utilization in California workers' compensation increased. Research conducted at the time linked these increases to the enhanced role of the primary treating physician and the PTP's presumption of correctness, which a 1996 court ruling (Minniear v. WCAB, 1996) had expanded to encompass all medical issues including the appropriateness of any given treatment. The expansion of the PTP's presumption limited the ability of claims administrators to question or object to medical utilization and only allowed challenges to the PTP's opinion if it could be proved that the opinion was not supported by the medical literature – a standard that was rarely overcome in the appeals process, even when it was clear that a given treatment was not curative.

In the wake of the Minniear decision, California workers' compensation treatment costs rose sharply, creating pressure for further reforms. Between 2002 and 2004, state lawmakers enacted several bills that led to fundamental changes in the workers' compensation medical benefit delivery system. AB 749 (2002), SB 228 (2003) and SB 899 (2004) eliminated the primary treating physician's rebuttable presumption of correctness, thus striking down the Minniear decision as operational law. SB 228 also sought to control workers' compensation medical costs and utilization and improve patient care by requiring the use of medical treatment utilization standards that incorporate evidence-based, peer-reviewed, nationally recognized standards of medical care, and along with SB 899 sought to update and tighten loopholes in fee schedules for physician services, pharmaceuticals and outpatient surgery facilities. In addition, SB 899 sought to spur the use of medical provider networks (MPNs) as a tool to manage medical treatment by expanding the networks' ability to control medical care from the first 30 days post-injury to the life of the claim, and introduced the use of the American Medical Association (AMA) Guides, 5<sup>th</sup> Edition as an evidence-based tool for determining permanent impairment. While the AMA Guides provided a more objective method for determining impairment, they also introduced more complexity to medical-legal evaluations that address impairment.

The 2002-2004 reforms altered the way in which medical benefits are delivered to injured workers and introduced an entirely new medical-legal process. Under the new system, a represented worker involved in a dispute over medical care, compensability, permanent disability, or apportionment was required to use a single evaluator – either an Agreed Medical Evaluator (AME) or Qualified Medical Evaluator (QME) -- to resolve the dispute, and if the attorneys representing both sides failed to agree on an AME, the represented worker was limited to one QME jointly selected from a state-assigned panel of three evaluators. An unrepresented injured worker also was provided a state-assigned panel of three evaluators from which to select a single QME.

In addition to the changes to the medical-legal process that followed the implementation of the 2002-2004 legislative reforms, changes to the regulations governing the amounts paid for these services also had an impact. In January 2006, the California Division of Workers' Compensation adopted a revised medical-legal fee schedule, which took effect for services provided on or after July 1, 2006. Under that schedule [CCR Section 9795(b)], conversion factor amounts used to calculate reimbursements for medical-legal services were increased from \$10 to \$12.50, and new billing requirements – including documentation of research used — were added for certain types of medical-legal reports. Changes to the medical-legal billing codes adopted in the 2006 regulations included the addition of new time-based codes for medical-legal testimony (ML 105) and for supplemental reports (ML 106).

Court rulings also impacted the medical-legal process. Two significant appellate decisions (Guzman v. Milpitas Unified School District, 2009 and Ogilvie v. City and County of San Francisco, 2009) each added to the complexity and cost of medical-legal evaluations by allowing parties to more readily rebut the permanent disability rating schedule (PDRS). These rulings allowed a PD rating determined under the AMA Guides portion of the 2005 PDRS to be rebutted by a rating based on:

- “other evidence of disability;”
- other generally accepted medical literature or criteria;
- other publications by the AMA or other medical organizations, including medical and non-medical information; and
- opinions of vocational experts.

In neither of these decisions, however, did the court offer concrete resources, procedures or required evidence to rebut the PDRS or to establish a new "fair and accurate" disability assessment, which opened the door to subjective, unrestricted and unpredictable evidence in the PD rating process and added more complex issues for the medical-legal evaluator to consider.

The most recent turn in the evolution of the California workers' compensation medical-legal process occurred in 2012 with the passage of SB 863, which instituted a new process for resolving disputes over workers' compensation treatment requests. As of January 1, 2013 for injuries occurring on or after that date, and as of July 1, 2013 for all dates of injury, disputes over the medical necessity of requested services are adjudicated through the independent medical review (IMR) process rather than the medical-legal process.

The following study measures the changes in the types and volume of medical-legal services used in California workers' compensation, as well as the changes in the average amounts paid as the medical-legal process has evolved. Much of the data reflects the medical-legal experience since 2007, the first full year after the adoption of the regulatory changes which introduced the billing codes for medical-legal testimony (ML 105) and supplemental evaluations (ML 106). Several exhibits provide data back to 2004 to provide historical context for the changes in medical-legal experience that took place following the implementation of the 2002-2004 reforms.

### Study Objectives

In order to effectively evaluate the impact of statutory, regulatory and judicial changes on the California workers' compensation medical-legal experience, the author analyzed payment data for medical-legal services. The results of this study can be used as benchmark data in future studies on the volume, complexity and reimbursement of medical-legal reports and testimony to determine the effect of moving medical necessity dispute determinations to the IMR process and away from the medical-legal process.

A secondary goal of this research was to use administrative data to examine the changing distribution of medical-legal services, with specific emphasis on the growth of supplemental (ML 106) reports which are submitted to augment or complete an initial medical-legal evaluation report.

## Data and Methodology

Using CWCI's Industry Research Information System (IRIS) database, the author identified and extracted detailed payment data for all services with a medical-legal code (ML 100 – ML 106).<sup>3</sup>

California Workers' Compensation Medical-Legal Billing Codes		
Code	Description	Fee Basis
ML 100	Missed appointment	For communications purposes only, does not imply compensation is owed
ML 101	Follow-up evaluation within 9 months of prior medical-legal evaluation	15-minute increments
ML 102	Basic comprehensive evaluation	Flat fee
ML 103	Complex comprehensive evaluation	Flat fee
ML 104	Comprehensive evaluation involving extraordinary circumstances	15-minute increments
ML 105	Medical-legal testimony	15-minute increments
ML 106	Supplemental evaluation	15-minute increments

The analyses in this report utilize either accident year or service year data. Accident year (AY) data includes all claims with a medical-legal service at any time during the life of the claim, beginning with AY 2004; while the service year data includes only those medical-legal services rendered within a given calendar year. Due to the regulatory changes for required payment amounts – including the adoption of the ML 105 and ML 106 billing codes that took effect in July 2006, the payment data, as well as all service year analyses, were limited to service years 2007 through 2014.

Medical-only claims consistently represent two-thirds of all California workers' compensation claims, and though medical-only claims sometimes do involve medical-legal evaluations, historically their occurrence has been very low, topping out at 3 percent for AY 2001 claims. Since the relatively small proportion of medical-legal services provided on medical-only claims would skew the results, the author eliminated medical-only claims and their medical-legal services from the data analysis.

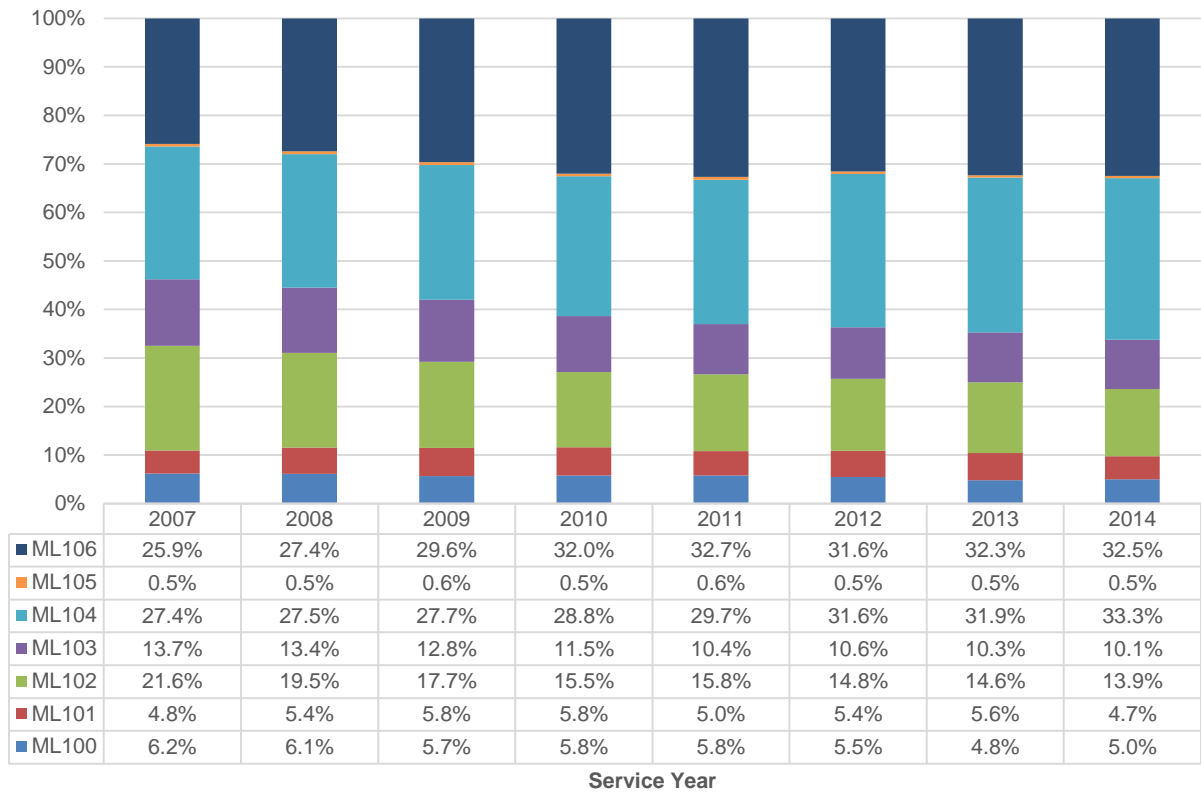
As previously noted, the 2006 medical-legal fee schedule changes added the new ML 105 and ML 106 billing codes to identify medical-legal testimony and supplemental evaluations respectively. Prior to this change, physicians billing for these services identified them by attaching modifier -96 (for medical-legal testimony) or modifier -97 (for supplemental evaluations) to the ML 104 bill code. Since these modifiers were appended for identification only and did not impact payment, they were not used in a consistent manner. To determine the amount of time that was associated with time-based medical-legal services (codes ML 101, ML 104 and ML 106), the author divided the paid amount by \$62.50 or \$78.13, depending on whether the provider was an Agreed Medical Evaluator (identified by modifier -94, warranting a 25 percent payment increase), then converted the derived value for 15-minute increments into hour values.

3. A complete listing of medical-legal service codes and their descriptions can be found in the Appendix.

## Results

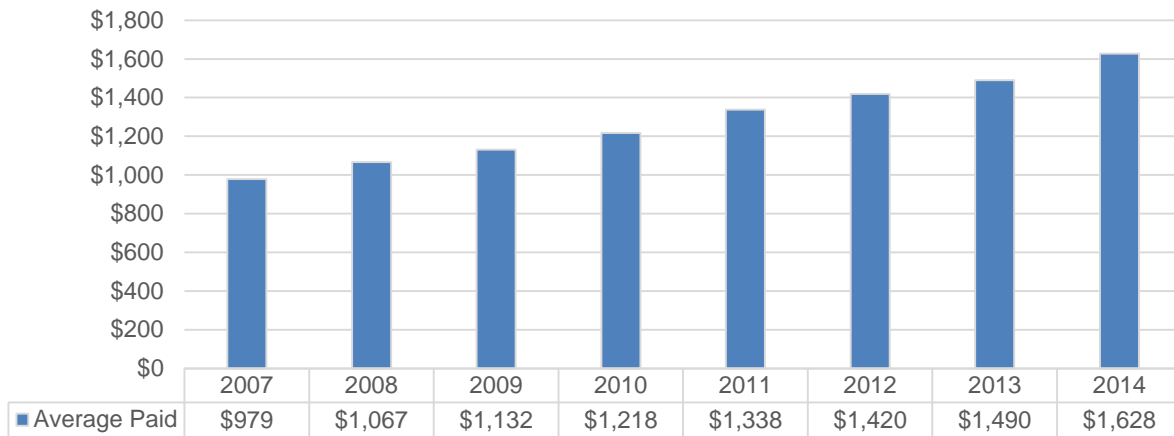
As Exhibit 1 shows, the mix of medical-legal services in the California workers' compensation system shifted during the 7-year service period under study. Between 2007 and 2014, ML 102 services, which are the least complex and least expensive medical-legal services, declined from 21.6 percent to 13.9 percent of all paid medical-legal codes in the system – a relative reduction of 35.6 percent. At the same time, the most complex and more expensive ML 104 codes increased from 27.4 percent to 33.3 percent – a relative increase of 21.5 percent.

**Exhibit 1: Percent of Total Medical-Legal Service by Service Type and Service Year**



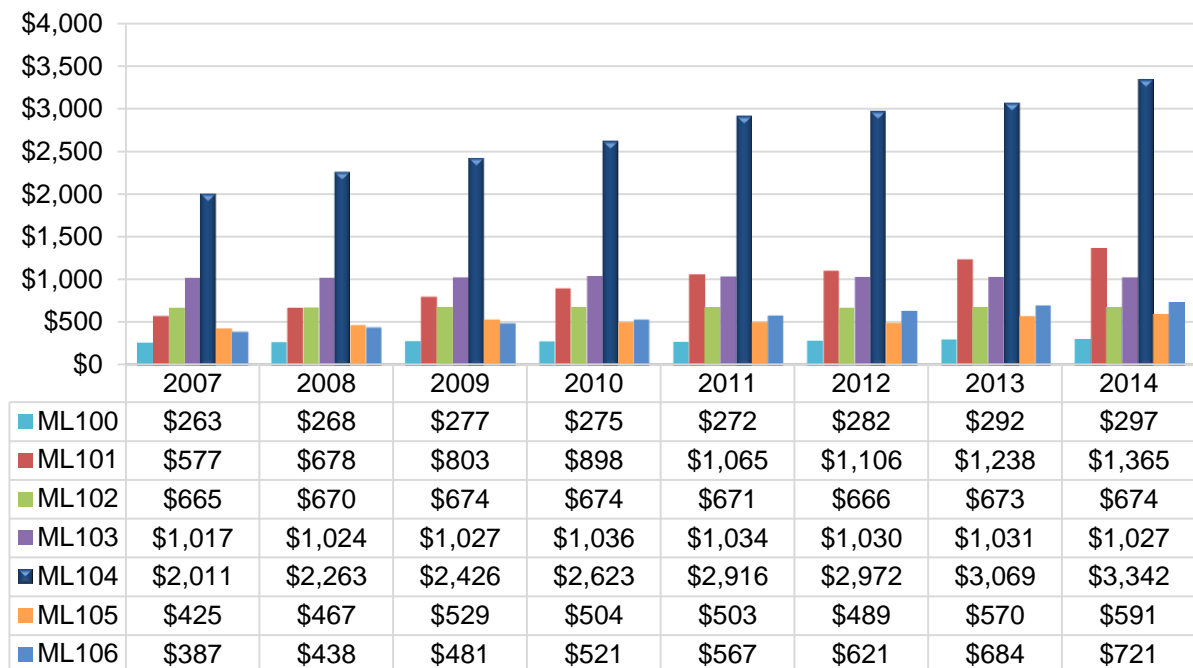
Though the conversion factor and relative values for medical-legal services have not changed since July 2006, Exhibit 2 shows a steady increase in the average paid per medical-legal service from 2007 to 2014.

**Exhibit 2: Average Paid per Medical-Legal Service by Service Year**



Medical-legal service fees are either time-based, with payments based on the time the physician spends in preparing the reports, or set at a flat fee. Payments for ML 101, ML 104, ML 105 and ML 106 codes are based on 15-minute time increments, while payments for ML 102 and ML 103 are based on flat fees. As shown in Exhibits 3 and 4, since 2007, the incremental cost increases in medical-legal services has been driven by an increasing share of services billed and paid on a time-spent basis rather than a flat-fee basis.

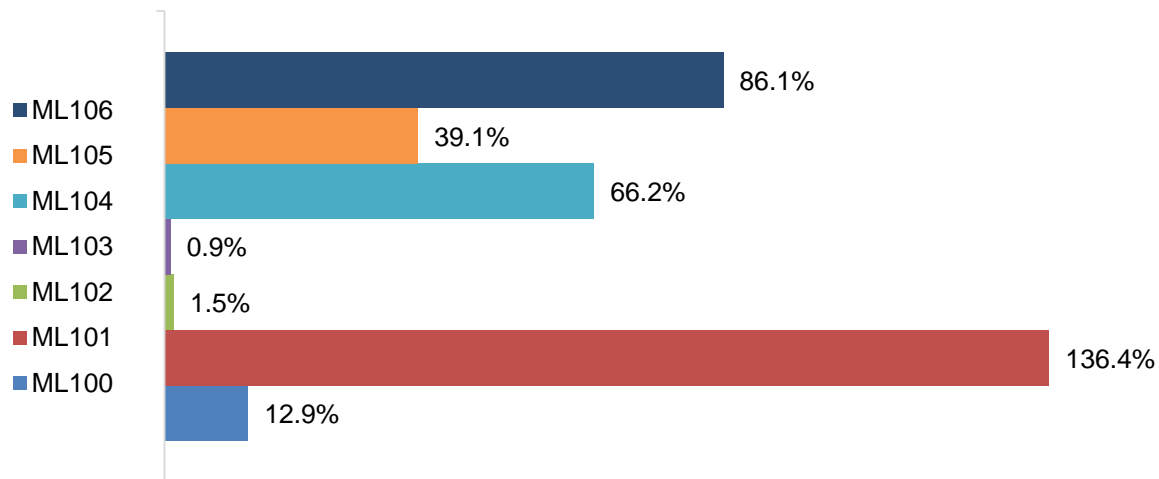
**Exhibit 3: Med-Legal Code Average Paid by Service Category & Service Year**



The data in Exhibit 3 show that average amounts paid per claim for ML 102 and ML 103 services, which are paid at a flat fee, have changed little since the 2006 fee schedule increase, while the average paid amounts for the time-based ML 101, ML 104 and ML 106 services have increased in each of the last seven service years. The average amounts paid for medical-legal testimony (ML 105 services), which are also time-based, fluctuated from 2007 to 2012, the year SB 863 was enacted, but in the two most recent years (2012 to 2014) the average amounts paid for the ML 105 services have increased along with most of the other medical-legal service categories, the exception being the ML 103 services, which are complex medical evaluations that are reimbursed at a flat fee.

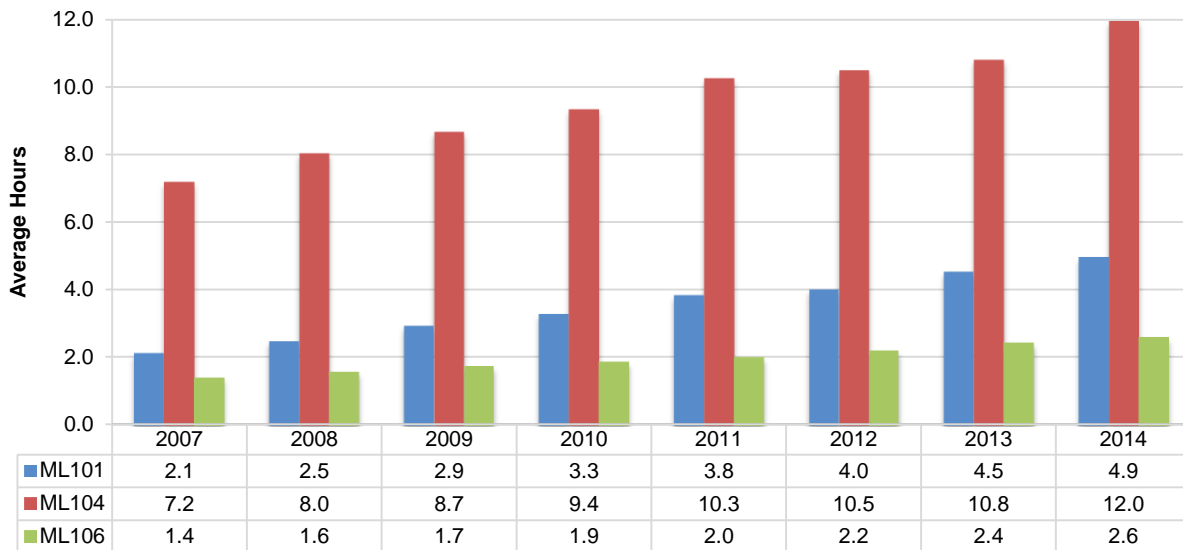
Exhibit 4 shows that the increases in the average amounts paid for time-based medical-legal services from 2007 through 2014 ranged from 39.1 percent for medical-legal testimony (ML 105 services) to 136.4 percent for follow-up evaluations within 9 months of a previous evaluation (ML 101 services). The increases in the average reimbursements for these time-based medical-legal services indicate that over the past eight years physicians have reported spending significantly more time in preparing these reports.

**Exhibit 4: 7-Year (2007 - 2014) Change in Average Paid**



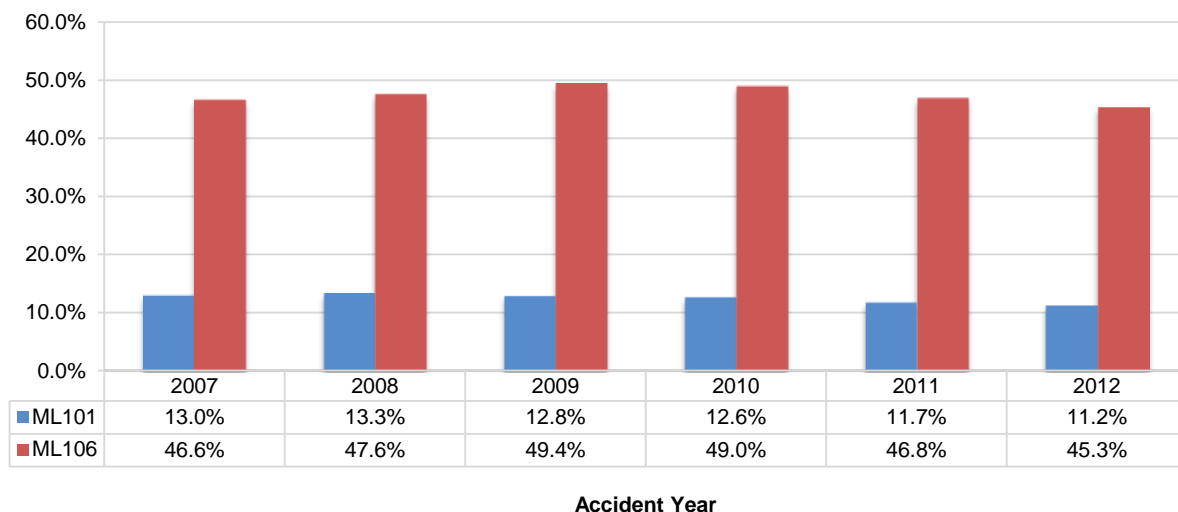
The results shown in Exhibit 5 confirm that the average number of hours associated with payments for each time-based service did increase steadily from 2007 to 2014. Unfortunately, it is not possible to identify from the data which element(s) of a medical-legal service accounted for the increased time required to complete the evaluation and/or report.

**Exhibit 5: Average Number of Hours per Medical-Legal Service Category by Year of Service**



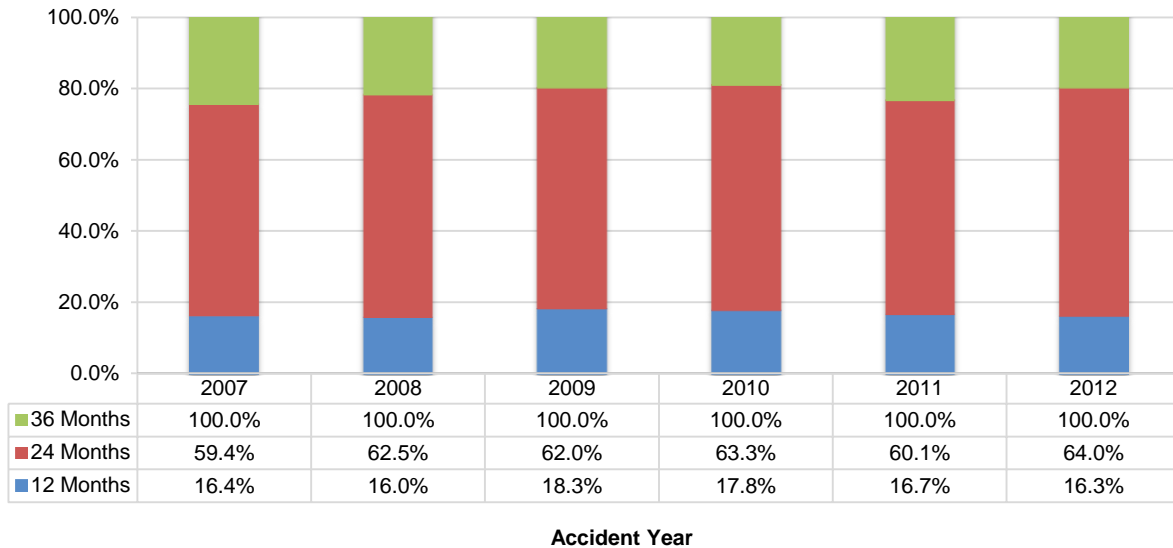
While there was a significant increase in the average amount paid per supplemental medical-legal service, the number of supplemental services relative to the number of claims in the study population showed little fluctuation. Exhibit 6 shows that nearly half of all AY 2007-2012 claims with medical-legal evaluations had at least one supplemental report that did not involve an evaluation of the injured worker (ML 106), while about one out of every eight or nine had an ML 101 follow-up evaluation and report within nine months of the original evaluation and report.

**Exhibit 6: Percentage of Claims with Medical-Legal Evaluations and Supplemental Reports**



To eliminate the effect of newer, less developed claims in which medical-legal services had not yet been rendered, but which likely would be as the claims aged, the author analyzed a subset of medical-legal claims that had been active for at least 36 months. Exhibit 7 shows that the percentage of those claims that had medical-legal evaluations and supplemental reports at 24 months post injury increased between AY 2007 and AY 2010, fell back close to the 2007 level in 2011, then rose to a new high of 64 percent in 2012.

**Exhibit 7: Cumulative Percent of Claims with Supplemental Report (ML106) at 12, 24 and 36 Months Post Injury (Claims with Medical Legal Services at 36 Months)**



Follow-up medical-legal evaluations performed within nine months of a previous evaluation are identified by code ML 101. Exhibit 8 shows the cumulative proportion of the subset of med-legal claims that were at least 36 months old that had ML 101 services at 12-, 24- and 36-months post injury. Among these claims, the proportion with first-year ML 101 services ranged from about one in six in AY 2011 to nearly one in four in AY 2009, but by the end of the second year, the percent of claims with ML 101 services was typically about three times what it had been after the first year, ranging from 61.0 percent to 67.2 percent.

**Exhibit 8: Cumulative % of Claims with Follow-up Evaluation w/in 9 Months (ML 101 Services) @ 12, 24, and 36 Months Post Injury (Claims with Medical Legal Services at 36 Months)**

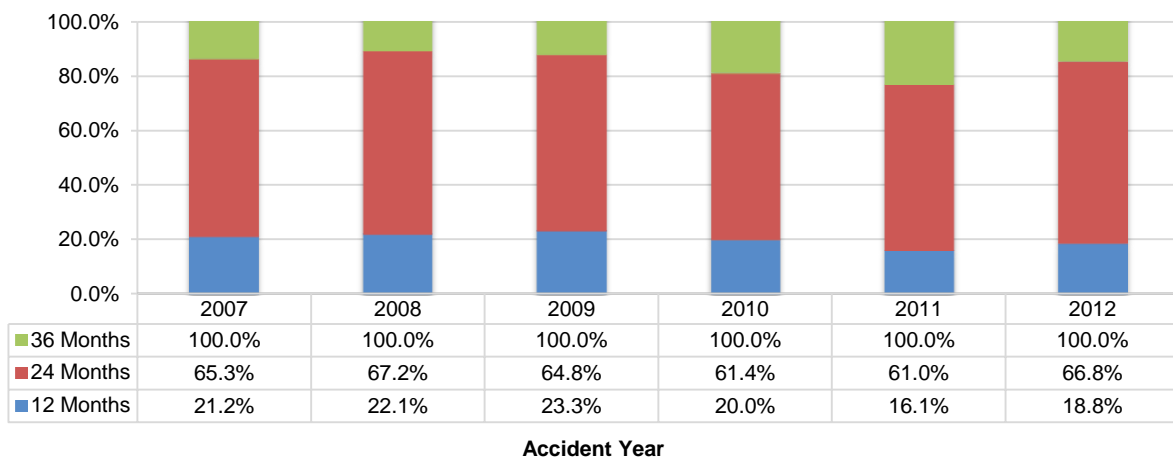


Exhibit 9 shows the average number of follow-up (ML 101) and supplemental (ML 106) reports per claim at 12, 24, and 36 months post injury. The AY 2007-2012 claims showed little variation in the number of these reports at these benchmarks, with a consistent average of 1.2 to 1.3 initial reports received within the first year, which increased to an average of 1.2 to 1.4 reports after three years. Similarly, there was an average of 1.3 supplemental reports within the first year of injury in all six accident years, and after three years the average number of ML 106 reports increased to between 1.6 to 1.7 reports.

**Exhibit 9: Average Number of Supplemental Medical-legal Reports per Claim by Accident Year at Intervals from Injury Date**

AY	Average Cumulative ML 101 per AY Claim			Average Cumulative ML 106 per AY Claim		
	1 Year	2 Years	3 Years	1 Year	2 Years	3 Years
2007	1.2	1.3	1.4	1.3	1.4	1.6
2008	1.3	1.3	1.4	1.3	1.5	1.7
2009	1.3	1.3	1.3	1.3	1.5	1.7
2010	1.2	1.3	1.4	1.3	1.5	1.7
2011	1.3	1.3	1.4	1.3	1.5	1.7
2012	1.2	1.2	1.2	1.3	1.5	1.6

The percent of claims with supplemental medical-legal reports (ML 106) is inflated, as data in Exhibit 10 shows, by physicians who bill for supplemental reports without performing an initial medical-legal evaluation. In these instances the use of the ML 106 billing code was invalid since the services did not supplement an original report. Furthermore, the proportion of ML 106 reports in which no initial evaluation was performed has increased in recent years, with AY 2013 claims data showing they accounted for about one out every six supplemental report billings received within the first year of injury, and one out of five supplemental reports received in the first two years.

**Exhibit 10: Percent of ML 106 without Primary Medical-Legal Service at Claim Age**

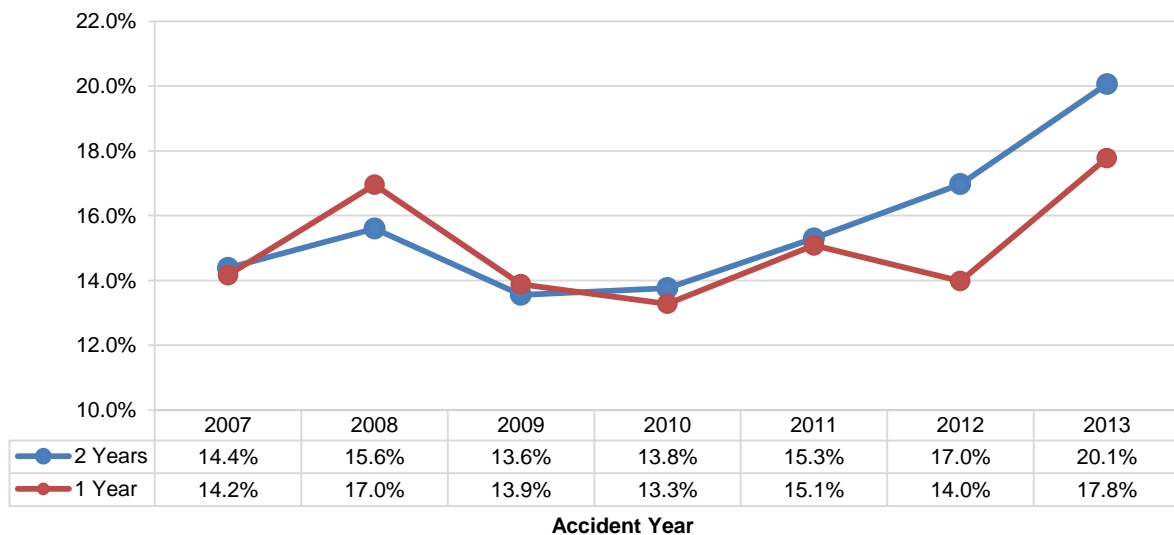
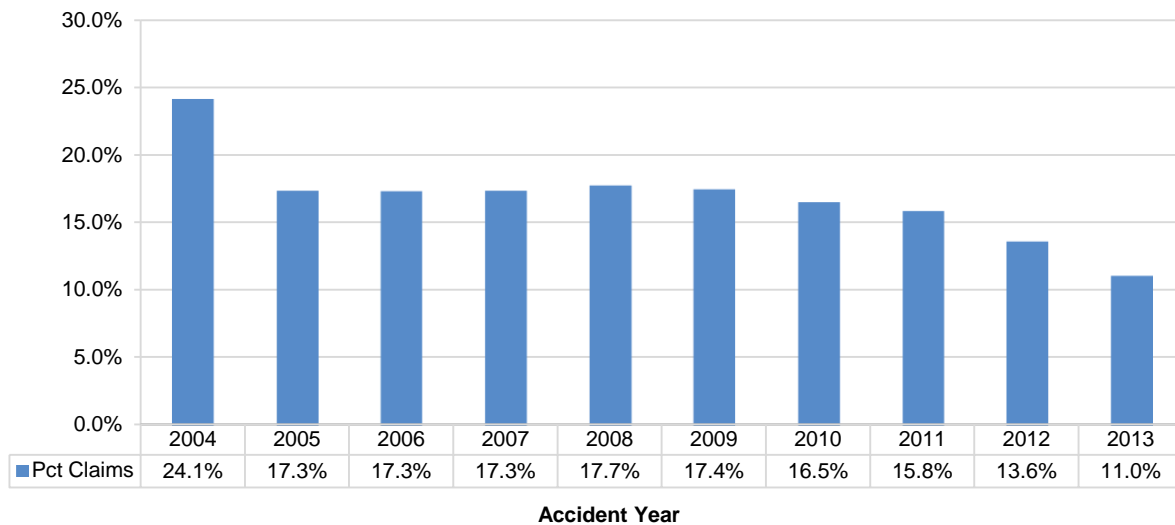


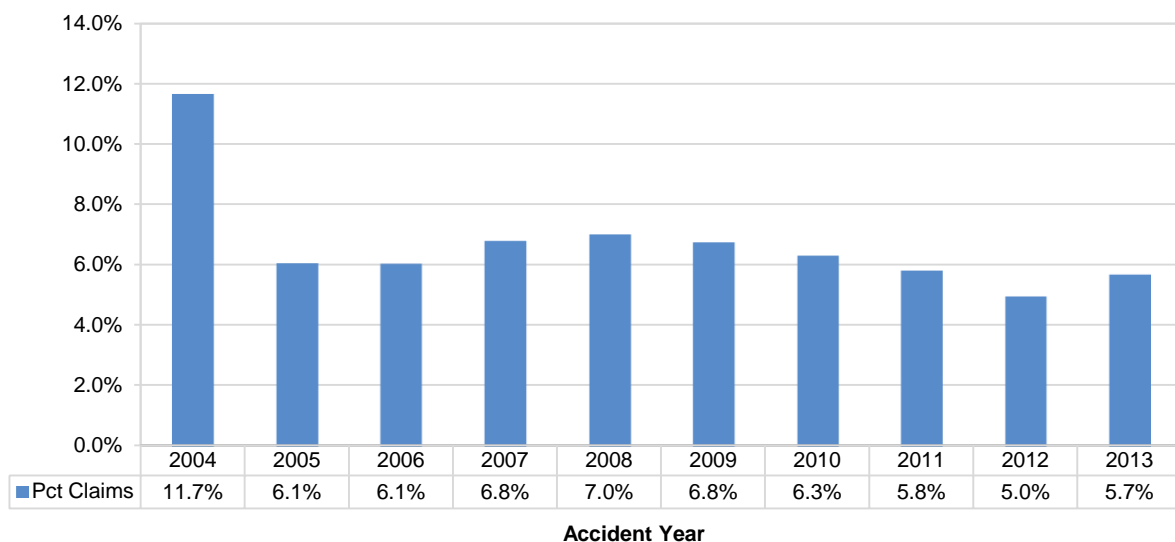
Exhibit 11 shows the percentage of indemnity claims with a medical-legal service declined from 24 percent in AY 2004 to 17.3 percent in AY 2005, a reduction that coincided with the implementation of SB 899. That percentage then held steady through AY 2009 before tailing off to a 10-year low of 11 percent in AY 2013, though the decline noted in the more recent years likely reflects the age of these claims, which are less developed and have had less time for issues to arise and medical-legal reports to be filed.

**Exhibit 11: Percent of Indemnity Claims with Medical-Legal Services**



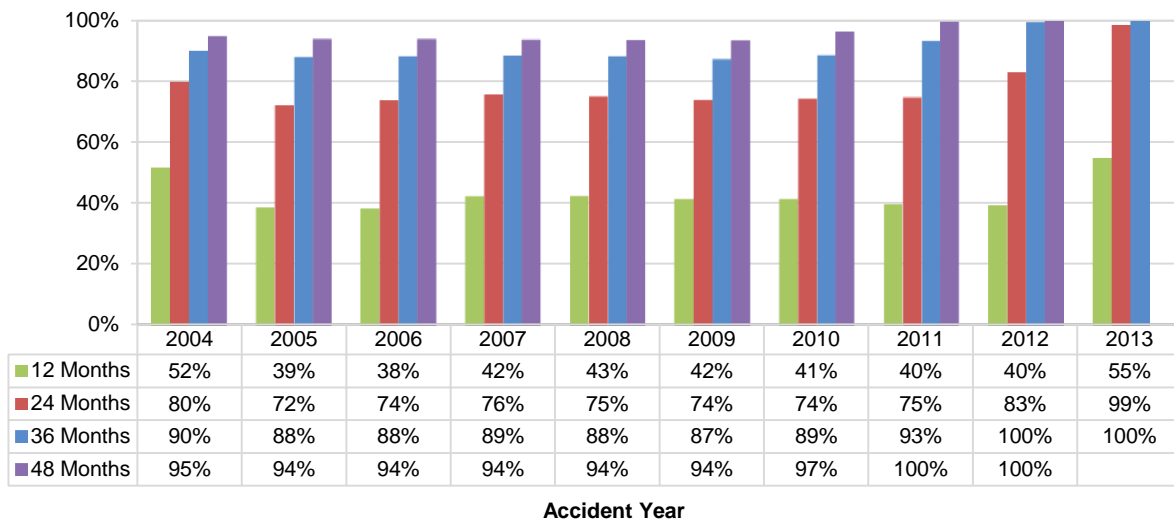
To refine the information related to the percent of indemnity claims that have medical-legal services, the author measured the proportion of claims in which the initial medical-legal service was performed within 12 months of the date of injury. The results, noted in Exhibit 12, also show the post-SB 899 decline in the percent of claims with a medical-legal service in 2005, as well as more recent AY 2009-2012 declines.

**Exhibit 12: Percent of Indemnity Claims with Medical-Legal Services within 12 Months of Injury**



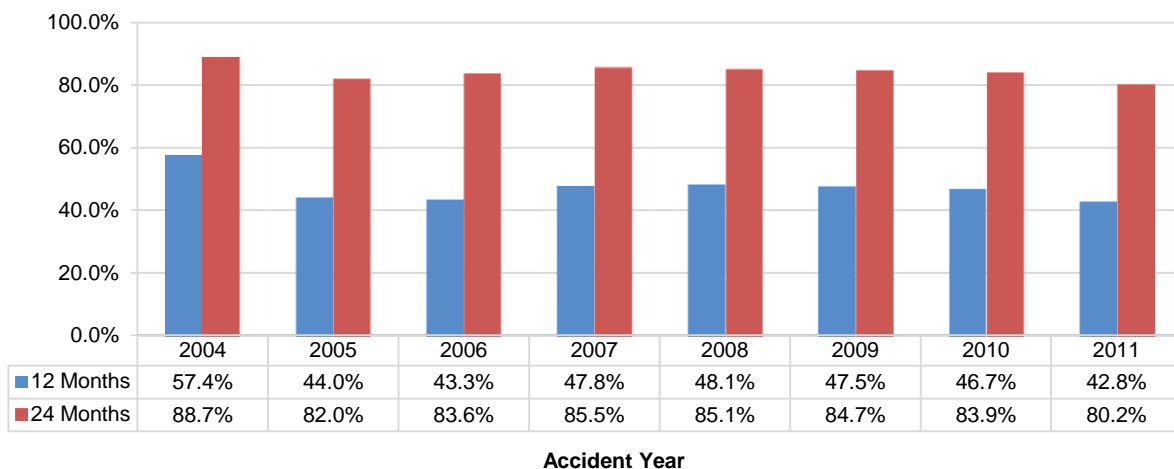
To gain insight into the trends shown in Exhibits 11 and 12, the author focused on how long after the injury date the initial medical-legal service was delivered. The medical-legal code with the oldest date of service for the associated claim was extracted from the dataset and the time between the injury date and the date of medical-legal service was measured in months. Exhibit 13 shows the cumulative percentage of medical-legal claims in which the initial evaluation had occurred at 12, 24, 36, and 48 months post injury, with results broken out for AY 2004 through 2013 claims. Since the 2004 reforms took effect, the percent of medical-legal claims in which medical-legal services were initiated at each of these benchmarks has been fairly stable, with the exception of the most recent years where the claims are newer and less developed.

**Exhibit 13: % of Med-Legal Claims w/1st M-L Service at 12, 24, 36, 48 Months**



Once again, to control for less developed claims in which medical-legal services had not yet been rendered but likely would be as the claims aged, the author used the subset of medical-legal claims that had been active for 36 months. Among these claims, roughly half of the initial medical-legal services were delivered in the first year following the injury (Exhibit 14).

**Exhibit 14: % of Med-Legal Claims w/1st M-L Service @ 12 & 24 Months, Claims ≥ 36 Months Old**



AY 2004 had the highest percentage of claims with first-year medical-legal evaluations (57.4 percent), though that proportion declined to 44 percent in 2005 and 43.3 percent in 2006. These declines were followed by an increase in the percentage of claims with first-year initial medical-legal evaluations beginning in AY 2007. Exhibit 14 also shows that for all eight accident years included in the analysis more than 80 percent of the initial medical-legal evaluations occurred in the first two years of claim development.

A review of AY 2007–AY 2012 data reveals that except for the ML 101 follow-up evaluations, the average number of days between an initial medical-legal evaluation and a subsequent evaluation or supplemental report decreased over that 6-year span (Exhibit 15). The biggest decrease in the elapsed time between the initial and subsequent evaluation (20.4 percent) was in the complex evaluations identified by ML 104, where the average number of days between an ML 104 and an ML 102, an ML 103 or a subsequent ML104 declined from 57.7 days for AY 2007 claims to 46 days for AY 2012 claims. Data on the average number of days between services was limited to the first two years of claim development to ensure that the average number of days was not skewed based on limited claim development time.

**Exhibit 15: Average Number of Days from Previous Primary (ML102, ML103, ML104) Service – Services Within 2 Years of Injury**

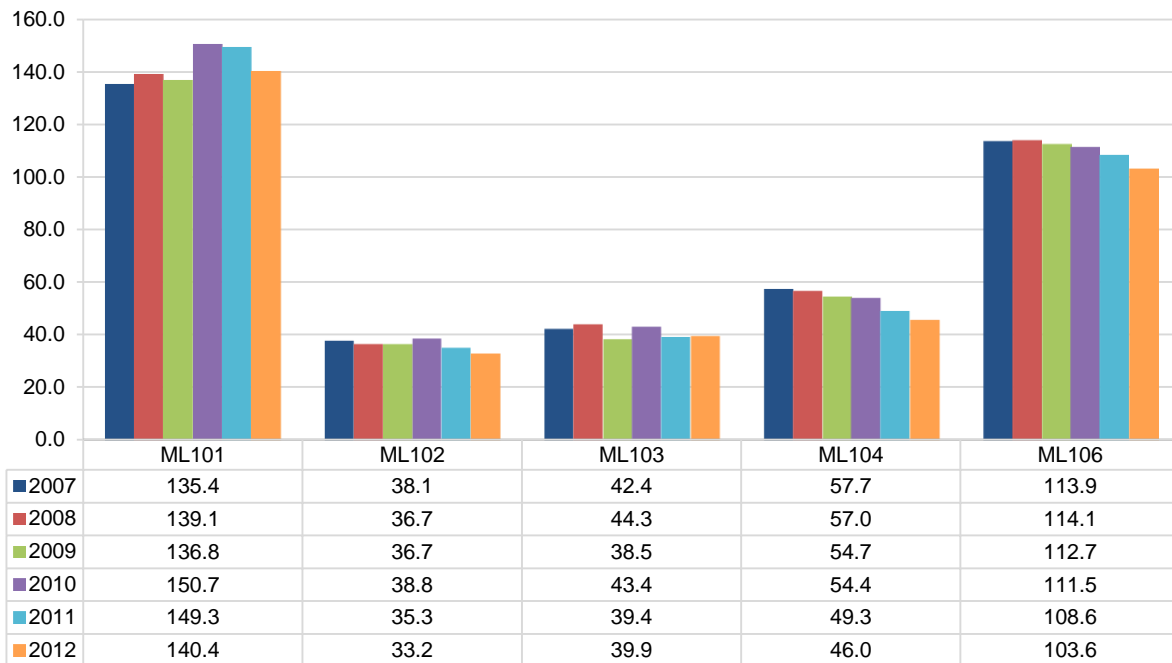
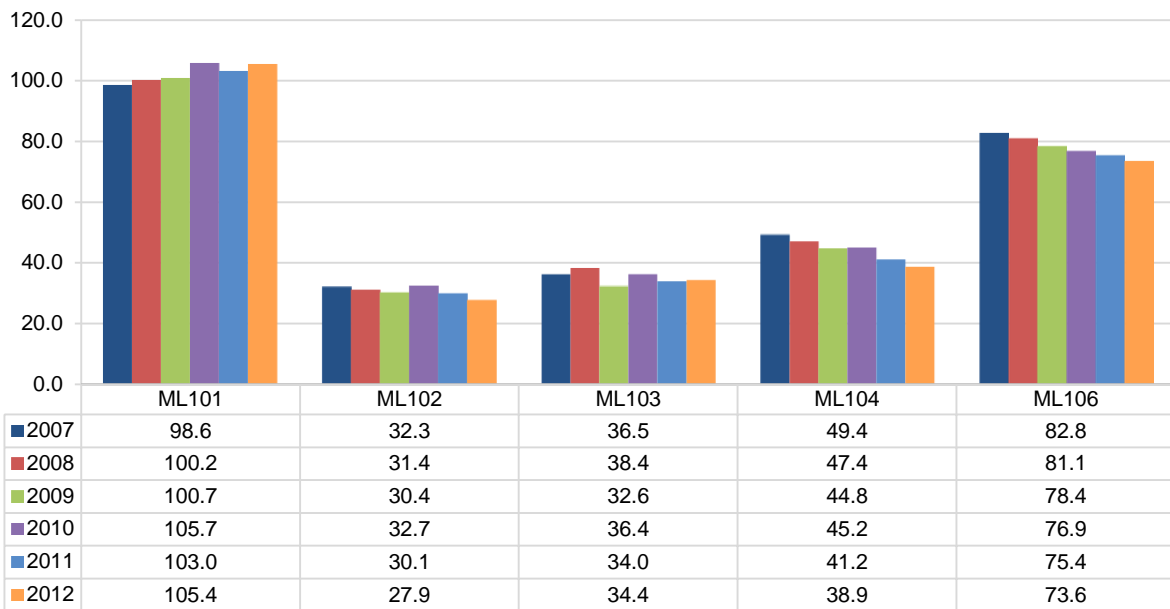


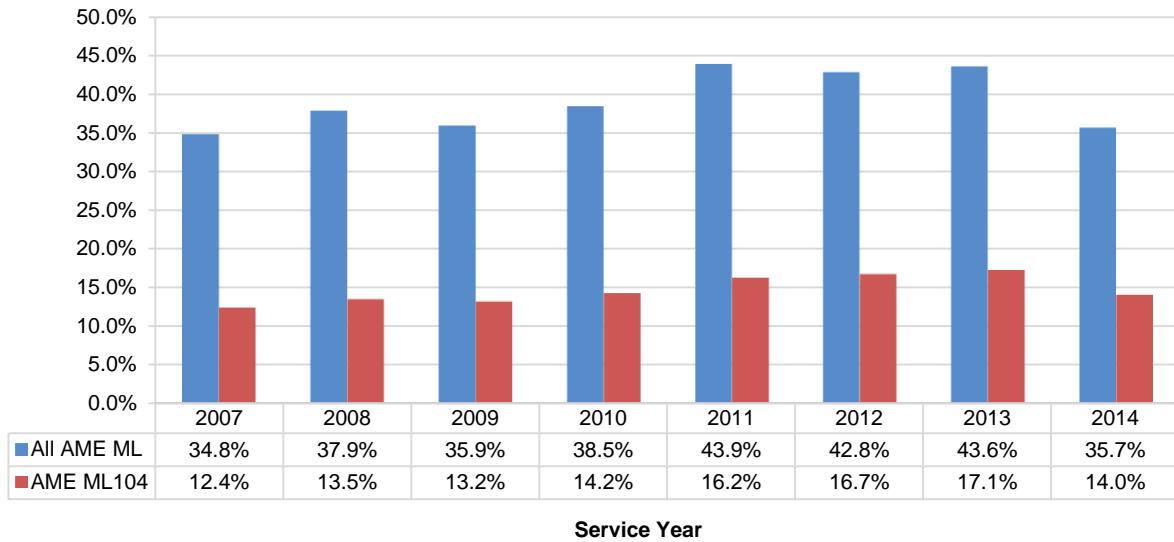
Exhibit 16 shows the average number of days from a previous medical-legal service irrespective of whether the previous service was a primary service (ML 102, ML 103 or ML 104) or a supplemental service. The AY 2007-2012 data again reveal reductions in the amount of time that elapsed between the primary evaluation and the subsequent medical-legal services (ranging between 5.7 percent and 21.3 percent during that 6 year period). The only exception was in the average amount of time between a primary medical-legal service and a follow-up service within 9 months (ML 101), where the elapsed time increased by 7 percent.

**Exhibit 16: Average Number of Days from Previous Medical-Legal Service - Services Within 2 Years of Injury**



The proportion of medical-legal services provided by an Agreed Medical Evaluator fluctuated between service years 2007 and 2014, increasing from 38.5 percent in 2010 to 43.9 percent in 2011, then holding relatively steady through 2013 before falling to 35.7 percent in 2014 -- which was almost back to the 2007 level (Exhibit 17). A slightly different pattern was noted for complex medical-legal evaluations (ML 104) provided by AMEs, which gradually increased from 12.4 percent of all medical-legal services in 2007 to 17.1 percent in 2013, but then declined to 14 percent in 2014, resulting in a net increase of 1.6 percentage points, or a relative increase of 12.9 percent over the 8-year span of the study.

**Exhibit 17: Percent of Medical-Legal Services Provided by Agreed Medical Evaluator (AME)**



## Discussion

Although medical-legal services have historically represented less than 10 percent of all California workers' compensation medical services, they are an important component in resolving disputes over permanent impairment, apportionment and medical treatment requests. For more than a quarter century, there have been significant legislative reforms that have altered the medical-legal process, including AB 276, the 1989 bill that restricted the number of medical-legal evaluations needed to determine the extent of an injured worker's permanent disability, and SB 31 in 1993, which mandated implementation of a fee schedule and creation of a more restrictive definition for compensable services. Subsequent reforms enacted between 2002 and 2004 (AB 749, SB 228 and SB 899) resulted in changes that included implementation of MPNs, utilization review standards, adoption of the AMA Guides for permanent impairment rating and the creation of new requirements for a single evaluator – either an AME or QME – to resolve medical-legal issues.

More recent legislative reforms negotiated in 2012 between representatives of the Brown Administration, labor and employers and encompassed in SB 863, removed disputes over medical treatment requests from the purview of the Workers' Compensation Appeals Board and the medical-legal process. A prospective evaluation of the SB 863 reforms by the Workers' Compensation Insurance Rating Bureau (WCIRB) assumed that medical-legal reports addressing medical treatment disputes would be replaced by IMR reports, resulting in a decrease in the volume and cost of medical-legal reports<sup>4</sup>, though the WCIRB's initial evaluation of post-IMR data, published in late 2014, found no reduction in the volume or cost of medical-legal reports.<sup>5</sup>

While the data is still too green to reach any final conclusions regarding the impact of the IMR process on medical-legal reports, the post-SB 863 medical-legal data from this analysis supports the WCIRB's initial findings. At the same time, it provides an in-depth analysis of the historical trends that began following the implementation of the 2004 reforms, showing that the proportion of indemnity claims that involved at least one medical-legal service within the first year of injury declined significantly immediately after the 2004 reforms, and though it did begin to increase in 2007, it still remains well below the 2004 level.

Furthermore, the data trends documented in this study reveal that since the medical-legal fee schedule was last revised in July 2006 there has been a steady increase in the average amounts paid for medical-legal evaluations categorized as “comprehensive... involving extraordinary circumstances...” (ML 104), supplemental reports (ML 106), and follow-up evaluations occurring within nine months of the physician's initial medical-legal evaluation (ML 101), with increases of 66.2 percent, 86.1 percent and 136.4 percent respectively. The increase in the average payment for the most complex level of service (ML 104) has been compounded by a 21.6 percent increase in the service's proportion of total medical-legal services.

The amount paid for medical-legal testimony also increased steadily over the 8-year service period of the study; resulting in a 39.1 percent increase in the amount paid for this service. While the per service cost associated with medical-legal testimony has increased, the need for the service has not increased over time; consistently representing half of one percent of total medical-legal services.

Without the ability to review associated reports it is not possible to identify factors that drove the increase in payments for the time-based medical-legal codes, but one possible driver is the need to fully address all factors related to disability, apportionment and need for medical care. There also appear to be other

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4. WCIRB. Senate Bill No. 863 WCIRB Cost Monitoring Report – Initial Retrospective Evaluation. October 28, 2013.

5. WCIRB. Senate Bill No. 863 WCIRB Cost Monitoring Report – 2014 Retrospective Evaluation. November 14, 2014.

unidentified factors influencing increased costs as evidenced by payment of services mischaracterized as medical-legal, which this study found encompassed at least 20 percent of the supplemental reports on AY 2013 claims, as illustrated in Exhibit 10.

Since it was not possible to isolate reports or portions of reports that address medical necessity, the author relied on empirical data to identify changes in the volume, frequency and complexity of reports that may have resulted from SB 863 legislative action. The implementation of the IMR process mandated by the 2012 reform bill did not affect claims with dates of injury prior to January 1, 2013 until July 1, 2013, so the data is too immature to determine the impact that IMR has had on the medical-legal process. The analyses of data from accident years 2007 through 2012 and service years 2007 through 2014 will, however, provide benchmark statistics to enable future analysis of the IMR process on medical-legal reporting.

## Appendix

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

#### **Section 9795(c)**

ML 100 – Missed appointment – for communication purposes only -- does not imply compensation owed.

ML 101 – Follow-up Medical-legal Evaluation. Limited to a follow-up evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. Billed in 15-minute increments.

ML 102 – Basic comprehensive medical-legal evaluation. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.

ML 103 – Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the defined complexity factors.

ML 104 – Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances. Evaluation requires four or more of the defined complexity factors listed under ML 103 and three or more hours of record review by the physician. Billed in 15-minute increments.

ML 105 – Medical-Legal testimony. Billed in 15-minute increments. Includes time for reasonable preparation and travel time. One hour minimum for a scheduled deposition.

ML 106 – Supplemental medical-legal evaluation. Billed in 15-minute increments.

#### **Section 9795(d)**

-92 Performed by a primary treating physician. For identification purposes only.

-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. Increases value by 1.1. Only applicable to ML 102 and ML 103.

-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, for an ML 102 or ML 103, the value of the procedure is modified by multiplying the normal value by 1.35.

-95 Evaluation performed by a panel selected Qualified Medical. For identification purposes only.

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## California Workers' Compensation Institute

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