California Workers' Compensation Institute

Research Update

An Early Look at the Impact of the New Med-Legal Fee Schedule

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Executive Summary

Medical-legal evaluations and their associated reports serve an important function in the California workers' compensation system, offering expert medical opinion to resolve medical disputes. Efficient and timely resolution of medical issues allows a case to move forward and a worker with a claimed injury to have their claim equitably resolved. Building on previous research on this topic, this study assesses the initial impact of changes to the reimbursement rules and fees that were implemented April 1, 2021. Key findings include:

- Compared to the same time period in 2019, the average payment for a comprehensive evaluation that includes a face-to-face examination of the injured worker increased by 52.9 percent.
- The average payment for supplemental evaluation reports increased by 39.1 percent when comparing service payments from 2019 to those from 2021.
- The new per-page record review fee added, on average, $1,917 to the base fee for comprehensive evaluations, $1,410 to the base fee for follow-up evaluations, and $1,437 to the base fee for supplemental evaluation reports.
- Physicians specializing in orthopedic surgery provided 53 percent of the medical-legal services during 2021 – internal medicine physicians were a distant second providing 9 percent of the services.
- The average number of reports varies with the age of the claim with injuries between 2000 – 2014 having 9 reports per claim and more recent, less developed claims from 2017 – 2021 ranging from 1.1 to 4.2 reports.
- 211 new physicians joined the pool of certified Qualified Medical Evaluators (QMEs) in 2021, while only 18 physicians became inactive, resulting in 2,554 active evaluators, a 3 percent increase from 2020 but a 1 percent decrease from 2019.
- The median number of service locations per QME increased from three in 2019 to four in 2021, with 25.6 percent of the QMEs registering 10 or more locations in 2021.

*Updated exhibits 5, 7, 8, and 23 along with associated text on July 12, 2022, and September 13, 2023.

Background

Medical-legal evaluations are used to resolve medical disputes that arise regarding compensability issues in workers' compensation claims. Physicians certified as QMEs by the Division of Workers' Compensation (DWC) and Agreed Medical Evaluators (AMEs) are deemed qualified to provide expert medical opinions related to claim issues including causation, permanent and stationary (P&S) status,[1] work status, as well as any associated permanent impairment, apportionment, need for future medical care, and work restrictions.[2] Senate Bill 863, signed by Governor Jerry Brown on September 18, 2012, contained a provision that removed disputes related to medical treatment requests from the medical-legal process, and effective January 1, 2013, established a new independent medical review (IMR) process for injuries occurring on or after that date, and for all other dates of injury effective July 1, 2013.

Regulations governing medical-legal evaluation and report services, and payment for those services, have undergone significant changes over the past three decades. Prior to enactment of Senate Bill 31 in the spring of 1993, fees paid for medical-legal services were based on charge data and varied by physician specialty. Effective August 3, 1993, the mandated Medical-Legal Fee Schedule (MLFS) established set fees based on the level of complexity[3] and removed specialist payment variability. Revisions made to the MLFS in 2006 included the addition of new codes to identify supplemental reports (ML106) and medical-legal testimony (ML105). Prior to the addition of separate codes these services were billed and paid using the time-based ML104 code with modifiers delineating the services (-97 for supplemental reports and -96 for medical-legal testimony). The 2006 revisions also increased the conversion factor used to calculate payments from $10.00 to $12.50 – the 25 percent increase was in-part to account for the assumption that the transition from evaluating permanent disability to evaluating permanent impairment using the Guidelines of the American Medical Association[4] would require more time to be spent by the evaluating physician.

The payment rates established in the 2006 MLFS remained in effect until the implementation of a new MLFS on April 1, 2021. Two significant factors underscored the need to update the fees defined under the MLFS regulations:

- The fees had not been updated in more than a decade, which was cited by the California State Auditor as a potential cause for a decline in the number of QMEs available for medical-legal evaluations;[5] and

- The complexity factor rules used to assign the level of service for comprehensive evaluations and resultant increases in hourly billing for extraordinary evaluations were a source of continual conflict.[6,7]

[1] "Permanent & Stationary" is a California workers' compensation term of art used to describe maximum medical improvement (MMI): the state where an individual's condition is unlikely to improve with further treatment.
[2] Title 8, California Code of Regulations §9793(e).
[3] $500 basic, $750 complex, $200/hour extraordinary, $250 follow-up
[4] SB 899 (2004) – Labor Code §4660(b)(1)
[5] Auditor of the State of California. *Department of Industrial Relations: Its Failure to Adequately Administer the Qualified Medical Evaluator Process May Delay Injured Workers' Access to Benefits.* November 2019. https://www.bsa.ca.gov/reports/2019-102/index.html
[6] *Dr. Timothy C. Howard, et al. v. California Department of Industrial Relations, et al*
[7] DWC. *Initial Statement of Reasons Subject Matter of Regulations: Workers' Compensation – Medical-Legal Fee Schedule. Title 8, California Code of Regulations Sections 9793, 9794 & 9795.* Oct 2020. https://www.dir.ca.gov/dwc/DWCPropRegs/2020/Medical-Legal-Fee-Schedule/Med-Legal-Fee-Schedule.html

The structure and payment methodology introduced in the 2021 MLFS is substantially different from the complexity-based structure and methodology of the prior fee schedule. Adoption of the new MLFS by the DWC Administrative Director was preceded by a series of public forums, stakeholder meetings, and mandatory public comment opportunities from May 2018 through December 2020.

The 2021 MLFS replaced varying payments based on three levels of complexity (basic - $625, complex - $937.50, and extraordinary - $250/hour), with a flat fee of $2,015 for comprehensive evaluations involving examination of the injured worker. The level of complexity, which must be factored into payment values under Labor Code §5307.6(a), is no longer addressed by differing code descriptions and varying payments. In lieu of complexity factors a new fee has been created to pay for review of medical records or other documents submitted by the injured worker's attorney, the injured worker for non-litigated claims, or the claims administrator or their attorney. The record review fee for new code MLPRR is $3.00 per page for pages exceeding 200 pages (200 pages are included in the $2,015 flat fee). Table 1 provides a side-by-side comparison of codes and assigned fees for medical-legal services under the 2006 MLFS and the 2021 MLFS.

Table 1: Comparison of 2006 MLFS and 2021 MLFS Codes and Fees

2006 MLFS	2021 MLFS
Missed Appointment	
ML100 - "does not imply compensation is necessarily owed"	ML200 - flat fee of $503.75
Comprehensive Medical-Legal Evaluations (involves face-to-face examination)	
ML102 - flat fee of $625	ML201 - flat fee of $2,015 plus $3.00 per page for records exceeding 200 pages
ML103 - flat fee of $937.50	
ML104 - $62.50/15 minutes ($250/hour)	
Follow-up Medical-Legal Evaluations (involves face-to-face examination)	
ML101 - $62.50/15 minutes	ML202 - flat fee of $1,316.25 plus $3.00 per page for records exceeding 200 pages
Supplemental Evaluation Report (no face-to-face examination)	
ML106 - $62.50/15 minutes	ML203 - flat fee of $650 plus $3.00 per page for records exceeding 50 pages
Medical-Legal Testimony	
ML105 - $62.50/15 minutes ($250/hour)	ML204 - $455/hour
Review of Sub Rosa Recordings	
Not separately paid	ML205 - $325/hour
Per Page Record Review	
Not separately paid	MLPRR - $3.00/page

Since medical-legal reports are intended to provide expert opinions on medical issues to resolve disputes, the quality of the reports and their usefulness for this purpose is foundational. In its November 2019 report the state auditor's office indicated that the quality of reports was in question, and the last analysis by the DWC found that approximately 85 percent of the reports reviewed in 2015/2016 were found to be substandard. In an effort to address deficiencies in reports that result in the submission of supplemental reports the revised MLFS regulations redefined the parameters used to bill for supplemental reports.

Study Objectives

The implementation of a significantly different MLFS in April of 2021 was intended to increase payments to QMEs and AMEs, as well as to curtail abuses and conflicts that arose with the use of complexity factors and time-based fees.[8] The DWC stated in its October 2020 *Initial Statement of Reasons (ISOR)* that its intent was to increase the reimbursement rate of medical-legal reports by "approximately 25%." The primary objective of this study is to measure the effect of the new rules and fees on reimbursements for medical-legal evaluations and reports by comparing payments made after the April 1, 2021, effective date to payments made prior to the changes.

In addition to measuring the impact of the changes in the medical-legal fees on medical-legal payments, the author analyzes utilization patterns, especially as they relate to billing and payment of supplemental evaluation reports. The utilization patterns for comprehensive evaluations and follow-up evaluations are also analyzed due to the change in the timeframe for billing follow-up evaluations (18 months since previous evaluation under the new MLFS compared to 9 months prior to April 1, 2021). Prior to this change, the comprehensive codes were used to determine the amounts billed and paid for face-to-face evaluation services once the 9-month timeframe expired.

Lastly, payments for missed appointments were not required under the 2006 MLFS. Under the new MLFS missed appointments for which mandatory payment is due are described under §9795. The regulation now also includes language that allows an employer to seek credit for the missed appointment fee against the injured worker's award if the charge resulted through the fault or neglect of the injured worker or their representative. The utilization and costs associated with missed appointments are also examined in this study.

Data and Methods

This study is based on data derived from accident year (AY) 2015 through 2021 claims. The service year data also runs from 2015 through 2021 and includes all medical-legal codes and payments with dates of service between January and October of each calendar year. Service dates were limited to January through October of each year to account for the timing of billing and payment.[9]

Detailed analysis of services provided from January through October 2021 includes the assigned diagnostic category. Diagnostic categories were not assigned to claims where medical-legal services were provided but no treatment services occurred.

[8] DWC. *Initial Statement of Reasons Subject Matter of Regulations: Workers' Compensation – Medical-Legal Fee Schedule. Title 8, California Code of Regulations Sections 9793, 9794 & 9795*. October 2020. https://www.dir.ca.gov/dwc/DWCPropRegs/2020/Medical-Legal-Fee-Schedule/Med-Legal-Fee-Schedule.html

[9] Evaluators may not submit a bill on the date of service, and claims administrators have 60 days from receipt of the bill to render payment. Additional time is required for claims organizations to submit payment data to CWCI for inclusion in the IRIS database.

After identifying claims with medical-legal service dates between January 1, 2021, and October 31, 2021, the author examined all medical-legal service records from calendar year 2000 forward to capture all medical-legal services for each identified claim. The physician's National Provider Identifier (NPI) was used to query the CMS National Plan and Provider Enumeration System (NPPES) NPI Registry for the taxonomy code describing their medical specialty. Additional internet searches were also used for publicly available information related to rendering physicians.[10]

Results

Exhibit 1 shows the distribution of indemnity and medical-only (MO)[11] claims for AY 2015 through AY 2021. Indemnity claims represented a declining share of the claims over the seven-year period, with the lowest percentage noted in the newest (AY 2021) data. However, some claims that were initially MO claims will become indemnity claims at a later date when temporary disability payments are made retroactively due to claim acceptance after delay or denial, or permanent disability payments are made after medical reporting supports the existence of permanent disability.

Exhibit 1: Distribution of Claims by Claim Type and Accident Year

Claim Type	2015	2016	2017	2018	2019	2020	2021
Indemnity	39.0%	38.0%	36.4%	37.2%	36.5%	37.3%	33.2%
MO	61.0%	62.0%	63.6%	62.8%	63.5%	62.7%	66.8%

Exhibit 2 shows the share of medical-only claims from each accident year that had at least one medical-legal service payment compared to the share of indemnity claims with at least one medical-legal service. The results show that from 2015 through 2021 the percent of indemnity claims with a medical-legal service decreased steadily, while the share of medical-only claims with a medical-legal service increased from 2.7 percent in AY 2015 to a high of 4.3 percent in AY 2020.

Exhibit 2: Percent of Claims with Medical-Legal Report by Accident Year

Claim Type	2015	2016	2017	2018	2019	2020	2021
Indemnity	39.9%	38.3%	36.5%	34.4%	29.9%	18.1%	2.7%
MO	2.7%	2.9%	2.8%	3.2%	3.7%	4.3%	1.2%

Exhibit 3 shows the average number of days between the injury date and the first date of service for medical-legal services that occurred within a year of the injury. The AY 2021 claims did not have 12 months development so the claim set for that population was more limited. For each of the study years the time to first medical-legal service was shorter for claims without indemnity payments.

Exhibit 3: Average Days from DOI to First Medical-Legal by Accident Year (1st 12 months of injury for pre-2021 claims)

Claim Type	2015	2016	2017	2018	2019	2020	2021
Indemnity	245	232	235	237	238	236	171
MO	209	195	203	208	216	227	164
Combined Average	241	228	231	233	234	234	168

[10] Since some physicians merely use the taxonomy code denoting "specialty" in describing their licensure or specialty credential augmented searches were necessary.

[11] Medical-only claims include claims that have payments that are considered "medical" (e.g., treatment, medical-legal) but no temporary or permanent disability payments.

The data does not include information that enable identification of the type of issue evaluated (*e.g.*, to determine causation on a denied claim), but the shorter timeframe noted for the medical-only claims may be associated with denied claims for unrepresented workers.

Acknowledging that the date of injury for cumulative trauma (CT) claims is not specific to an event[12] and may precede the filing of a claim by a significant period of time,[13] the author also calculated the average number of days from the claims administrator notification to the first medical-legal service (Exhibit 4). Comparing the combined average number of days from the injury date to the first medical-legal service shown in Exhibit 3 to the combined average number of days from the claims administrator notification to the first medical-legal service shown in Exhibit 4 indicates a difference of about 20 days, a result that was fairly consistent across all accident years. This suggests that with the inclusion of the CT claims, the average amount of time that elapses between the date of injury and the first medical-legal is lengthened by about 20 days.

Exhibit 4: Average Days from Claims Administrator Notification to First Medical-Legal by Accident Year (1st 12 months of injury for pre-2021 claims)

Claim Type	2015	2016	2017	2018	2019	2020	2021
Indemnity	226	214	216	217	221	218	157
MO	185	176	178	183	192	192	136
Combined Average	221	209	211	211	215	209	147

Supplemental evaluation reports are submitted after a report for a comprehensive or follow-up evaluation has been completed and new information becomes available that must be included in the QME's/AME's analysis. Exhibit 5 shows the average, median, and maximum number of supplemental reports submitted for AY 2015 through AY 2021 indemnity claims.

Exhibit 5: Number of Supplemental Reports per Indemnity Claim by Accident Year

AY	Average	Median	Maximum
2015	0.86	0	17
2016	0.81	0	14
2017	0.78	0	12
2018	0.69	0	13
2019	0.56	0	13
2020	0.34	0	9
2021	0.11	0	2

The average number of supplemental reports ranged from 0.11 among the youngest (AY 2021) claims to 0.86 for the most developed (AY 2015 claims), the median number of supplemental reports across all seven years was 0, indicating higher volume claims, as reflected in the maximum report numbers, may be driving the averages to approach almost one supplemental report for every claim.

[12] Labor Code §5412 defines the date of injury assigned to a CT injury as "…that date upon which the employee first suffered disability therefrom and either knew, or in the exercise of reasonable diligence should have known, that such disability was caused by his present or prior employment."
[13] Jones, S.L., David, R.B., and Hayes, S. Cumulative Trauma in California Workers' Compensation. *CWCI Research Note*. December 2016.

The average number of days from the preceding comprehensive evaluation to the supplemental report, broken out by the year of service for the supplemental reports and by claim type, is shown in Exhibit 6. The results varied significantly across all seven service years, with supplemental report services in 2015 averaging the fewest number of days from the preceding comprehensive report – a result that held true for both indemnity claims, where the average was 65.9 days, and MO claims, where the average was 49.5 days.

Exhibit 6: Average Days from Comprehensive Evaluation to Supplemental Report based on Year of Service for Supplemental Report

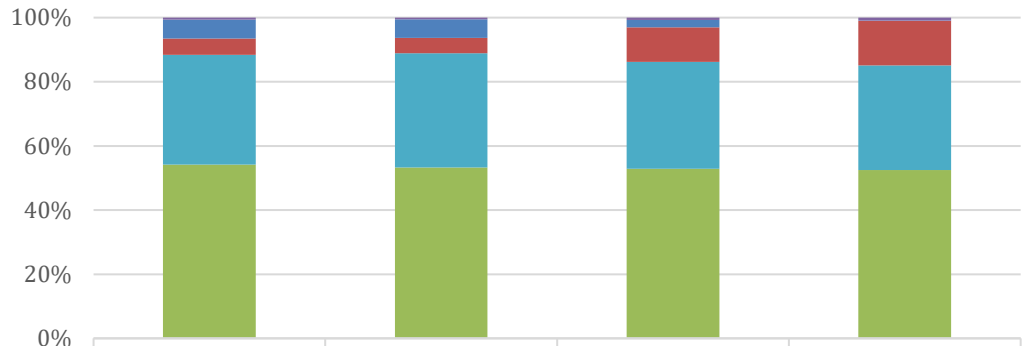
Claim Type	2015	2016	2017	2018	2019	2020	2021	All
Indemnity	65.9	108.7	140.7	152.3	196.0	185.3	207.4	175.3
MO	49.5	94.6	139.6	164.4	203.5	198.6	196.0	186.8
All	64.5	107.8	140.7	153.0	196.6	186.7	205.3	176.4

As in prior CWCI studies examining medical-legal services,[14,15] this study compares the mix of medical-legal services based on the year in which the services occurred. To gain a better understanding of the impact of the MLFS revisions the author focused on the most recent calendar years. With the understanding that the COVID-19 pandemic impacted service delivery, the author included calendar year 2019 data in the fee schedule analysis in order to measure pre-pandemic experience.

Exhibit 7 shows the distribution of services for each calendar year, combining the 2006 MLFS codes for basic (ML102), complex (ML103) and extraordinary (ML104) into the comprehensive category (ML201) defined under the 2021 MLFS. While the distribution of services was stable between 2019 and 2020, the 2021 distributions show a shifting pattern. It must be noted that services provided during the first three months of 2021 were billed and paid under the 2006 MLFS.

[14] Jones, S.L. The Changing Nature and Cost of the Medical-Legal Process in California Workers' Compensation. *CWCI Research Note.* February 2016.
[15] Jones, S.L. Changes in the QME Population and Medical-Legal Trends in California Workers' Compensation. *CWCI Research Update*. February 2018.

Exhibit 7: Service Volume Distribution by Service Year



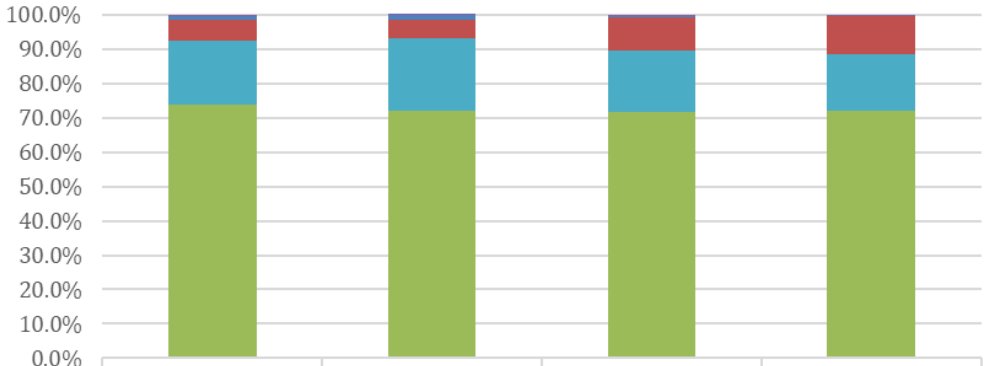
	2019	2020	2021	Apr-Oct 2021
Testimony	0.6%	0.5%	0.8%	0.9%
Missed Appointment	5.9%	5.8%	2.3%	0.1%
Follow-up Eval	5.1%	4.7%	10.8%	13.8%
Supplemental	34.2%	35.6%	33.4%	32.6%
Comprehensive	54.1%	53.3%	52.8%	52.5%

To better measure the impact of the fee schedule changes, the 2021 medical-legal service distributions were also calculated beginning with April services. The most notable shift that occurred involved follow-up evaluations that include an examination of the injured worker. Exhibit 7 shows a significant increase in the share of services for follow-up evaluations following implementation of the new fee schedule, which included new rules (change from 9 months to 18 months between follow-up and previous evaluation) and fee calculation (time-based to flat fee, with the per page add-on).

The increase in evaluations involving a face-to-face examination (59.2 percent in 2019 and 63.6 percent in 2021), correlates with the decrease in missed appointments (5.9 percent in 2019 to 2.3 percent in 2021). The decreased volume of missed appointments may be a positive outcome of the regulatory change that allows a claims administrator to seek credit against the injured worker's award if the missed appointment was incurred through the fault or neglect of the injured worker or their representative.

Exhibit 8 shows the change in the distribution of total payments for each type of medical-legal service and reflects the change in the mix of services both before and after the new MLFS took effect. The sharp increase in follow-up evaluations seen in Exhibit 7 is reflected in the increased share of payments for these services, with the April through October services growing to 11.3 percent of total medical-legal payments.

Exhibit 8: Distribution of Medical-Legal Payments by Type of Service
Service Years 2019, 2020, 2021 and April through October 2021

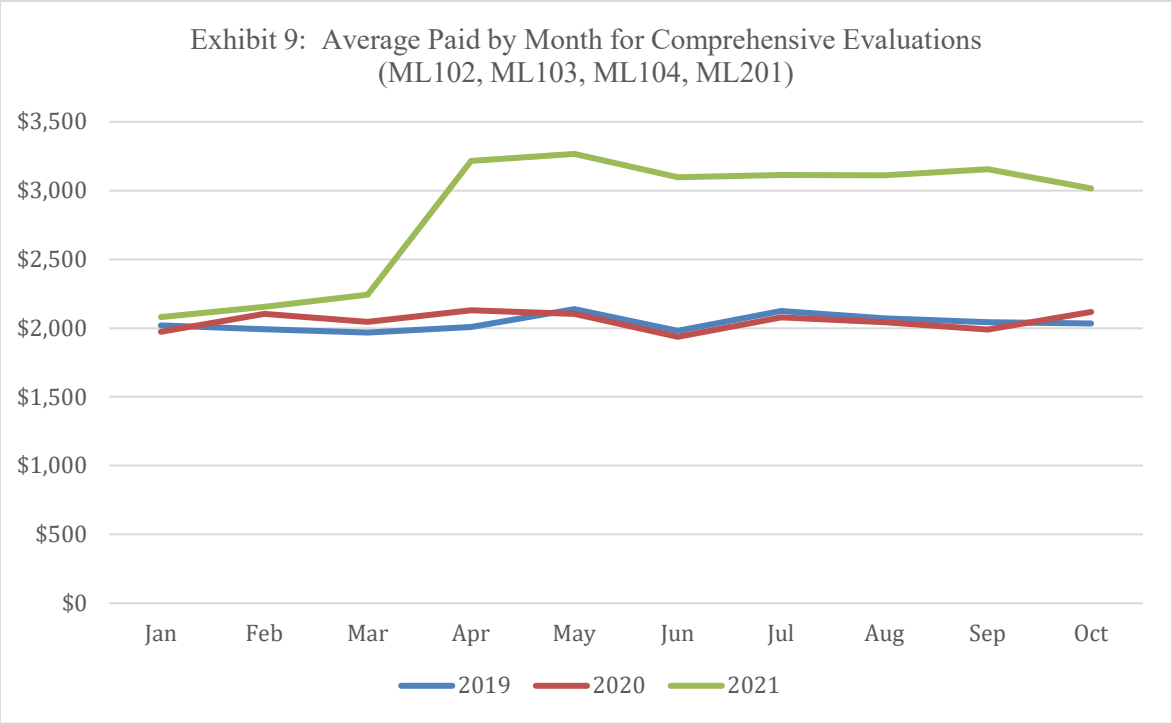


	2019	2020	2021	Apr-Oct 2021
Testimony	0.3%	0.2%	0.3%	0.3%
Missed Appointment	1.4%	1.5%	0.4%	0.0%
Follow-up Eval	5.8%	5.3%	9.7%	11.3%
Supplemental	18.7%	21.0%	17.9%	16.4%
Comprehensive	73.8%	72.1%	71.7%	72.0%

Focusing on the payment amounts, the author also calculated and compared the average payments for comprehensive evaluations on a month-by-month basis. The averages for the pre-April 2021 services were weighted to account for variable payments based on complexity (ML102, ML103, ML104). The post-April 2021 comprehensive evaluations included the total costs associated with the evaluation, including any record review add-on (MLPRR). The total costs for all calculated averages included fee multipliers (i.e., interpreter services required, service by an AME, psychiatrist, psychologist, or a toxicology examination).[16]

Exhibit 9 shows that the average payment for a comprehensive medical-legal evaluation increased from $2,008 in April of 2019 to $3,217 in April of 2021 - a 60.2 percent increase. After fluctuating each month, the data show that by October 2021, the average amount paid for a comprehensive evaluation had increased 48.2 percent over the 2019 level, while the overall average for the April through October 2021 period was up 52.9 percent compared to the corresponding period in 2019.

[16] The 2021 MLFS retained the 10% multiplier for use of an interpreter during an examination, increased the multiplier for an AME from 25% to 35%, and created new multipliers for psychologists and psychiatrists (100%), and specialists performing toxicology evaluations (50%). These multipliers apply to the flat fee.



The service mix for the pre-April 2021 evaluations (Exhibit 10), provides additional context for the dramatic increase in the average payment for services. The flat fee for evaluations that were previously considered "basic" increased by at least 222 percent, while those that were "complex" increased by 115 percent.

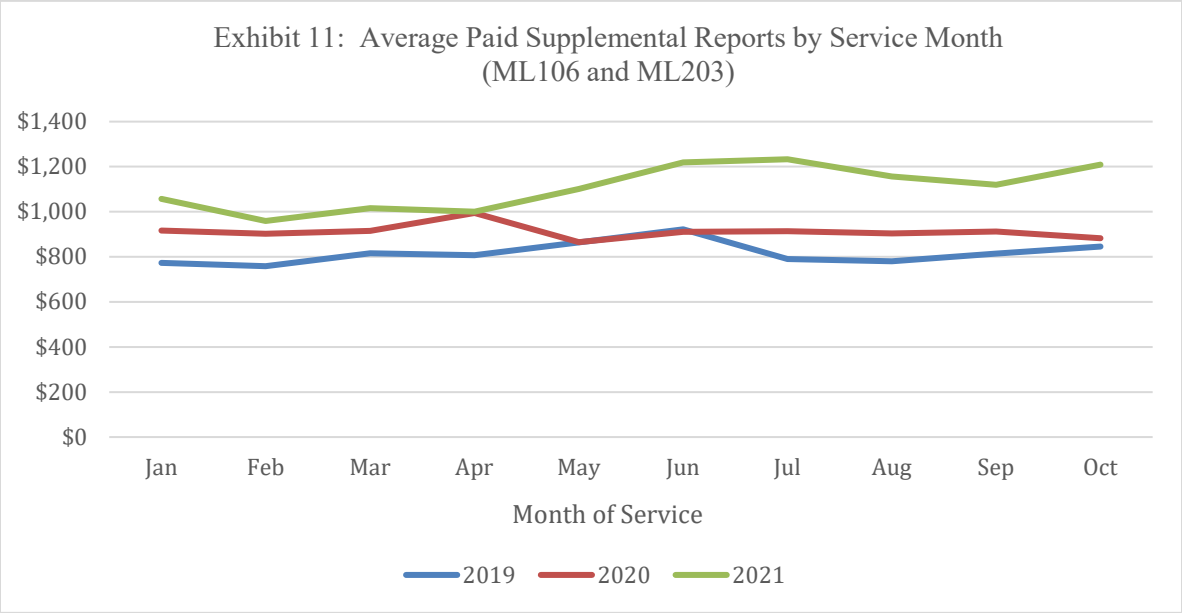
Exhibit 10: Fees and Distribution of 2006 MLFS Comprehensive Evaluation Services

Level	Fee	2019	2020
Basic	$625	39.8%	40.5%
Complex	$937.50	18.0%	17.3%
Extraordinary	$250/hour	42.2%	42.2%

As noted earlier, under the new schedule, fees for supplemental reports that were previously time-based ($62.50 for each 15-minute increment) are reimbursed at a flat fee of $650, plus any per-page add-on amount for record review exceeding 50 pages. Whereas the data showed an immediate increase in the average payment for comprehensive evaluations in April 2021, the increase in the average payments for supplemental reports was more gradual, which likely resulted from a differing implementation parameter for this service as the new payment structure did not apply to supplemental reports requested prior to April 2021, even if the report was issued on or after April 1, 2021.

Exhibit 11 shows the gradual increase in the average payment for a supplemental report began as soon as the new MLFS took effect in April 2021, and by July it had climbed to $1,233, up 56.1 percent from the 2019 average of $790. Average supplemental report payments then fluctuated, declining from July through September, then increasing again in October, when they rose to $1,209.

Thus, the average payment for a supplemental report during the first seven months under the new MLFS was $1,153, up 39.1 percent compared to the same seven-month period of 2019.



The average payments for both comprehensive evaluations and supplemental reports are also influenced by the add-on fee for review of records that were submitted for inclusion in the evaluator's assessment of the injured worker's condition. Exhibit 12 provides statistics for the separately payable review of records fee associated with each underlying evaluation service. Follow-up evaluations had the lowest percentage of per-page add-on fees (25 percent), while one-third of supplemental reports had additional per-page fees, and 40 percent of comprehensive evaluation services had records in excess of 200 pages, resulting in higher payments.

Exhibit 12: Per Page Record Reviews for Additional Pages*

Service Type	Percent w/ MLPRR	Median Pages	Avg Pages	Max Pages	Median Paid	Avg Paid	Max Paid
Comprehensive w/ MLPRR	40.1%	273	639	13,412	$819	$1,917	$40,236
Follow-up w/ MLPRR	25.0%	204	470	6,697	$612	$1,410	$20,091
Supplemental w/ MLPRR	30.3%	162	479	17,538	$486	$1,437	$52,614
MLPRR Only		233	665	7,436	$699	$1,995	$22,308

*All values are reflective of the MLPRR codes only and do not include base pages or flat fees for underlying service type.

The data reveals wide variations in the number of records reviewed for each service type. The median number of excess pages associated with comprehensive evaluations was 273, which in combination with the average page count (639 pages) illustrates the wide variation in the number of pages associated with comprehensive evaluations in the study sample; ranging from one page to 13,412 pages. The median add-on fee of $819, combined with the flat fee of $2,015, yields a median value of $2,834 when more than 200 pages were reviewed. Within the sample, the highest amount paid for per-page record review associated with a comprehensive evaluation was $40,236.

Per-page review of records associated with supplemental reports showed even greater variability with a median of 162 pages, an average of 479 pages, and the highest number of pages totaling 17,538, which resulted in an additional payment of $52,614. The data also included records for per-page review of records that were not immediately associated with an underlying service. In these cases, the data did not include another service or missed appointment with the same service date.

Calendar Year 2021 Medical-Legal Activity: Claim Characteristics

To better understand the types of claims that include medical-legal services the author examined a subset of claims that had medical-legal service dates from January through October of 2021. The majority of injured workers engaged with the medical-legal process in 2021 had injuries that occurred within the previous three years, and more than half (54.3 percent) had medical-legal services within two years of injury (Exhibit 13). A sizeable share of claims with medical-legal activity in 2021 were more than seven years old – 9.2 percent were AY 2000 – 2014 claims.

Exhibit 13: Claims with Medical-Legal Service During 2021 by Accident Year

AY	Pct Claims
2000-2014	9.2%
2015	3.6%
2016	5.4%
2017	8.5%
2018	14.7%
2019	27.6%
2020	26.8%
2021	4.2%

The author also looked at the distribution of claims by claim type, segmenting the sample into those claims that had at least one indemnity payment and those with medical payments but no indemnity, then determining their share of medical-legal services and payments, which are noted in Exhibit 14.

Exhibit 14: Distributions by Claim Type

Claim Type	Pct Claims	Pct ML Volume	Pct ML Paid
Indemnity	78.6%	85.6%	84.9%
Medical Only	21.4%	14.4%	15.1%
Total	100%	100%	100%

More than three-quarters (78.6 percent) of the claims in the subsample were indemnity claims, and they accounted for 85.6 percent of the medical-legal services and 84.9 percent of the medical-legal payments in 2021.

Claims with medical-legal services during 2021 had high litigation rates, with indemnity claims having a slightly higher level of attorney involvement (88.7 percent) than medical-only claims (86.1 percent) (Exhibit 15). The high litigation rate is not surprising given that medical-legal services are sought in response to disputes.

Exhibit 15: Litigation Status by Claim Type (YOS 2021)

	Indemnity	MO	Combined
Non-Litigated	11.3%	13.9%	11.9%
Litigated	88.7%	86.1%	88.1%
Total	100%	100%	100%

Each claim in the study population was assigned to a Diagnosis Category based on an algorithm developed by CWCI that uses ICD-10[17] diagnosis codes submitted by medical providers with billed services. Exhibit 16 shows the top ten diagnosis categories represented in the study population, broken out by type of claim. The overwhelming share of claims fell into categories associated with musculoskeletal injuries, with 2.3 percent categorized as mental health conditions.

Exhibit 16: Top Ten Diagnosis Categories by Claim Type (YOS 2021)

Diagnosis Category	Indemnity	MO	Combined
Diseases/disorders - spine	39.1%	34.2%	38.4%
Diseases/disorders – joints	13.1%	8.8%	12.5%
Trauma - diseases/disorders - joints	11.7%	4.8%	10.7%
Disorders - connect, soft tissue, bone	5.0%	6.8%	5.3%
Strains/sprains/dysfunctions - non-vertebral	4.1%	7.2%	4.5%
Strains/sprains/dysfunctions - spine	2.8%	8.4%	3.6%
Fracture - lower extremity	3.7%	0.5%	3.3%
Injury - head, cranial, intracranial	2.5%	1.7%	2.4%
Mental and neurodevelopmental disorders	1.9%	5.0%	2.3%
Fracture - shoulder or arm	2.2%	0.4%	2.0%
Top Ten Share	86.2%	77.9%	85.0%

Provider Characteristics

In addition to identifying the types of medical conditions evaluated by medical-legal physicians, the author extracted information related to the QMEs and AMEs to compare the mix of medical specialties to the mix of injuries. For purposes of comparison, and because the nature of the requested medical-legal evaluations was unknown, the author combined all orthopedic specialists

[17] International Statistical Classification of Diseases and Related Health Problems is a code set developed and maintained by the World Health Organization and is used as the standard classification system for all healthcare delivered in the United States.

under Orthopedic Surgery (e.g., spine, hand, etc.). Similarly, all internal medicine specialists (e.g., cardiology, pulmonology, etc.) were combined under Internal Medicine specialists, and psychologists, psychiatrists and neuropsychologists were combined under Mental Health specialists.

Given the nature of the medical conditions being evaluated, as noted in Exhibit 16, it is not surprising that orthopedists accounted for more than half of all medical-legal services in 2021. The orthopedists' 53.0 percent share of the medical-legal services, combined with chiropractors' 6.9 percent means that orthopedic evaluations accounted for 60 percent of the services (Exhibit 17). Although mental and neurodevelopmental disorders accounted for 2.3 percent of the diagnostic categories, physicians specializing in this area represented 6.0 percent of medical-legal services. This is likely related to the inclusion of mental health factors in chronic pain cases[18] and in cases where etiology is in question.

Exhibit 17: Top Ten Specialties Based on Share of Medical-Legal Services (combined specialties)

Specialty	Pct Codes
Orthopedic Surgery (inclusive)	53.0%
Internal Medicine (inclusive)	9.0%
Chiropractor	6.9%
Physical Medicine & Rehabilitation	6.6%
Pain Medicine	6.4%
Mental Health	6.0%
Neurology	3.9%
Preventive Medicine - Occupational Medicine	1.1%
Otolaryngology	1.1%
Podiatrist	1.0%
Top Ten Total	95.1%

The specialty of an evaluating physician may not only be related to the medical condition being evaluated -- it may also be related to the length of time the claim has been active. Exhibit 18 provides aggregated information for claims with at least one medical-legal service in 2021. Although most of the claims had a single medical specialty reporting, there were claims that had multiple specialists reporting, with up to 6 specialists on an AY 2020 claim and 9 specialists on an AY 2004 claim.[19]

As claims age, the number of medical-legal services provided increases. Among the claims with medical-legal services in 2021, older claims (from AY 2000 through 2014) averaged 9 medical-legal service codes, with as many as 48 medical-legal codes noted on a single claim (Exhibit 18). With increased services, the total amount paid per claim for medical-legal services also increased – the average total paid per claim for newer claims (AY 2021) was $2,717, compared to an average of $10,099 for AY 2015 claims. The maximum total amount paid was correlated with the number of

[18] Mills, S., Nicolson, K. P., & Smith, B. H. (2019). Chronic pain: a review of its epidemiology and associated factors in population-based studies. *British journal of anesthesia*, *123*(2), e273–e283. https://doi.org/10.1016/j.bja.2019.03.023

[19] The author was unable to identify the specific provider for 6.3 percent of the services – those records were excluded from the calculations.

specialists reporting on a claim. One claim from AY 2019 had seven separate specialists (physical medicine & rehabilitation, otolaryngology, ophthalmology, neurology, psychology, urology and internal medicine) reporting, with aggregate medical-legal payments on that claim totaling $104,260, which represented 3.7 percent of the total medical cost of the claim.

In comparison, an AY 2011 claim had reports from 10 different medical-legal physicians (orthopedic surgery, neurology, cardiology, dermatology, psychiatry, psychology and one unidentified). Those physicians were paid a total of $119,713 for medical-legal evaluations, which represented 67.5 percent of the total medical cost of the claim.

Exhibit 18: Claims with ML Service During 2021 - Service Statistics

AY	Avg Specialty Count	Max Specialty Count	Avg ML Code Cnt	Max ML Code Cnt	Avg Total ML Paid	Max Total ML Paid	Avg Share of Medical Paid
'00-'14	2.4	9	9.0	48	$17,842	$119,713	22.2%
2015	1.8	6	5.8	30	$10,099	$69,627	23.5%
2016	1.7	6	5.0	37	$8,515	$85,619	23.0%
2017	1.5	7	4.2	38	$7,278	$63,011	22.5%
2018	1.4	7	3.3	23	$5,773	$75,000	23.2%
2019	1.2	7	2.3	16	$4,050	$104,260	22.1%
2020	1.1	5	1.6	10	$3,087	$72,539	27.8%
2021	1.0	3	1.1	4	$2,717	$20,087	64.1%

QME Population

This section examines the population of physicians in the DWC's QME database that is used for the panel QME process. One of the goals of the DWC in increasing the reimbursement levels for QMEs and AMEs was to attract new physicians, thereby increasing the number of evaluators available for panel assignment.

The number of participating physicians declined from 2019 to 2020, with 143 becoming inactive during 2019 and 158 becoming inactive in 2020, though the decline was somewhat mitigated by the addition of 77 new participants in 2020 (Exhibit 19). The number of participants increased to 2,554 in 2021, with 211 new physicians becoming certified.

Exhibit 19: Calendar Year Comparison of QME Population

	2019	2020	2021
Number of Physicians	2,571	2,489	2,554
Inactivated	143	158	18
Added		77	211

Exhibit 20 compares the distribution of the QME population by medical specialty for calendar years 2019, 2020, and 2021. The mix of specialists was stable across this three-year period and the results varied little from the QME specialty distribution noted in CWCI's 2018 QME study.[20]

The QME population remains heavily concentrated in the top ten specialties, which continue to represent approximately 85 percent of all 41 specialties listed for selection in the database. Chiropractors, who accounted for 18.1 percent of the QMEs in 2021, continue to represent the largest share of the QME population, followed by orthopedic surgeons, who accounted for one out of every six QMEs in 2021.

Exhibit 20: QME Specialty Mix - Calendar Year Comparison

Specialty	2019	2020	2021
Chiropractic	19.1%	18.8%	18.1%
Orthopedic Surgery	16.9%	16.5%	16.6%
Psychology	14.4%	14.1%	13.2%
Spine	9.9%	11.8%	11.6%
Psychiatry	6.5%	6.1%	6.0%
Internal Medicine	5.1%	4.9%	4.9%
Hand	4.0%	3.9%	3.9%
Physical Medicine & Rehabilitation	3.7%	3.5%	3.7%
Pain Medicine	3.7%	3.4%	4.1%
Neurology	2.3%	2.5%	2.6%
Top Ten Share	85.6%	85.5%	84.6%

In 2021, more than 23 percent of certified QMEs were registered in the DWC database with two or more specialties, and that percentage has shown little change over the past three years (Exhibit 21).

Exhibit 21: QMEs with Multiple Specialties

Number	2019	2020	2021
Two	20.5%	20.6%	20.8%
Three	3.0%	3.0%	2.8%
Four	0.0%	0.0%	0.0%

Orthopedic surgery is the most common example of multiple specialties, with a physician registering for orthopedic surgery, spine, and hand panels. Although anesthesiology is a listed specialty, in claims where anesthesiologists serve as QMEs the physician is providing pain medicine expertise, so the author did not count anesthesiology and pain medicine as two specialties.

In addition to anesthesiology, pain medicine specialists also listed other specialties. Half of the physicians registered for pain medicine listed a second specialty, and 72.3 percent of these pain medicine physicians also listed themselves as available for physical medicine and rehabilitation panels (Exhibit 22).

[20] Jones, S.L. Changes in the QME Population and Medical-Legal Trends in California Workers' Compensation. *CWCI Research Update*. February 2018.

Exhibit 22: Pain Medicine with Additional Specialty (Calendar Year 2021)	
Specialty	Pct
Physical Medicine & Rehabilitation	72.3%
Neurology	13.8%
Internal Medicine	6.2%
Psychiatry	3.1%
Occupational Medicine	1.5%
Neurological Surgery	1.5%
Family Practice	1.5%

While the number of specialists within the QME population must be adequate to meet the needs of injured workers seeking medical-legal evaluations, the location of the specialists is also important. SB 863 included a provision that limited the number of locations from which a QME may provide evaluations to 10.[21] Despite this limit, the data show that for each study year approximately 11 to 14 percent of the QMEs provided medical-legal services in more than 10 locations (Exhibit 23). This is likely a result of a physician engaging with different management companies[22] throughout the year, but it does point to a fair amount of fluidity in QME movement.

Exhibit 23: Locations per QME			
	2019	2020	2021
Average	5.0	5.1	5.2
Median	3	3	4
Percentage of QMEs with 10 or More Locations			
10 locations	9.3%	10.2%	14.3%
More than 10 locations	14.4%	14.3%	11.3%
Percent 10 or more	23.6%	24.5%	25.6%

The findings shown is Exhibit 23 reveal a shift in the percentage of QMEs operating out of multiple locations, and an increase in the use of virtual office space and rental of medical office space for evaluations.

The data also shows that multiple locations are sometimes recorded when a physician lists more than one suite at a given street address. These values show an increase in the number of a given QME's office locations since previous CWCI research found that the average number of locations in 2012 and 2017 were 3.7 and 3.9 respectively, with median values of 1 in 2012 and 2 in 2017.[23]

[21] Labor Code §139.2(h)(3)
[22] Management companies provide support services to QMEs including scheduling, office space for the evaluation, billing, records management, and report writing assistance.
[23] Jones, S.L. Changes in the QME Population and Medical-Legal Trends in California Workers' Compensation. *CWCI Research Update*. February 2018.

Agreed Medical Evaluators

AMEs accounted for 21.9 percent of comprehensive medical-legal evaluations in 2021, down from 24.1 percent in 2020, and 23.1 percent in 2019. Although some QMEs are engaged to perform agreed medical evaluations, there are some physicians who are engaged as AMEs but are not certified as QMEs. The 2021 bill data showed 12 non-QME physicians acting in the capacity of an AME. Labor Code §4062.2(a) allows for the use of an AME in cases where the injured worker is represented by an attorney. Providing evaluations in the role of an AME may also be considered in the QME application process.[24]

Discussion

Data for the first seven months following implementation of the new Medical-Legal Fee Schedule shows that the significant increase in average reimbursement well exceeded the DWC's goal of a 25 percent increase. Average payments for comprehensive evaluations, which accounted for 52.5 percent of the medical-legal services between April and October of 2021, increased by 52.9 percent.

The replacement of three levels of evaluations that ranged from basic to extraordinary with a single comprehensive evaluation reimbursed at a flat fee of $2,015 may have had the biggest impact on the average payment amounts. Under the new MLFS, basic evaluations, which had been billed under ML102, accounted for approximately 40 percent of evaluations that were rolled into the new comprehensive service (ML201). The flat fee payment for these services increased by 222 percent. At the same time, the more complex evaluations which had been billed under ML103, accounted for 18 percent of the new ML201 evaluations, and payments for these more complex services increased by 115 percent.

The new per-page review of records fee also factored into the increase in payments; adding an average of $1,917 and a median of $819 to the $2,015 payment flat fee for comprehensive evaluations. With the per-page review of records fee acting as a proxy for the level of complexity, the new fee schedule appears to result in as much variability in payments as the previous fee schedule that had a time-based payment for services that were deemed to be extraordinary. The study sample included many medical-legal services for which significant amounts were paid under the 2006 fee schedule's time-based (ML104) fee calculation, including a March 2021 service for which $69,500 was paid, as well as other examples of evaluations paid under the new MLFS where the number of pages reviewed far exceeded the base number provided in the schedule, triggering significant additional per page fees for comprehensive (ML201), follow-up (ML202), and supplemental (ML203) reports. This included one ML201 report from July 2021 that involved a review of 13,412 pages, resulting in a per-page review payment of $40,236, in addition to the $2,720.25 flat fee that included a 35 percent increase for an AME.

Addressing the prevalent use of supplemental reports, the 2021 MLFS expanded the procedure description for supplemental reports (ML203), stipulating that fees would not be allowed for reports addressing issues or medical records that should have been reviewed and addressed in the preceding comprehensive report. It is still too early to adequately assess the extent to which the new regulatory language acts as a mitigating factor for these expenses.

[24] Title 8, California Code of Regulations §11(e)(2)

As for the effect that the new MLFS has had on attracting and retaining QMEs, the DWC database of certified QMEs shows that the pool of physicians marginally increased in 2021, after declining in 2020. A previous CWCI study showed that the QME population declined between 2012 and 2017 (from 3,239 to 2,578),[25] but the 2019 population of 2,571 reflects stability from 2017 to 2019. After decreasing to 2,489 in 2020, the QME population increased to 2,554 in 2021. Although there were hopes that increased reimbursement for physicians specializing in toxicology or oncology (a 50 percent multiplier added to the flat fee) would encourage their participation in the system, early results have not borne that out, as most of the newly certified physicians are orthopedic surgeons.

CWCI will continue to monitor the utilization and cost of med-legal services under the new MLFS in future research as more developed data become available.

About the Author

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California Workers' Compensation Institute

The California Workers' Compensation Institute, incorporated in 1964, is a private, nonprofit organization of insurers and self-insured employers conducting and communicating research and analyses to improve the California workers' compensation system. Institute members include insurers that collectively write more than 80% of California workers' compensation direct written premium, as well as many of the largest public and private self-insured employers in the state. Additional information about CWCI research and activities is available on the Institute's website (www.cwci.org).

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[25] Jones, S.L. Changes in the QME Population and Medical-Legal Trends in California Workers' Compensation. *CWCI Research Update*. February 2018.