IMPORTANT CHANGES WITH THE NEW MED-LEGAL FEE SCHEDULE

First, this is not a complete guide to billing. CSIMS will offer billing webinars to members in April and at our October 2021 conference. This is a brief review of the main changes that will affect how you prepare and bill for reports.

In some ways the new fee schedule is simpler

Code 200 a missed appointment
Code 201 any evaluation that is not a reevaluation
Code 202 any evaluation occurring in the 18 months after any evaluation (an initial evaluation or a. re-evaluation)
Code 203 a supplemental report
PRR this is the additional code used for payment based on medical records.
You must include a list of records reviewed. It would be wise to include an excerption of those records. The easiest way to determine pages is to have an electronic file. Then the only dispute will be if a party has forgotten to count each condensed page of a deposition as 4 pages. In your report you will need to point out that the attestation was incorrect because the party forgot to accurately count the deposition pages. You should try to get a corrected attestation but having an electronic file will support your position if you have to go to IBR.

PRR with Code 200: $3/page for all the records. You will not be able to charge for reviewing these records again if the evaluation occurs.

With Code 201: $3/page per page for every page after the first 200

With Code 202 $3/page for all the pages after the first 200 unless they are records sent to you previously. YOU CANNOT CHARGE FOR RECORDS THAT YOU HAVE PREVIOUSLY REVIEWED IN AN INITIAL EVALUATION, A PRIOR RE-EVALUATION OR A SUPPLEMENTAL REPORT. What will happen if you do? Who knows. The defense may pay or they may choose to report you to the DWC. The DWC may warn you or take some other action including placing you on probation. Realistically if you make a good faith effort to comply with this provision but make an error you are unlikely going to be punished.

With code 203 $3/page for every page over 50 pages

Some of the most important changes have to do with receipt of medical records

To get paid for reviewing records there must be a declaration from the party sending the records that they have met certain requirements. There is a sample declaration that follows.

This will include records sent to you before the new fee schedule went into effect ,but the evaluation was after the new fee schedule went into effect. If you do not have a declaration, then you may not be paid for any records you review.

If you do not have a declaration by the time you prepare your report, then you should wait for a declaration, a letter requesting a supplemental report and and then write a supplemental report addressing the records. Clearly this is not ideal but at least it is financially beneficial to the provider. Because a supplemental report pays $650 and includes only the first 50 pages (as opposed to 200 pages with an initial evaluation) you will receive an extra $1,100. ($650 plus credit for an extra 150 pages at $3/page)

Supplemental reports may also be contentious

To qualify for a supplemental report charge, the report cannot be on an issue which the evaluator should have addressed in a prior report. Clearly this provision may be subject to abuse by payors. In private discussions with the DWC it is not meant to include issues which were addressed but on which a party has a question or disagreement.

This does mean that you cannot defer issues in your initial evaluation. If you write apportionment or impairment deferred until P&S you could be asked to write a supplemental report and not be paid. Instead you should address each issue as fully as possible. As an example without records you might state that you are apportioning 100% of the impairment to the industrial injury because the defense has failed to provide evidence for apportionment. Now you have addressed the issue with an explanation. If you need imaging studies for impairment then provide the impairment as best you can but state that your opinion may change with new information.

The issues the parties want addressed include AOE for each claimed body part, apportionment, work preclusions, impairment, P&S status, and future medical care. Sometime they have specific questions regarding past history, availability for modified work, pre-existing pathology or periods of temporary disability. You must answer these questions or you will be writing supplemental reports without reimbursement. We also suggest reviewing and being familiar with the critical required elements of every medical legal report as described in 8 CCR 10682: https://www.dir.ca.gov/t8/10682.html DON'T GIVE THE DEFENSE AN EXCUSE NOT TO PAY YOU.

Look for our upcoming webinar on billing in April and remember you can always ask questions on the messaging board.