

Supporting Analysis:

The dispute regards the payment amount for Medical-Legal services (ML104 Modifier 94) and supply code 99070. The Claims Administrator based its reimbursement of ML104 on ML103 with the explanation "Procedure code ML104 has been changed because the factors which are required to meet the criteria for this code were not clearly and concisely identified in the report or the requirements for ML104." The Claims Administrator reimbursed \$1.80 for the billed procedure 99070 with the explanation "Allowed fee is based on invoice/proof of cost."

CPT 99070 – Supplies and materials (except spectacles) provided by the health care provider over and above those usually included with the office visit or other services (must be identified and quantified; list drugs, trays, supplies, or materials provided)

ML104 – Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:

(1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon.

(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;

(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

ML103 – Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth below. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon:

(1) Two or more hours of face-to-face time by the physician with the injured worker;

(2) Two or more hours of record review by the physician;

(3) Two or more hours of medical research by the physician;

(4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;

(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;

- (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation;
- (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
- (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances;
- (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
- (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

Modifier 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, then the value of the procedure is modified by multiplying the normal value by 1.35.

The Provider submitted a report titled “Very Complex Orthopedic Agreed Medical-Legal Evaluation” and a separate invoice/statement of charges. The invoice indicated the following time spent by the Provider: History 2 hours; record review 3.5 hours; and report dictation 3 hours. The report documented the following complexity factors: Causation; record review; physical examination and history 2 hours; and case complexity/ extraordinary circumstances.

The medical record documented two complexity factors: Two or more hours of face-to-face time by the physician with the injured worker; and two or more hours of record review by the physician. The causation complexity factor was not met: a written request for the party or parties to address causation was not submitted as part of the documentation; and it does not appear a bona fide issue of medical causation was discovered in the evaluation. The Provider documented in the report, the parties agreed prior to the evaluation, the case was complex and involved extraordinary circumstances. A written agreement by the parties was not submitted as part of the documentation. Per review of the Medical-Legal report, the documented Medical-Legal services did not demonstrate the requirements of ML104; therefore, no additional reimbursement is recommended.

The Claims Administrator reimbursed the Provider \$1,171.88 for ML103 which included the additional allowance (1.25) for the use of Modifier 94. The reimbursement of ML103 Modifier 94 by the Claims Administrator was correct.

The second disputed code is CPT 99070. The documentation did not include a description of services or supplies billed under the procedure code 99070. The Provider billed \$2.00 and was reimbursed \$1.80 by the Claims Administrator. Without documentation of the type of service or supply, additional reimbursement is not recommended for the billed procedure code 99070.

There is no additional reimbursement warranted per the Medical-Legal code ML104 Modifier and Official Medical Fee Schedule code 99070.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ML103	94	1	\$1,484.34	\$1,171.88	\$1,171.88	\$0.00	OMFS
99070		1	\$0.20	\$1.80	\$1.80	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, Medical-Legal regulations and comparison with explanation of review. This was determined correctly by the Claims Administrator and the payment of \$1,173.68 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

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