

Supporting Analysis:

The dispute regards the amount paid for a Medical-Legal service (ML104 Modifier 95) performed on date of service 9/10/2013. The Claims Administrator based its reimbursement of the billed code ML104 on ML102 with the explanation "Based on the documentation the following factors were met for determining the level of reimbursement: #4 However, per the ML FS the following are not considered factors or were not met #6 and #7."

ML102 - Basic Comprehensive Medical-Legal Evaluation. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104

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.

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.

Modifier 95 - Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

The Medical-Legal report submitted by the Provider met the required four complexity factors of ML104. The provider documented four hours of record review time and forty five minutes of face to face time, which met the criteria of complexity factor four. The complexity factor number four counts as two complexity factors. The complexity factor of apportionment was met. The report documented a discussion and review of multiple injuries to one body region (spine). The Provider apportioned current back “symptomatology as 100% due to physical demands of job and 0% to the nonindustrial causation” and “In reference to the upper extremity claims, as far as there is no impairment apportionment is not an issue.” The documentation included the written request for causation to be addressed or determined. The causation complexity factor was met. Based on the documentation submitted, four complexity factors were documented; the evaluation involved prior multiple injuries to the same body part or parts being evaluated; and three or more hours of record review. The report documented an examination of the spine, upper and lower extremities.

Based on the submitted documentation, reimbursement for the Medical-Legal Code ML104 (23 units) is warranted. The Provider documented in the beginning of the report the following: four hours of record review; 45 minutes of face to face time; 1 hour of report preparation time; addressing issue of causation; and addressing issue of apportionment.

The additional reimbursement of \$812.50 is warranted per the Medical-Legal code ML104 Modifier 95.

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
ML104	95	23	\$812.50	\$1,437.50	\$625.00	\$812.50	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for Medical-Legal code ML104 Modifier 95 (\$812.50) for a total of \$1,147.50.

