



**REDUCTION IN NUMBERS OF  
QUALIFIED MEDICAL  
EXAMINERS AND PROPOSED  
NEW REGULATIONS  
REGARDING QME BILLING**

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# Labor Code §4628

- (a) Except as provided in subdivision (c), no person, other than the physician who signs the medical-legal report, except a nurse performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the non-clerical preparation of the report, including all of the following:
- (1) Taking a complete history;
  - (2) Reviewing and summarizing prior medical records;
  - (3) Composing and drafting the conclusions of the report.

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- (b) The report shall disclose the date when and location where the evaluation was performed; that the physician or physicians signing the report actually performed the evaluation; whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 and shall disclose the name and qualifications of each person who performed any services

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in connection with the report, including diagnostic studies, other than its clerical preparation. If the report discloses that the evaluation performed or the time spent performing the evaluation was not in compliance with the guidelines established by the administrative director, the report shall explain, in detail, any variance and the reason or reasons therefor.

- (c) If the initial outline of a patient's history or excerpting of prior medical records is done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

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- (d) No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.
- (e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.

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- (f) Knowing failure to comply with the requirements of this section shall subject the physician to a civil penalty of up to one thousand dollars (\$1,000) for each violation to be assessed by a workers' compensation judge or the appeals board. All civil penalties collected under this section shall be deposited in the Workers' Compensation Administrative Revolving Fund.
- (g) A physician who is assessed a civil penalty under this section may be terminated, suspended, or placed on probation as a qualified medical evaluator pursuant to subdivisions (k) and (l) of Section 139.2.

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- (h) Knowing failure to comply with the requirements of this section shall subject the physician to contempt pursuant to the judicial powers vested in the appeals board.
- (i) Any person billing for medical-legal evaluations, diagnostic procedures, or diagnostic services performed by persons other than those employed by the reporting physician or physicians, or a medical corporation owned by the reporting physician or physicians shall specify the amount paid or to be paid to those persons for the evaluations, procedures, or services. This subdivision shall not apply to any procedure or service defined or valued pursuant to Section. 5307.1

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- (j) The report shall contain a declaration by the physician signing the report, under penalty of perjury, stating:

“I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.”

The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county wherein it was signed.

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- (k) The physician shall provide a *curriculum vitae* upon request by a party and include a statement concerning the percent of the physician's total practice time that is annually devoted to medical treatment.

# Labor Code § 4628 (a)(1)

The doctor must take a complete history.

## **Labor Code § 4628(a)(2-3)**

The doctor must review and summarize prior medical records.

The doctor must compose and draft the conclusions of the report.

# Labor Code § 4628(b)

Report date and location where evaluation was performed; and that the doctor signing the report actually performed the report (evaluation?). Time must be in compliance with 139.2(5)(j) and shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation.

# Labor Code § 4628(c)

If the initial outline of a patient's history or excepting of prior medical records is not done by the physician, the physician must review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identity and determine the relevant medical issues.

## Labor Code § 4628(d)

No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.

# Labor Code § 4628(e)

Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.

## **Labor Code § 4628(f)**

Knowing failure to comply with the requirements of this section shall subject the physician to a civil penalty of up to one thousand dollars (\$1,000) for each violation to be assessed by a workers' compensation judge or the appeals board. All civil penalties collected under this section shall be deposited in the Workers' Compensation Administration Revolving Fund.

# Labor Code § 4628(g)

A physician who is assessed a civil penalty under this section may be terminated, suspended, or placed on probation as a qualified medical evaluator pursuant to subdivisions (k) and (l) of Section 139.2.

# Labor Code § 4628(h)

Knowing failure to comply with the requirements of this section shall subject the physician to contempt pursuant to the judicial powers vested in the appeals board.

# Labor Code § 4628(i)

Any person billing for medical-legal evaluations, diagnostic procedures, or diagnostic services performed by persons other than those employed by the reporting physician or physicians, or a medical corporation owned by the reporting physician or physicians shall specify the amount paid or to be paid to those persons for the evaluations, procedures, or services. This subdivision shall not apply to any procedure or service defined or valued pursuant to Section 5307.1.

# Labor Code § 4628(j)

The report shall contain a declaration by the physician signing the report, under penalty or perjury, stating:

“I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.”

The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county where it was signed.

# Labor Code § 4628(k)

The physician shall provide a *curriculum vitae* upon request by a party and include a statement concerning the percent of the physician's total practice time that is annually devoted to medical treatment.



**TITLE 8, CCR § 9795**

# Labor Code § 9795

- (a) The schedule of fees set forth in this section shall be *prima facie* evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

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- (b) The fee for each evaluation is calculated by multiplying the relative value by \$12.50, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.

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(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

<i>CODE</i>	<i>B.R.</i>	<i>PROCEDURE DESCRIPTION</i>
ML100		<i>Missed Appointment for a Comprehensive or Follow-up Medical-Legal Evaluation.</i> This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.
<i>CODE</i>	<i>R</i>	<i>PROCEDURE DESCRIPTION</i>
ML101	5	<i>Follow-up Medical-Legal Evaluation.</i> Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities:

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		review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML102	50	<i>Basic Comprehensive Medical-Legal Evaluation.</i> Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML103	75	<i>Complex Comprehensive Medical-Legal Evaluations.</i> Includes evaluations which require three of the complexity factors set forth below.

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		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;

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		(4) Four or more hours spent on any combinations 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 issues of medical causation, upon written request of the party or parties requesting the report;
		((7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more

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		employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of <i>Guides to the Evaluation of Permanent Impairment</i> (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in the Table of Contents of <i>Guides to the Evaluation of Permanent Impairment</i> (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
		(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
		(9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before

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		June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code Section 4610.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML104	5	<i>Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances.</i> 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

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		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 includes copies of medical evidence relied upon;
		(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which require 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

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		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.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML105	5	Fees for medical-legal testimony. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent

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		related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of one hour for a schedule deposition.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML106	5	Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report, or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

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(d) The services described by Procedure Codes ML101 through ML106 may be modified under the circumstances described in this subdivision. The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

-92 Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-93 Interpreter needed at time of examination, or other circumstances which impair communication between the

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Physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be 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, then the value of the procedure is modified by multiplying the normal value by 1.35.

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- (e) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable and shall be reimbursed in the same manner as set forth in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1.
- (f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments; (2) medical-legal testimony provided on or after the effective

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date of the 2006 amendments; and (3) supplemental medical-legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.

Note: Authority cited: Sections 133, 462, 5307.3 and 5307.6, Labor Code.

Reference: Sections 139.2, 4061, 4061.5, 4062, 4610.5, 4620, 4621, 4622, 4625, 4626, 4628, 5307.6 and 5402, Labor Code.

# History

1. Repealer and new section filed 8-3-93; operative 8-3-93. submitted to OAL for printing only pursuant Government Code section 11351 (Register 93, No. 32).
2. Change without regulatory effect amending subsection (a) and subsection (c) medical-legal evaluation procedure code ML104 filed 8-27-93 pursuant to section 100, title 1, California Code of Regulations (Register 93, No. 35).
3. Amendment of section heading, section and Note filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).

# History

4. Amendment filed 2-24-99; operative 4-1-99 (Register 99, No. 9).
5. Change without regulatory effect amending subsections (b) and (d) filed 6-12-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 24).
6. Amendment of section and Note filed 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Code section 11340.9(g) (Register 2006, No. 26)

# History

7. Amendment of subsection (c) (medical-legal evaluation procedure code ML103) and amendment of Note filed 12-31-2012 as an emergency; operative 1-1-2013 pursuant to Government Code section 11346.1(d) (Register 2013, No.1). A Certificate of Compliance must be transmitted to OAL by 7-1-2013 or emergency language will be repealed by operation of law on the following day.

8. Amendment of subsection (c) (medical-legal evaluation procedure code ML103) and amendment of Note refiled 7-1-2013 as an emergency; operative 7-1-2013 (Register 2013, No. 27). A Certificate of Compliance must be transmitted to OAL by 9-30-2013 or emergency language will be repealed by operation of law on the following day.

# History

9. Amendment of subsection (c) (medical-legal evaluation procedure code ML103) and amendment of Note refiled 9-30-2013 as an emergency; operative 10-1-2013 (Register 2013, No. 40). A Certificate of Compliance must be transmitted to OAL by 12-30-2013 or emergency language will be repealed by operation of law on the following day.

10. Certificate of Compliance as to 9-30-2013 order, including further amendment of subsection (c) (medical-legal evaluation code ML103), transmitted to OAL 12-30-2013 and filed 2-12-2014; amendments effective 2-12-2014 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 7).



**PROPOSED CHANGES TO § 9795**

(a) The schedule of fees set forth in this section shall be *prima facie* evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each evaluation is calculated by multiplying the relative value by \$12.50, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service. If prior agreement of the parties is required under any provision of this regulation, the physician may not condition performance of the evaluation on receipt of prior agreement of the parties.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

<i>CODE</i>	<i>B.R.</i>	<i>PROCEDURE DESCRIPTION</i>
ML100		<i>Missed Appointment for a Comprehensive or Follow-up Medical-Legal Evaluation.</i> This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML 101	5	<i>Follow-up Medical-Legal Evaluation.</i> Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities:

		review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour. <u>No more than 3 hours may be billed for report preparation under this code.</u>
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML102	50	<i>Basic Comprehensive Medical-Legal Evaluation.</i> Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML103	75	<i>Complex Comprehensive Medical-Legal Evaluation.</i> 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 <u>actually and necessarily incurred for the production of the medical-legal report and were required for the evaluation, and the circumstances uniquely specific to the actual evaluation being performed</u> which made these complexity factors applicable to the evaluation:
		(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. <u>An evaluator who specifies this complexity factor must provide in the body of the report a list and a summary of the medical records reviewed pursuant to Labor Code § 4628(a)(2). All criteria except the amount of hours must also be satisfied to use record review in combination under subdivision (4) and (5) of this code;</u>

		<p>(3) <u>Two or more hours of medical research by the physician, using sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon this complexity factor. An evaluator who specifies this complexity factor must also (A) explain in the body of the report why the research was reasonably necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (C) excerpt or include copies of medical evidence relied upon. All criteria except the amount of hours must also be satisfied to use medical research in combination under subdivision (4) and (5) of this code;</u></p>
		<p>(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. <u>Any complexity factor used as a standalone may not be used in combination under this subdivision.</u></p>

		<p>(5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors, <u>provided that some portion of time has been devoted to each of the three factors. Any complexity factor used a stand-alone may not be used in combination under this subdivision.</u></p>
		<p>(6) Addressing <u>and providing an analysis of</u> the issue of medical causation, <u>provided that the physician and the parties agree prior to the start of the evaluation that the issue of medical causation is a disputed medical fact the determination of which is essential to the adjudication of the claim for benefits and the parties agree that the physician may use causation as a complexity factor in billing the evaluation:</u></p>
		<p>(7) Addressing the issue of apportionment, when <u>items (A) and (B) below both apply:</u></p> <p style="padding-left: 40px;"><u>(A) The determination of this issue requires the physician to evaluate and provide an apportionment analysis of (i) the</u></p>

		<p>claimant's employment by three or more employers, <u>(ii)</u> three or more <u>dates</u> of injuries to the same body system or body region as delineated in <u>the chapter headings of the Table of Contents of <i>Guides to the Evaluation of Permanent Impairment</i> (Fifth Edition), published by the American Medical Association, 2000 [incorporated herein by this reference]</u>, or <u>(iii)</u> two or more <u>dates</u> of injuries involving two or more body systems or body regions as delineated in that Table of Contents.</p> <p><u>(B) The evaluator finds the injured worker to be medically Permanent and Stationary or to have reached Maximum Medical Improvement.</u></p>
		(8) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML104	5	<i>Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances. The physician shall be</i>

		<p>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:</p>
		<p>(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 <u>actually and necessarily incurred for the production of the medical-legal report and</u> required for the evaluation, and the circumstances which made these complexity factors <u>uniquely and specifically</u> applicable to the <u>actual</u> evaluation <u>being performed</u>. <u>The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be bill for report preparation.</u></p>
		<p>(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 ML103, including</p>

		<p>three or more hours of record review by the physician. <u>The report must include all information required to claim each complexity factor relied upon, and no more than three hours may be bill for report preparation.</u></p>
		<p>(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the <u>start of the evaluation</u>, that the evaluation involved extraordinary circumstances. <u>Any request by the physician for agreement that an evaluation involves extraordinary circumstances shall be accompanied by a statement by the physician articulating the factors and extraordinary circumstances relevant to the evaluation that justify the request.</u> When billing under this <u>subdivision of the code</u> 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</p>

		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.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML105	5	<i>Fees for medical-legal testimony.</i> The physician shall be reimbursed at the rate of RV5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of one hour for a scheduled deposition.
<i>CODE</i>	<i>RV</i>	<i>PROCEDURE DESCRIPTION</i>
ML106	5	<i>Fees for supplemental medical-legal evaluations.</i> The physician shall be reimbursed at the rate of RV 5, or his or her

		<p>usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the result of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation. <u>No more than three hours may be billed for report preparation under this code. No more than two hours may be billed medical research under this code. In order to bill for medical research under this code, the physician must use sources that have not been cited in any prior medical report authored by the physician in the preceding 12 months in support of a claim citing or relying upon medical research in billing. An evaluator who bills for medical research under this code must also (A) explain in the body of the report why the research was reasonably</u></p>
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		<u>necessary to reach a conclusion about a disputed medical issue, (B) provide a list of citations to the sources reviewed, and (c) excerpt or include copies of medical evidence relied upon.</u>
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(d) The services described by Procedure Codes ML101 through ML206 may be modified under the circumstances described in this subdivision. The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

-92 Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-93 Interpreter needed at time of examination, or other circumstances which impair communication between physician and the injured work and significantly increase the time needed to conduct the examination. Requires a description of the circumstances and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be 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, then value of the procedure is modified by multiplying the normal value by 1.35.

-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.

(e) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable and shall be reimbursed in the same manner as set forth in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1.

(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments; (2) medical-legal testimony provided on or after the effective date of the 2006

amendments; and (3) supplemental medical legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.

If, at the end of the deposition, questions have been raised that concern you with respect to any conclusions in your report, you may request to re-examine the applicant.