



**State of California**  
**Division of Workers' Compensation**  
**Request for Independent Bill Review**  
 California Code of Regulations, title 8, section 9792.5.8

<b>Employee Information</b>		
Employee Name (Last, First, Middle):		
Date of Injury (MM/DD/YYYY):	Claim Number:	
Date of Birth (MM/DD/YYYY):	Employer Name:	
<b>Provider Information</b>		
Provider Name:	Contact Name:	
Address:		
Phone:	Fax Number:	
E-mail Address:	NPI Number:	
Provider Type: <input type="checkbox"/> Ambulance <input type="checkbox"/> Clinical Laboratory <input type="checkbox"/> DMEPOS Supplier <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Interpreter <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Qualified Medical Evaluator <input type="checkbox"/> Agreed Medical Evaluator <input type="checkbox"/> Treating Physician <input type="checkbox"/> Other Practitioner – specify: _____		
Provider Specialty:		
<b>Claims Administrator Information</b>		
Claims Administrator Name:	Contact Name:	
Address:		
Phone:	Fax Number:	
E-mail Address:		
<b>Bill Information</b>		
Applicable Fee Schedule(s): <input type="checkbox"/> Physician Services <input type="checkbox"/> Inpatient Hospital Services <input type="checkbox"/> Hospital Outpatient Departments and Ambulatory Surgical Centers <input type="checkbox"/> Pharmaceutical <input type="checkbox"/> Pathology and Laboratory Services <input type="checkbox"/> DMEPOS <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Medical-Legal Fee Schedule <input type="checkbox"/> Interpreter <input type="checkbox"/> Other – specify: _____ Or: <input type="checkbox"/> Contract for Reimbursement Rates		
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Service (MM/DD/YYYY):		
Service/Good Code in Dispute (include modifier, if any):		
Amount Billed:	Amount Paid:	Amount in Dispute:
Reason for Disputing Reduction or Denial of Full Payment:		
<b>Consolidation</b>		
Should the Request be Consolidated with Other Disputed Billed Services or Goods? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for Consolidation:		
Disputed Service/Good to be Consolidated (list all; use attachment if necessary):		
Date of Service (MM/DD/YYYY):		
Service/Good Code in Dispute (include modifier, if any):		
Amount Billed:	Amount Paid:	Amount in Dispute:
Reason for Disputing Reduction or Denial of Full Payment:		
<b>Documents to Accompany Request (Must be Indexed and Separated)</b>		
The original billing itemization and original supporting documentation.		
The explanation of review provided in response to the original billing.		
The request for second bill review and original documentation supporting second review.		
The explanation of review provided in response to the second bill review request.		
If applicable, the relevant contract provisions for reimbursement rates.		
Provider Signature:	Date:	
<b>If mailed, send to: DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630.</b> <b>Concurrently send a copy of this request to the Claims Administrator.</b>		

## INSTRUCTIONS FOR REQUEST FOR INDEPENDENT BILL REVIEW

**Overview:** If the only dispute between a medical provider and a claims administrator regarding a bill for medical treatment services or a bill for medical-legal expenses is the amount of payment and the second bill review did not resolve the dispute, the provider may request independent bill review (IBR) from a conflict-free payment and billing expert. The Division of Workers' Compensation (DWC) has contracted with an independent bill review organization (IBRO) to provide an efficient means of resolving workers' compensation billing disputes.

IBR can be requested electronically or by submitting this form. The electronic form can be accessed at DWC's website at <http://www.dir.ca.gov/dwc/IBR.htm>.

**Form Instructions:** The requesting provider must complete all fields in the Employee Information, Provider Information, and Claims Administrator Information sections. Be sure to list your correct National Provider Identifier (NPI) number and indicate your provider type and specialty in the checkboxes shown.

Under Bill Information, select the applicable fee schedule under which the review will be conducted. IBR will only resolve billing disputes involving the amount of payment owed to the provider for services or goods rendered under a fee schedule adopted by DWC, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11. IBR will not determine: (1) a reasonable fee for services or goods where that category of services or goods is not covered by a fee schedule or a contract for reimbursement rates; or (2) the proper selection of an analogous code or formula based on a fee schedule or, if applicable, a contract for reimbursement rates, unless the fee schedule or contract allows for such analogous coding.

Complete the remaining fields in the Bill Information section for the disputed service or good in dispute.

- State the date of the second bill review decision.
- Indicate whether the billed service was authorized.
- State the date of service.
- State the billing code of the service or good whose payment is in dispute. Include the modifier, if any.
- State the amount billed, the amount paid, and the amount in dispute.
- State the reason for disputing the reduction or denial of full payment
- A copy of the documents listed at the bottom of the form must be provided with your request. You must index and arrange the documents so that each category of documents can be separately identified. A copy of these documents must be concurrently sent the claims administrator with a copy of this form. Any document that was previously provided to the claims administrator or originated from the claims administrator need not be served if a written description of the document and its date is served

**Consolidation:** You may consolidate your request with other disputed billed services. Two or more requests for IBR, up to a maximum of twenty (20), by a single provider may be consolidated if DWC or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services. Consolidation is allowed when: (1) requests for IBR by a single provider involving multiple dates of medical treatment services involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule or, if applicable, under a contract for reimbursement rate, and the total amount in dispute does not exceed \$4,000.00; or (2) requests for IBR by a single provider involving multiple billing codes under applicable fee schedules or, if applicable, under a contract for reimbursement rates, with no limit on the total dollar amount in dispute and involves one injured employee, one claims administrator, and one date of medical treatment service.

**Disaggregation:** Upon review, the IBRO may disaggregate your single request into separate IBR requests if it does not meet the consolidation standards indicated above. For any single request that must be disaggregated, the same \$335.00 fee shall be charged for each additional IBR request as charged for one IBR review request.

## INSTRUCTIONS FOR REQUEST FOR INDEPENDENT BILL REVIEW (cont.)

Should your request be disaggregated, you will be notified in writing by IBRO, who will provide the reasons for disaggregation and the amount of the additional fee or fees required to perform IBR.

**When to apply:** A request for IBR must be made within thirty (30) days from the date of service of the final determination (the explanation of review) made by the claims administrator on your request for second bill review. If you fail to request IBR within 30 days and the only dispute remaining between you and the claims administrator is the amount of payment, your bill will be considered satisfied and neither the claims administrator nor the employee shall be liable to you for any further payment.

**Fee:** An IBR application fee of **\$335.00** must accompany this form. The fee must be paid electronically, if the request is made electronically, or must accompany this form if the request is sent by mail. Checks must be made out to Maximus Federal Services, Inc. If, as a result of the IBR review, any additional payment is found owing from the claims administrator, the claims administrator must reimburse the amount of the fee in addition to the amount found owing.

**How to Apply by Mail:** Send the form, with the stated fee, to: DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. **Forms that are not sent to this address will be returned by DWC and not considered filed. Concurrently send a copy of this request and supporting documents to the Claims Administrator.**