State of California
Division of Workers' Compensation

Request for Independent Bill Review

California Code of Regulations, title 8, section 9792.5.8

Employee Information		
Employee Name (Last, First, Middle):		
Date of Injury (MM/DD/YYYY):	Claim Number:	
Date of Birth (MM/DD/YYYY):	Employer Name:	
Provider Information		
Provider Name:	Contact Name:	
Address:		
	Phone:	Fax Number:
E-mail Address:	NPI Number:	
Provider Type: ☐ Ambulance ☐ Clinical Laboratory ☐ DMEPOS Supplier ☐ Inpatient Hospital ☐ Hospital Outpatient ☐ Interpreter ☐ Ambulatory Surgical Center ☐ Pharmacy ☐ Qualified Medical Evaluator ☐ Agreed Medical Evaluator ☐ Treating Physician ☐ Other Practitioner – specify:_____		
Provider Specialty:		
Claims Administrator Information		
Claims Administrator Name:	Contact Name:	
Address:		
E-mail Address	Phone:	Fax Number:
Bill Information		
Applicable Fee Schedule(s): ☐ Physician Services ☐ Inpatient Hospital Services ☐ Hospital Outpatient Departments and Ambulatory Surgical Centers ☐ Pharmaceutical ☐ Pathology and Laboratory Services ☐ DMEPOS ☐ Ambulance Services ☐ Medical-Legal Fee Schedule ☐ Interpreter ☐ Other – specify:_____ Or: ☐ Contract for Reimbursement Rates		
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? ☐ Yes ☐ No	
Date of Service (MM/DD/YYYY):		
Good/Service Code in Dispute (include modifier, if any):		
Amount Billed:	Amount Paid:	Amount in Dispute:
Reason for Disputing Reduction or Denial of Full Payment:		
Documents to Accompany Request (Must be Indexed and Separated)		
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:	
If mailed, send to: DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. Concurrently send a copy of this request to the Claims Administrator.		

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 https://ibr.dir.ca.gov. Concurrently send the form and supporting documents to the Claims Administrator.

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 goods and services rendered under a fee schedule adopted by Statute or the 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 where that category of services 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 good or service 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 good or service 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 to 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

INSTRUCTIONS FOR REQUEST FOR INDEPENDENT BILL REVIEW (cont.)

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.**