California Workers' Compensation Institute
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April 9, 2013

VIA E-MAIL to dwcrules@dir.ca.gov

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation, Legal Unit
Post Office Box 420603
San Francisco, CA 94142

RE: Written Testimony on Proposed Permanent Independent Bill Review Regulations Sections 9792.5.1 - 9792.5.15 and 9793 - 9795

Dear Ms. Gray:

These written comments on proposed permanent regulations relating to Independent Bill Review (IBR) are presented on behalf of members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 80% of California's workers' compensation premium, and self-insured employers with $36B of annual payroll (20% of the state's total annual self-insured payroll).

Insurer members of the Institute include ACE, AIG, Alaska National Insurance Company, AmTrust North America, Chubb Group, CNA, CompWest Insurance Company, Crum & Forster, Employers, Everest National Insurance Company, Farmers Insurance Group, Fireman's Fund Insurance Company, The Hartford, Insurance Company of the West, Liberty Mutual Insurance, Pacific Compensation Insurance Company, Preferred Employers Insurance Company, Springfield Insurance Company, State Compensation Insurance Fund, State Farm Insurance Companies, Travelers, XL America, Zenith Insurance Company, and Zurich North America.

Self-insured employer members are Adventist Health, Agilent Technologies, City and County of San Francisco, City of Santa Ana, City of Santa Monica, City of Torrance, Contra Costa County Schools Insurance Group, Costco Wholesale, County of San Bernardino Risk Management, County of Santa Clara Risk Management, Dignity Health, Foster Farms, Grimmway Enterprises Inc., Kaiser Foundation Health Plan, Inc., Marriott International, Inc., Pacific Gas & Electric Company, Safeway, Inc., Schools Insurance Authority, Sempra Energy, Shasta County Risk Management, Southern California Edison, Sutter Health, University of California, and The Walt Disney Company.

Introduction
The Institute congratulates the staff of the Division of Workers' Compensation. The effort staff members have expended and volume of work they have accomplished in writing and modifying regulations to implement Senate Bill 863 in such a short period of time is nothing short of amazing. The Institute supports the comments submitted by the California Chamber of Commerce and the California Coalition on Workers' Compensation (CCWC); and by the American Insurance Association (AIA) on the draft regulations. In addition, the Institute offers the recommendations and comments that follow.

Bill review is possibly the most technical and complex endeavor in the workers' compensation system. It requires a thorough understanding of the rules and instructions promulgated by the division and extensive experience to do it correctly. Because the determination of the Independent Bill Reviewer will be presumed correct, there is concern that in the rush to meet the statutory deadline, reviewers will lack the necessary expertise and training to function well within the system. These regulations do not provide any discussion of reviewer's qualifications, certifications, or experience. Because an appeal from an IBR determination will be limited, the workers' compensation community needs to have confidence that the reviewers will be subject to scrutiny from the agency, and training in the rules and regulations relevant to their work. At a minimum, we expect that the independent bill reviewers will be required to have the training currently mandated for workers' compensation bill reviewers by Insurance Code section 2592.

Recommended changes are indicated by highlighted underscore and ~~strikeout~~. CWCI comments are indicated by italicized and highlighted *text*.

Independent Bill Review Regulations

Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011

Section 9792.5.1 Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides.

(a) The *California Division of Workers' Compensation Medical Billing and Payment Guide*, ~~version 1.1,~~ which sets forth billing, payment and coding rules for paper and electronic medical treatment bill submissions, is incorporated by reference. Version 1.1 of this Guide is effective for bills received on and after January 1, 2013 (or the date the regulation is adopted). It may be downloaded from the Division of Workers' Compensation through the Department of Industrial Relations' website at www.dir.ca.gov or may be obtained by writing to:

DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
ATTN: MEDICAL BILLING AND PAYMENT GUIDE
P.O. BOX 71010
OAKLAND, CA 94612

> *As written, version 1.1 of the Medical Billing and Payment Guide appears to apply retroactive to October 15, 2011. If that is not what the Administrative Director intends, the*

Institute recommends clarifying that version 1.1 of this Guide apply to bills received by the claims administrator on and after the effective date of these regulations.

(b) The *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide*, ~~version 1.1,~~ which sets forth billing, payment and coding rules and technical information for electronic medical treatment bill submissions, is incorporated by reference. Version ~~1.1~~ 1.2 of this Guide is effective for bills received on and after January 1, 2013 (or the date the regulation is adopted). It may be downloaded from the Division of Workers' Compensation website at www.dir.ca.gov or may be obtained by writing to:

DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
ATTN: MEDICAL BILLING AND PAYMENT COMPANION GUIDE
P.O. BOX 71010
OAKLAND, CA 94612

The Companion Guide proposed for adoption is version 1.2, not version 1.1. This appears to be an inadvertent typographical error. As written, the Companion Guide proposed for permanent adoption also appears to apply retroactive to October 15, 2011. If that is not what the Administrative Director intends, the Institute recommends clarifying that version 1.2 of this Companion Guide applies to bills received by the claims administrator on and after the effective date of these regulations.

§ 9792.5.4 . Second Review and Independent Bill Review – Definitions

This section is applicable to billings received on or after January 1, 2013, (or the effective date of these revised regulations) ~~medical treatment~~ for services and goods rendered~~,~~ pursuant to Labor Code sections 4600 and 4603.2, ~~or~~ and medical-legal expenses incurred~~,~~ pursuant to Labor Code section 4620 ~~on or after January 1, 2013~~.

The Institute urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013 (or on the effective date chosen by the Administrative Director, since emergency regulations have been in effect since January 1, 2013) as this will apply the new statutory provisions to billings and billing disputes as soon as possible, as intended by the Legislature, and under a single set of rules on a going-forward basis.

Senate Bill 863 imposes new billing and payment requirements that include additional documentation that must be submitted with billings, new payment timeframes, and new content for explanations of review and for explanations of second review (Labor Code section 4603.2 et. al.). Section 84 of Senate Bill 863 mandates that the new statutory provisions of the Bill apply to all pending matters unless a specific date is indicated. Since the new requirements are also prerequisites for subsequent steps in the bill review

and bill dispute process, the Institute believes that these regulations must apply all these new requirements to billings received on and after January 1, 2013 (or the effective date of these regulations). Doing so applies the new provisions on the soonest date that allows billing providers and payers alike to comply with all the requirements, and ensures that the billing providers and payers are operating under the same single set of rules on a going-forward basis.

Fee schedules are applied by date of service, however bill review timeframes and rules are triggered throughout this and other healthcare industries by date of bill receipt. If these regulations are applied by date of service, two separate sets of rules must be followed, depending on the date of service. This creates unnecessary complexity, confusion and potential for disputes. For example, which rules apply if a bill includes dates of service both before and after the effective date? It also means that bill review systems must program and maintain two different sets of timeframes and rules -- an unnecessary hardship and unnecessary expense. And when these rules are updated in the future, if they are also effective according to the date of service, multiple sets of timeframes and rules must be maintained.

But, whichever method of application the Administrative Director chooses to apply, the Institute believes it must be consistent. If regulations are to apply the Senate Bill 863 provisions in Labor Code section 4603.2 according to the date of service, it must do so for all the provisions in that section and the Administrative Director must clarify in section 9792.5.1(a) and (b) that the new payment and explanation of review timeframes also apply only to bills with dates of service on or after January 1, 2013.

Replacing "medical treatment for services rendered" with "services and goods rendered pursuant to Labor Code sections 4600 and 4603.2;" and "medical-legal expenses incurred" with "medical-legal expenses incurred pursuant to Labor Code section 4620" clarifies that the section is applicable to all the services and goods described in those sections. As currently written, there may be confusion and dispute over what is and is not "medical treatment." Alternatively, add to this section the definition recommended below in (j).

(a) "Amount of payment" means the amount of money paid by the claims administrator for either:

(1) ~~Medical treatment s~~Services rendered by a provider or goods supplied in accordance with Labor Code sections 4600 or 4603.2 that ~~was~~ were authorized ~~by~~ pursuant to Labor Code section 4610, and for which there exists ~~an applicable~~ a fee schedule for that category of services, including but not limited to schedules located at sections 9789.10 to 9789.111, or for which- a contract for reimbursement rates exists under Labor Code section 5307.11.

These recommended changes clarify that the services include services listed in Labor Code section 4603.2, and must be subject to a fee schedule for that category of services. "Including but not limited to" is added to cover fee schedules that may be adopted in the future.

(2) Medical-legal expenses, as defined by Labor Code section 4620, where the payments ~~for the services~~ are determined ~~by~~ in accordance with sections 9793-9795 and 9795.1-9795.4.

These changes are suggested for additional accuracy.

(b) "Billing Code" means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule, located at sections that include, but are not limited to 9789.10 to 9789.111, or in the Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).

To cover other fee schedule sections promulgated by statute or that may be adopted by the Administrative Director.

(c) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

The Institute recommends adding to this definition other administrators of injured employee's claims such as CIGA, SISF and UEF.

(d) "Contested liability" means the existence of a good-faith issue which, if resolved against the injured worker, would defeat the right to any workers' compensation benefits or the existence of a good-faith issue that would defeat a provider's right to receive compensation for medical treatment ~~services~~ provided in accordance with Labor Code sections 4600 and 4603.2 or for medical-legal expenses defined in Labor Code section 4620.

Here and elsewhere in these regulations, if the recommended definition of "medical treatment" is not adopted, additional reference to 4603.2 is necessary, and/or references to "services and goods" in lieu of "medical treatment."

(i) "Provider" means a provider of medical treatment services or goods whose billing processes are governed by Labor Code section 4603.2 or 4603.4, or a provider of medical-legal services whose billing processes are governed by Labor Code sections 4620 and 4622~~, that has requested a second bill review and, if applicable, independent bill review to resolve a dispute over the amount of payment for services according to either a fee schedule established by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11~~.

This definition of "provider" applies whether or not a second bill review and, if applicable, IBR is requested.

(j) "Medical treatment" means the treatment, goods, and services to which an employee is entitled under Labor Code Sections 4600 and 4603.2.

SB 863 added the following language to clarify the character of related medical services:

> *"4603.2(b)(1) Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services …"*

It is therefore essential that the regulation encompass the entire range of medical services and goods to which the employee is entitled, and that the regulation reflect the Legislature's inclusion of ancillary services provided by pharmacies, interpreters, copy services, transportation services, and home health care services. There is still considerable confusion over whether these ancillary services are within the definition of medical treatment under section 4600, even after the 2011 en banc opinion in Guitron v Santa Fe Extruders, 76 CCC 228. This definition is necessary to reflect the relevant statutory provisions and to provide a full definition of medical treatment.

§ 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment ~~services rendered~~ that is received on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or a bill for medical-legal expenses ~~incurred~~ that is received on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.

The Institute urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013 (or the effective date of these regulations) as this applies the new provisions at the soonest possible time, as intended by the Legislature, and under a single set of rules on a going-forward basis.

See previous discussion on pages 3 and 4 regarding triggering SB 863 provisions regarding bills by dates received instead of dates of service.

(b) The second review must be requested within 90 days of:

(1) ~~The date of s~~Service of the explanation of review provided by a claims administrator in conjunction with the payment, adjustment, or denial of the initially submitted bill~~, if a proof of service accompanies the explanation of review~~. The explanation is served when it is placed in the U.S. mail, faxed, or emailed to the provider, or when it is personally served on the provider.

(A) ~~The date of receipt of the explanation of review by the provider is deemed the date of service, if a proof of service does not accompany the explanation of review and the claims administrator has documentation of receipt~~

~~(B) If the explanation of review is sent by mail and if in the absence of a proof of service or documentation of receipt, the date of service is deemed to be five (5) calendar days after the date of the United States postmark stamped on the envelope in which the explanation of review was mailed.~~

(2) ~~The date of s~~Service of an order of the Workers' Compensation Appeal Board resolving any threshold issue that would preclude a provider's right to receive compensation for the submitted bill. The explanation is served when it is placed in the United States mail, faxed, or emailed to the provider, or when it is personally served.

A document is served when it is placed in the U.S. mail, faxed, emailed, or personally served. If served by mail, fax, email, or any method other than personal service, the time for exercising or performing any right or duty to act shall be extended by five calendar days from that date of service if the service is in California, by ten calendar days if outside California but within the United States, and by twenty calendar days if outside the United States. See CCR section 10507 and California Code of Civil Procedure Section 1013.

(c) The request for second review shall be made as follows:

(1) For a non-electronic medical treatment bill~~s~~, the second review shall be on ~~either~~:

(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The Second Review Bill ~~bill~~ shall be marked on the standard billing forms as further specified in the Medical Billing and Payment Guide version 1.1, using the National Uniform Billing Committee (NUBC) Condition Code Qualifier "BG" followed by NUBC Condition Code "W3" in the field designated for that information to indicate a request for second review, or, for the ADA 2006 form, the words "Request for Second Review" will be marked in Field 1, or for the NCPDP WC/PC Claim Form, the words "Request for Second Review" may be written on the form.

This change clarifies that the Medical Billing and Payment Guide version 1.1 can be consulted for additional information.

(B) ~~Requested on the~~ The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6, shall be attached to the Second Review Bill.

The Administrative Director has proposed two methods for requesting a second bill review: (1) submitting the initially reviewed standard billing form modified by the second request code; or (2) submitting a Request for Second Bill Review form (DWC Form SBR-1). The Institute recommends adopting a single method for paper medical treatment bills. Specifically, require the Second Bill Review form (DWC Form SBR-1) to be attached to the modified standard billing form. This provides both the necessary billing information and prominently identifies requests for second bill review for rapid processing. It also will ensure second review bills are not delayed, especially during the inevitable learning curve period when billing providers are still learning where to place

the second request code, and how to fill out the SBR-1 form. One of the underlying principles of SB 863 was to reduce system friction by streamlining processes. Having one standard process will promote uniformity and efficiency within the IBR system.

(f) Within 14 days of receipt of a request for second review, the claims administrator shall respond to the provider with a final written determination on each of the items or amounts in dispute by issuing an explanation of review. The determination shall contain all the information that is required to be set forth in an explanation of review under Labor Code section 4603.3, including an explanation of the time limit to raise any further objection regarding the amount paid for services and how to obtain independent bill review under Labor Code section 4603.6.

(1) The 14-day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the claims administrator.

~~(2) Any properly documented itemized service provided and not paid within the timeframes described in Labor Code section 4603.2(b)(2) and (3) shall be paid at the rates then in effect and increased by fifteen (15) percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the provider's initial itemized billing, if the claims administrator untimely communicates the final written determination under this section.~~

The Legislature could have provided authority in SB 863 to assess a penalty and interest retroactive to the date of receipt of the initial bill for a claims administrator's failure to respond to a final written determination within 14 days of a request for second review, but chose not to do so. The imposition of specific penalties and interest is a legislative policy determination and must have a specific statutory foundation. The Administrative Director may not implement penalties and interest without this specific authority. Audit penalties, however are applicable for failure to comply with the provision.

§ 9792.5.6. Provider's Request for Second Bill Review – Form

Provider's Request for Second Bill Review. DWC Form SBR-1.

See the attached Request for Second Bill Review forms; one with recommended changes identified by underscore and strikeout, and a clean version without the underscore and strikeout. The reasons for the recommended changes are summarized as follows:

- *Some fields are reordered into a more logical order and spacing*
- *Some prompts are abbreviated for brevity and space*
- *Some prompts, such as for addresses, are merged for clarity*
- *The prompt for authorization status is added to listings of disputed services*
- *The signature line clarifies that the provider's original signature is required*

- *The instructions are modified for clarity and accuracy.*

§ 9792.5.7. Requesting Independent Bill Review.

(a) If the provider further contests the amount of payment made by the claims administrator on a medical treatment bill submitted pursuant to Labor Code sections 4603.2 or 4603.4 and~~, for medical treatment services rendered~~ received on or after January 1, 2013 ~~(or effective date of these regulations), submitted pursuant to Labor Code sections 4603.2 or 4603.4~~, or a medical-legal bill submitted pursuant to Labor Code section 4622~~,for medical-legal expenses incurred~~ and received on or after January 1, 2013 (or the effective date of these regulations)~~, submitted pursuant to Labor Code section 4622~~, following the second review conducted under section 9792.5.5, the provider shall request an independent bill review. ~~Unless consolidated under section 9792.5.12, a~~ A request for independent bill review shall ~~only~~ resolve:

> *The Institute urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013 (or the effective date of these regulations), as this applies the new provisions as soon as possible, as intended by the Legislature, and under a single set of rules on a going-forward basis.*
>
> *See previous discussion on proposed section 9792.5.4 regarding triggering SB 863 provisions regarding bills by dates received instead of dates of service.*
>
> *The Legislature could have authorized the Administrative Director to permit consolidation of requests for independent Bill Review (IBR) in SB 863, but did not. The Institute believes that adding a process to consolidate requests is an unlawful expansion of the scope of the statute that thwarts its purpose. As a practical matter, we are also concerned that neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.*

(1) For a bill for medical treatment services, a dispute over the amount of payment for services and goods billed by a single provider involving one injured employee, one claims administrator, and one date of service or discharge, ~~and one billing code under~~ in accordance with the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.

> *At a minimum, every independent bill review must encompass all goods and services provided on the same date of service that are billed by a single provider on a single claim. If not, a provider can easily manipulate the process and evade fee schedule rules and the Correct Coding Initiative (CCI) edits in order to obtain undeserved payment, leaving the claims administrator without recourse. Payment for a particular single service on a bill often depends on the payment for other services provided on the same day. If only one service code is reviewed, a provider will be able to evade the CCI edits and other rules that apply when certain other codes are billed. Such behavior will negatively impact the injured employee's quality of care and result in higher costs.*

Other revisions are recommended to improve accuracy.

(2) For a bill for medical-legal expenses, a dispute over the amount of payment for any services and goods billed by a single provider involving one injured employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation, if any.

See previous comment.

(b) Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review. Issues that are not eligible for independent bill review shall include:

~~(1) The determination of a reasonable fee for services where that category of services is not covered by a fee schedule adopted by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11.~~

The proposed regulation is too restrictive and is an unlawful alteration of the scope of the statute. IBR will cover the disputes where resolution is least needed (those covered by fee schedules) and will leave the disputes where resolution is most needed (those not covered by fee schedules) to judges who do not have the training and expertise required to make reasonable determinations in this complicated area.

Legislative intent from section 1 of SB 863 states:
"Existing law provides no method of medical billing dispute resolution short of litigation. Existing law does not provide for medical billing and payment experts to resolve billing disputes and billing issues are frequently submitted to workers' compensation judges without the benefit of independent and unbiased findings on these issues. Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system"

Nothing in section 4603.6 restricts the independent bill review to a category of services covered by a fee schedule adopted by the Administrative Director. The Administrative Director has no authority to adopt a regulation that restricts the scope of the statute. Mendoza v Huntington Hospital, WCAB (2010) 75 CCC 634.

Independent Bill Review is a process that was intended to provide specific cost reductions. By excluding bills from the statutorily required IBR process, the Administrative Director impermissibly narrows the scope of the statute, limits the effectiveness of IBR, and eliminates cost reductions projected by the Legislature.

~~(2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.~~

Determining the reasonable amount of payment is most definitely part of a bill reviewer's duties. Just as a bill reviewer must examine a report to verify that it supports the level of service or code billed and to determine the code under which it should be paid, examining the report that must support a "by report" code or other code that is not assigned a value, and identifying an analogous code or value for payment is reasonable and proper. It should not be forbidden; whether or not the methodology is specifically addressed in a schedule.

According to the General Instructions in the current Physician section of the OMFS:

> *"Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.*
>
> *By Report (BR): Procedures coded BR (By Report) are services which are unusual or variable.*
>
> *An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are:*
>
> - *complexity of symptoms;*
> - *final diagnosis;*
> - *pertinent physical findings;*
> - *diagnostic and therapeutic procedures;*
> - *concurrent problems;*
> - *follow-up care.*
>
> *In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed."*

While the methodology is specifically addressed in this section of the OMFS, there is no guarantee it will be in a future version of this schedule, or in other fee schedules or fee schedule sections.

(c) The request for independent bill review must be made within 30 calendar days of:

Labor Code section 4603.6(a) specifies "within 30 calendar days of service of the second review."

(1) ~~The date of s~~Service of the final written determination issued by the claims administrator under section 9792.5.5(f)~~, if a proof of service accompanies the final written determination~~. The final written determination is served when it is placed in the United States mail, faxed, or emailed to the provider, or when it is personally served. If served by mail, fax, email, or any method other than personal service, the time to request independent review is extended by 5 calendar days to allow for time until receipt.

~~(2) The date of receipt of the final written determination by the provider, if a proof of service does not accompany the final written determination and the claims administrator has documentation of receipt.~~

~~(3) The date that is five (5) calendar days after the date of the United States postmark stamped on the envelope in which the final written determination was mailed if the final written determination is sent by mail and there is no proof of service or documentation of receipt.~~

> *A document is served when it is placed in the United States mail, faxed, emailed, or personally served. If served by mail, fax, email, or any method other than personal service, the time for exercising or performing any right or duty to act shall be extended by five calendar days from that date of service if the service is in California, by ten calendar days if outside California but within the United States, and by twenty calendar days if outside the United States. See CCR section 10507 and California Code of Civil Procedure Section 1013.*

(d)(1) The request for independent bill review shall be made in one of the following manners:

(A) Completing and electronically submitting the online Request for Independent Bill Review form, which can be accessed on the Internet at the Division of Workers' Compensation's website. The website link for the online form can be found at https://ibr.dir.ca.gov. Electronic payment of the required fee of $335.00 shall be made at the time the request is submitted.

> *Note: The link is to a DWC IBR page. There appear to be errors on that page that we suggest could be corrected as follows:*
> *"You must send in the application request within thirty (30) days from the date ~~you received~~ the final ~~utilization review decision~~ written determination was sent to you. An additional five (5) calendar days are allowed to account for delivery time. "*
> *The website link for the online form is not yet available on that page.*

(B) Mailing the Request for Independent Bill Review form, DWC Form IBR-1, set forth in section 9792.5.8, and simultaneously paying the required fee of $335.00 as instructed on the form.

(2) The provider ~~will~~ shall include with the request form submitted under this subdivision, either by electronic upload or by mail, a copy of the following documents:

> *"Shall" is the term used to denote a requirement.*

(e) The provider ~~may~~ shall include in a single request for bill review the billing codes for all disputed payments for services or goods provided to a single injured employee on a single date of service or discharge ~~that two or more disputes that would each constitute a separate request for independent bill review be consolidated for a single determination under section 9792.5.12~~.

All disputed billings for a single date of service for services provided to a single injured employee must be reviewed in concert, and therefore must be submitted for review on a single form. They must be considered together because billing and payment rules that apply to a single billing code are often different from those for multiple codes on the same date of service. For example, payment for one code may be included in the payment for another billed for the same service date. In fact, when considering the proper payment amount, a reviewer must consider all the services documented and billed for a single service date; the amount already paid and the explanations for the payment; and the statutes, rules and regulations that affect payment.

Alternatively, if independent bill review for all disputed billings services to one injured employee provided on a single date of service are not required to be requested together, then all such disputes submitted separately must be identified and reviewed together.

§ 9792.5.8. Request for Independent Bill Review Form

Request for Independent Bill Review. DWC Form IBR-1.

See the attached Request for Independent Bill Review forms; one with recommended changes identified by underscore and strikeout, and a clean version without the underscore and strikeout. The reasons for the recommended changes are summarized as follows:

- *Some fields are reordered into a more logical order and spacing*
- *Some prompts are abbreviated for brevity and space*
- *Some prompts, such as for addresses, are merged for clarity*
- *In the Provider Type section, the single prompt and box for Treating Physician has been replaced by separate prompts and boxes for the Primary Treating Physician, and the Secondary Treating Physician because some rules and payments are affected by these different treating physician categories. An additional prompt and box has been added for "other Practitioner – specify____" to capture other types of providers*
- *The consolidation section has been deleted because the Institute believes that consolidations are not supported in SB 863*
- *The signature line clarifies that the provider's original signature is required*

- *The mailing information for Maximus is deleted because the Institute believes that the forms should not be sent to Maximus until they are reviewed by the DWC or a designee with no financial interest in the outcome of an eligibility determination*

- *The instructions are modified for clarity and accuracy*

- *The Consolidation and Disaggregation paragraphs have been deleted for the reason described above*

- *The Institute recommends adding an additional five days to the 30 days from the date of service of the final written determination and including an explanation for the additional days*

- *In the How to Apply by Mail section, the injured employee is instructed to copy the claims administrator and is advised that forms not sent as instructed will not be considered filed. The language that says the form will be returned if it is not sent as directed is deleted in case it does not go to a location that will return it.*

§ 9792.5.9. Initial Review and Assignment of Request for Independent Bill Review to IBRO.

(a) Upon receipt of the Request for Independent Bill Review under section 9792.5.7, the Administrative Director, or his or her designee, shall conduct a preliminary review to determine whether the request is ineligible for review. In making this determination, the Administrative Director shall consider:

(1) The timeliness and completeness of the request;

(2) The date of receipt of the billing and whether- a second request for review of the bill was timely requested and was completed;

To determine eligibility due to timely request, the date of billing receipt is needed.

(3) Whether, for a bill for medical treatment services, the medical treatment was provided or referred by the primary treating physician and authorized by the claims administrator under Labor Code section 4610 and, if authorized, whether the written authorization was submitted together with the billing.

The DWC also needs to know whether the treatment was provided or referred by the primary treating physician and whether a written authorization was submitted with the billing.

(4) If the required fee for the review was ~~not~~ paid;

The condition is better stated in the affirmative.

(b) If the request appears eligible for review, the Administrative Director, or his or her designee, shall notify the provider and the claims administrator within 5 days from receipt of the request by the most efficient means available that request for independent bill review has been submitted and appears eligible for assignment to an IBRO. The notification shall contain:

The Institute recommends specifying a timeframe here. The Institute recommends five days to allow time for the other steps in the process.

Because the IBRO has a direct financial conflict of interest, the Institute does not believe it proper to designate Maximus to receive or to perform any initial review of the form before the request is determined to be eligible and is assigned for review.

(1) An independent bill review case or identification number;

This corrects a minor typographical error.

(2) The date the Request for Independent Bill Review, DWC Form IBR-1, was received by the Administrative Director

(3) A statement that the claims administrator may dispute eligibility for independent bill review under subdivision (a) by submitting a statement with supporting documents, and that the Administrative Director or his or her designee must receive the statement and supporting documents within fifteen (15) calendar days of the date the Administrative Director received the Request as designated on the notification~~, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically~~.

The Institute suggests counting these timeframes from the date the Administrative Director received the Request, which date can be designated on the notification.

Section 10507 specified the same additional five days, whether notification is by mail, fax or email.

(c) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(3) must be concurrently served on the other party. Any document that was previously provided to the other party or originated from the other party need not be served if a written description of the document and its date is served.

Stating that the documents must be concurrently filed on the other party will ensure timely receipt.

(d) Upon receipt of ~~the~~ documents ~~requested in~~ pursuant to subdivision (b)(3), or, if no documents have been received, upon the expiration of fifteen (15) days of the date the Administrative Director received the Request as designated on the notification, ~~if the notification~~

~~was provided by mail, or within twelve (12) days of the date designated on the notification if the notification was provided electronically,~~ the Administrative Director, or his or her designee, shall conduct a further review in order to make a determination as to whether the request is ineligible for independent bill review under subdivision (a).

Again, the Institute suggests counting these timeframes from the date the Administrative Director received the Request, which can be the date designated on the notification.

Section 10507 specified the same additional five days, whether notification is by mail, fax or email.

(e) If the review conducted under either subdivision (a) or subdivision (d) finds that the request is ineligible for independent bill review, the Administrative Director shall, within ~~fifteen~~ thirty (~~15~~30) calendar days ~~following receipt of the documents requested in subdivision (b)(3) or, if no documents are received, the expiration of the time period indicated above~~ of the date the Administrative Director received the Request as designated on the notification, issue a written determination informing the provider and claims administrator that the request is not eligible for independent bill review and the reasons therefor.

Allowing 15 days from the date the Administrative Director (AD) received the Request for documents disputing eligibility, and 30 days from the same date for the AD to issue the determination, is a simpler, easier to track timeframe.

(1) If a request is deemed ineligible under this section, the provider shall be reimbursed the amount of $270.00.

(f) If the Administrative Director or his or her designee determines from the review conducted under subdivision (a) or (d), whichever applies, that the request is eligible for independent bill review, the Administrative Director shall assign the request to an IBRO for an independent bill review within thirty (30) calendar days of the date the Administrative Director received the Request. Upon assignment of the request, the IBRO shall notify the parties in writing that the request has been assigned to that organization for review. The notification shall contain:

The statute requires this timeframe.

(3) Identification of the claim and disputed amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622~~,~~;

The claim number is also needed.

§ 9792.5.10. Independent Bill Review - Document Filing.

(a) The independent bill reviewer assigned the request shall review all information provided by the parties to determine if any additional information is necessary to resolve the dispute. If the independent bill reviewer determines that additional information is necessary, the independent bill reviewer shall contact the claims administrator and the provider in writing to request the information.

(b) If the independent bill reviewer requests information from either the claims administrator or the provider, or both, the party shall ~~file~~ transmit the documents to ~~with~~ the independent bill reviewer at the address listed in the correspondence in Section 9792.5.9(f) within ~~35~~ 30 days of receipt of the request and concurrently to ~~, if the request is made by mail, or 32 days of the request, if the request is made electronically. The filing~~ party shall serve the non-filing party ~~with the documents requested by the independent bill reviewer~~.

"Transmit" is preferable because its meaning is clear. The term "file" may be subject to unnecessary interpretation and dispute.

If the independent bill reviewer requests additional documents, Labor Code section 4603.6(e) requires the parties to "respond with the documents requested within 30 days." Additional time would apply only if parties are required to submit the documents within 30 days of the independent bill reviewer serving the request; however this is not what Labor Code section 4603.6(e) requires. Requiring parties to respond within 30 days of receiving the request is simpler, more straightforward and easier to track. Adding the term "concurrently" ensures that the documents will be sent to the other party in a timely fashion.

§ 9792.5.11. Withdrawal of Independent Bill Review.

(a) ~~Following the submission of all required documents under section 9792.5.10 or 9792.5.12, the provider may withdraw his or her request for independent bill review, before a determination on the amount of payment owed, if the provider and claims administrator settle their dispute regarding the amount of payment of the medical bill. If the provider and claims administrator settle their dispute, they shall make a written joint request for withdrawal and serve it on the independent bill reviewer.~~ The provider may withdraw his or her request at any time before the determination is issued by submitting a written request to the Administrative Director, the claims administrator, and as applicable, the IBRO and independent bill reviewer. If the claims administrator pays the disputed amount to the provider before the determination, the claims administrator will notify the provider, Administrative Director, IBRO and/or reviewer and the request will be withdrawn.

It is reasonable for a provider to withdraw the request before a determination is issued by providing written notice to the Administrative Director, the claims administrator, the IBRO and the reviewer. It is important that the claims administrator notify the Administrative Director, IBRO and independent bill reviewer as applicable, if it pays the disputed amount prior to the determination, otherwise a determination and order of the Administrative Director may unnecessarily require a duplicate payment.

(b) If a request for independent bill review is withdrawn under this section, the provider shall not be reimbursed the fee provided with the request under section 9792.5.7(d).

§ 9792.5.12. Independent Bill Review - Consolidation or Separation of Requests.

(a) With a request for independent bill review submitted under section 9792.5.7, a provider may request combining two or more requests for independent bill review together for the purpose of having the payment reductions contested in each request resolved in a single determination issued under section 9792.5.14.

(b) In applying this section, the following definitions shall be used:

(1) "Common issues of law and fact" means the denial or reduction of the amount of payment in each request was made for similar reasons and arose from a similar fact pattern material to the reason for the denial or reduction.

(2) "Delivery of similar or related services" means like or coordinated medical treatment services or items provided to one or more injured employees.

(3) "Pattern and practice" means ongoing conduct by a claims administrator that is reasonably distinguishable from an isolated event.

(c) Two or more requests for independent bill review by a single provider may be consolidated if the Administrative Director or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services.

(1) Requests for independent bill review by a single provider involving multiple dates of medical treatment services may be consolidated and treated as one single independent bill review request if the requests involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, and the total amount in dispute does not exceed $4,000.00.

(2) Requests for independent bill review by a single provider involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service.

(3) Upon a showing of good cause and after consultation with the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Requests to be consolidated under the subdivision shall involve multiple injured

~~employees, one claim administrator, one billing code, one or multiple dates of service, and aggregated amounts in dispute up to $4,000.00 or individual amounts in dispute less than $50.00 each.~~

~~(d) Upon filing a request for independent bill review under section 9792.5.7, the provider, if requesting the consolidation of separate requests, shall, in addition to providing the filing fee of $335.00, specify all of the requests for independent bill review sought to be consolidated with a description of how the requests involve common issues of law and fact or delivery of similar or related services. Once consolidation has been granted no other disputes shall be added to the consolidated disputes.~~

~~(e) The IBRO may disaggregate into separate independent bill review requests a single request that does not meet the standards set forth in subdivision (c) of this section. For any independent bill review request that must be disaggregated, the same fee shall be charged for each additional independent bill review request as charged for one independent bill review request.~~

~~(1) If an independent bill review request must be separated, the IBRO shall immediately provide notice in writing to the provider and claims administrator stating the reasons for disaggregation, and shall inform the provider of the additional fee or fees required to perform the independent bill review.~~

~~(2) Within ten (10) days following receipt of the notification informing the provider of the separation of requests, the provider shall submit to the IBRO any additional fee or fees necessary to conduct independent bill review. The failure to provide the additional fee or fees shall subject the request to a determination of ineligibility under section 9792.5.9.~~

~~(f) Nothing in this section shall extend the time for issuing a determination required by Labor Code section 4603.6 (e).~~

~~Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.~~
~~Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.~~

The Legislature could have authorized the Administrative Director to permit the consolidation of requests for independent Bill Review (IBR) in Senate Bill 863, but it did not. The Institute believes that adding a process to consolidate requests is an unlawful expansion of Statute that thwarts its purpose. We are also concerned that neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.

§ 9792.5.13. Independent Bill Review – Review.

(a) If the request for independent bill review involves the application of the Official Medical Fee Schedule (OMFS) for the payment of medical treatment services or goods as defined in Labor Code section 4600, the independent bill reviewer shall apply the provisions of sections 9789.10

to ~~9789.111~~ 9792.5.3, relevant statutes, judicial rulings, and other rules and regulations to determine additional amounts or overpayments, if any, that are to be paid to the provider or reimbursed to the claims administrator.

Sections 9789.10 to 9789.111 do not cover all rules and requirements for payment. Fee schedules are applied according to date of service. Sections 9790 through 9792.5.3, for example also must be applied. "Medical treatment" payments are affected by numerous other statutes, as well as case law and rules and regulations, and independent bill reviewers must apply them all.

(b) If the request for independent bill review involves the application of a contract for reimbursement rates under Labor Code section 5307.11 for the payment of medical treatment services as defined in Labor Code section 4600, the independent bill reviewer shall apply the contract and all other statutes, case law, rules and regulations to determine additional amounts, or overpayments, if any, that are to be paid to the provider or reimbursed to the claims administrator.

The Institute believes that when reviewing bills, the independent bill reviewer must at all times consider all relevant statutes, case law, and rules and regulations, and must determine any overpayments as well as underpayments.

(c) If the request for independent bill review involves the application of the Medical-Legal Fee Schedule (M/L Fee Schedule) for services defined in Labor Code section 4620, the independent bill reviewer shall apply the provisions of sections 9793-9795 and 9795.1 to 9795.4 and all other statutes, case law, rules and regulations to determine additional amounts~~,~~ or overpayments, if any, that are to be paid to the provider or reimbursed to the claims administrator.

(d) In applying this section, the independent bill reviewer shall apply the provisions of the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, and all applicable statutes, case law, rules and regulations as if the bill is being reviewed for the first time; and shall consider each Bill Adjustment Reason Code, associated DWC Explanatory message and Payer Instruction; each Claims Adjustment Reason Code and Remittance Advice Remark Code and associated Description in the explanations of review issued; and the National Correct Coding Initiative and other nationally accepted coding references.

It is important that the Independent bill reviewer review and investigate as needed each explanatory message or code to consider whether factors apply that are not obvious from the required submissions. The reviewer must also utilize tools of the trade such as NCCI and other coding references.

§ 9792.5.15. Independent Bill Review – Implementation of Determination and Appeal.

(b) Pursuant to Labor Code section 4610.6(f), the provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by filing a petition with the Workers' Compensation Appeals Board

Since the specifics of Labor Code section 4610.6(f) have been deleted, a citation to that section is appropriate.

Medical Billing and Payment Guide Version 1.1

1.0 Standardized Billing / Electronic Billing Definitions

(a) "Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider or health care facility and is authorized by law to collect payment from the responsible payer after the person who was entitled to payment has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all rights, title, and interests in the remaining accounts receivable to the assignee.

The Legislature, in Senate Bill 863, adopted Labor Code section 4903.8 to clarify under what circumstances a lien payment can be made to persons or parties other than those entitled to payment at the time the expenses were incurred. In doing so, the Legislature clarified that an assignee is entitled to payment only if the person who was entitled to payment has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all rights, title, and interests in the remaining accounts receivable to the assignee. The Institute urges the Administrative Director to include this standard in the definition of an assignee.

(k) A contested bill or a contested portion of a bill is one that is reduced or not paid for a reason other than adjustment made pursuant to an applicable fee schedule or contract.

Adding a definition for "contested bill" will identify which bills are "contested." Providers do not bill at or below the maximum reasonable Official Medical Fee Schedule allowances or contracted fees; they routinely submit bills to California workers' compensation claims administrators and to other types of payers at high standard rates and rely on payers to adjust them to "rates then in effect," under the prevailing fee schedule or contract. One reason providers bill significantly above scheduled and contracted fees is to avoid violating Medicare rules that forbid billing other payers at rates lower than Medicare's; another reason is that it is more efficient to rely on the payer to calculate the allowable fees and apply the payment rules than having to program and calculate those rates and rules themselves. The claims administrator is providing a service in this respect. Such a billing is not "contested" unless the provider claims that the amount paid was not accurately reviewed according to the fee schedule or to the contract rate. Bills that are reduced or denied for reasons other than adjustment to an applicable fee schedule or contract are "contested bills."

(m) "Explanation of Review" (EOR) means the explanation of payment or the denial of the payment ~~as defined~~ issued in the manner described in Appendix B. Paper EORs conform to Appendix B - 3.0. Electronic EORs are issued using the ASC X12N/005010X221 Health Care Claim Payment/Advice (835). No explanation of review is required when a bill is paid in full. EORs use the following standard codes:

This characterization may be preferable as Appendix B describes the content requirements of the explanation of review and the manner in which it must be conveyed.

Explanations of review have historically been issued to explain why a service or item was paid at less than the amount billed. They have not historically been required or issued when the billed fee was paid in full. I see no CARC/ RARC in Appendix B that can be used when making a payment in full. Since no explanation of review is necessary when a bill is paid in full, the Institute recommends that the Administrative Director clarify that an explanation of review is not required when a bill paid in full.

(p) "Itemization of services" means the list of medical treatment, goods or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form or electronic ~~claim~~ format.

Since the meaning of the term "claim" in workers' compensation is not the meaning intended here, the Institute suggests deleting the term here.

(q) "Medical Treatment" means the treatment, goods and services as defined by Labor Code Sections 4600 and 4603.2(b).

Labor Code Section 4603.2(b) adds clarity as it includes a more comprehensive listing of services provided pursuant to Labor Code Section 4600.

(t) Official Medical Fee Schedule (OMFS) means all of the fee schedules for services described in Labor Code sections 4600 and 4603.2, including, but not limited to those found in Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - ~~9789.111~~ 9792.1)~~,~~ adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600. These include the following schedules: Physician's services; Inpatient Facility; Outpatient Facility; Clinical Laboratory; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); Ambulance; and Pharmaceutical.

These recommended modifications are more inclusive of current and anticipated fee schedules.

6.2 Timeframes: Original Treatment Bills That Are Contested, Denied, Or Considered Incomplete.

(a) If the non-electronic bill or a portion of the bill is contested, denied, or considered incomplete, the claims administrator shall so notify the health care provider, health care facility or billing agent/assignee in the explanation of review. The explanation of review must be issued within 30 days of receipt of the bill and must provide notification of the items being contested, the reason for contesting those items and the remedies open to the health care provider, health care facility or billing agent/assignee. The explanation of review will be deemed timely if sent by first class mail and postmarked on or before the thirtieth day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth day after receipt. A contested bill or a contested portion of the bill is one that is not paid in full and is reduced or not paid for a reason other than adjustment made pursuant to an applicable fee schedule or contract.

Providers do not bill at or below the maximum reasonable Official Medical Fee Schedule allowances or contracted fees; they routinely submit bills to California workers' compensation claims administrators and to other types of payers at high standard rates and rely on payers to adjust them to "rates then in effect," under the prevailing fee schedule or contract. One reason providers bill significantly above scheduled and contracted fees is to avoid violating Medicare rules that forbid billing other payers at rates lower than Medicare's; another reason is that it is more efficient to rely on the payer to calculate the allowable fees and apply the payment rules than having to program and calculate those rates and rules themselves. The claims administrator is providing a service in this respect. Such a billing is not "contested" unless the provider claims that the amount paid was not accurately reviewed according to the fee schedule or to the contract rate. Bills that are reduced or denied for reasons other than adjustment to a fee schedule or contract are "contested bills."

6.4 Penalty

(a) Any non-electronically submitted bill determined to be complete, not paid within 45 days (60 days for a governmental entity) or objected to within 30 days if contested, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).

See comments under the recommended definition of a contested bill.

7.3 Electronic Bill Attachments

(a) All attachments to support an electronically submitted bill shall contain the following information in the body of the attachment or inscribed on the face of the attachment:

(1) Patient's name

(2) Claim Number (if available)

(3) Unique Attachment Indicator Number

(4) Date of Service

(5) Date of Injury

(6) Social Security Number (if available)

(7) Date of Birth

If a claim number is not provided, the employee's social security number or date of birth and date of injury are necessary to identify the injured employee and claim, and the date of service is sometimes needed to identify the correct billing.

3.1 Field Table NCPDP

NCPDP WORKERS' COMPENSATION/PROPERTY AND CASUALTY UCF USAGE INSTRUCTIONS

Paper Form Item #	NCPDP WC/PC Claim Form Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
4	Patient First Name	R	310-CA	Individual First Name	
5	Patient Street Address	R	322-CM	Free-form text for address information	
6	Patient City	R	323-CN	Free-form text for city name	
7	Patient State	R	324-CO	Standard State/Province Code as defined by appropriate government agency	
17	Claim Reference	S	435-DZ	Identifies the claim number assigned by the Workers' Compensation	Enter the claim number assigned by the workers' compensation Payer, if

Paper Form Item #	NCPDP WC/PC Claim Form Field Description	Workers' Compensation Paper Fields (Required/ Situational/Optional/ Not Applicable)	NCPDP D.0 Data Element	Comments	California Workers' Compensation Instructions
				program	known. If claim number is not ~~known~~ assigned, then enter the value of 'Unknown'

The pharmacy must enter the claim number if assigned. It must not be sufficient for the individual completing the form to routinely enter "unknown" because he or she does not "know" the claim number.

Appendix B. Standard Explanation of Review

Paper Explanation of Review

The paper EOR must include all of the data elements indicated as "R" (required) in Appendix B - 3.0 Table for Paper Explanation of Review. For data elements listed as "S" (situational) the data element is required where the circumstances described are applicable. Data elements listed as "O" (optional) may be included in the EOR, but are not required. The payer may include additional ~~messages and data~~ explanatory language in order to provide further detail to the provider. The Division of Workers' Compensation has not developed a standard paper form or format for the EOR. Payers providing paper EORs may use any format as long as all required and relevant situational data elements are present.

The 3.0 Field Table for Paper Explanation of Review specifies use of the DWC Bill Adjustment Reason Codes and DWC Explanatory Messages as situational data elements (Fields 41 and 52.) The Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk includes the DWC Bill Adjustment Reason Codes, a description of the billing problem the code is describing, the Explanatory Message, and any special instructions or additional information required when using that code. The paper EOR does not utilize the Claims Adjustment Reason Codes or the Remittance Advice Remark Codes. These are included in the table in order to provide a crosswalk between the DWC Bill Adjustment Reason Codes and the corollary CARC and RARC codes used in electronic EORs. The claims administrator ~~shall~~ may utilize additional narrative explanatory language to supplement the DWC Bill Adjustment Reason Codes Explanatory Message ~~where necessary~~ to more fully explain why the bill is adjusted, denied, or considered incomplete.

The Institute recommends maintaining the standard DWC reason codes and DWC Explanatory Messages, but permitting additional narrative explanatory language.

Electronic Medical Billing and Payment Companion Guide Version 1.2

Recommendation: The Institute recommends replacing the term "clean bill" with "complete bill" or otherwise "complete bill" wherever it appears in the Guides, including in the table of contents, the section 9.0 introduction, and in the text, headings and diagrams of sections 9.1, 9.2.1, 9.3, and 9.3.1 of this Guide.

The term "clean bill" is not defined and may cause confusion.

Preface

….

Documentation Change Control

The Companion Guide content is subject to change.

Documentation change control is maintained in this document through the use of the Change Control Table shown below. Each change made to this companion guide after the creation date is noted along with the date and reason for the change. The changes noted and dated 01/01/2013 in the table are effective for bills received on and after January 1, 2013 (or the date these regulatory changes are adopted).

Change Control Table			
Date	**Page(s)**	**Change**	**Reason**
01/01/2013	Throughout Document	See Rulemaking Documents: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/IBR_Regs.htm	See Rulemaking Documents: Initial Statement of Reasons and Final Statement of Reasons: http://www.dir.ca.gov/dwc/DWCPropRegs/IBR/IBR_Regs.htm

The Institute recommends that the Division clarify here that the changes apply to all bills received on and after January 1, 2013 (or the date these regulations are adopted) so that there is no confusion in the regulated community over when they are effective.

The Institute recommends copying and pasting into this table the changes and reasons from the rulemaking documents. The table will be more helpful and user friendly if the changes are noted here as stated above the table.

Medical-Legal Independent Bill Review Regulations

§9793. Definitions.

As used in this article:

….

(e) "Disputed medical fact" means an issue in dispute~~, including~~ where there has been an objection under Section 4062 of the Labor Code to a medical determination made by a treating physician concerning: (1) the employee's medical condition; (2) the cause of the employee's medical condition; (3), 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 June 30, 2013 treatment for the employee's medical condition; or (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition~~, or (5) the employee's medical eligibility for rehabilitation services~~.

The first recommended change is for accuracy.

Since the vocational rehabilitation benefit was repealed in 2003, it is no longer relevant or necessary for treating doctors to address medical eligibility for vocational rehabilitation.

(f) “Explanation of review” means the document described in Labor Code sections 4603.3(a) and 4622 that is provided to a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician ~~when~~ by the claims administrator ~~has objected to the cost of~~ upon payment, adjustment or denial of a billing for ~~a~~ medical-legal expenses.

The recommended changes are suggested for accuracy.

(~~g~~ h) "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:

….

(2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to

prohibit a physician from addressing in the report additional related medical issues other than issues concerning disputes over utilization review decisions pursuant to Labor Code section 4610.5.

According to Labor Code section 4610.5(b), disputes over utilization review decisions described in Labor Code section 4610.5(a) shall be resolved only in accordance with the IBR track specified in Labor Code section 4610.5.

(m) "Supplemental medical-legal evaluation" means an evaluation including an evaluation in response to a request for factual correction pursuant to Labor Code section 4061(d), which (A) does not involve an examination of the patient, (B) is based on the physician's review of records ~~test results~~ or other medically relevant information which was not available to the physician at the time of the initial examination except for the results of laboratory or diagnostic tests which were ordered by the physician as part of the original evaluation, ~~or a request for factual correction pursuant to Labor Code section 4061(d),~~ (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.

The evaluator may not profit from failing to address records and other medically relevant information which was available to the evaluator at the time of the initial examination, or the results of tests ordered by the physician as part of the original evaluation. This is also consistent with the procedure description of supplemental medical-legal evaluations in section 9795(c) that clearly states:

> *"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."*

§9794. Reimbursement of Medical-Legal Expenses.

(c) A claims administrator who contests all or any part of a bill for medical-legal expense, or who contests a bill on the basis that the expense does not constitute a medical-legal expense, shall pay any uncontested amount and notify the physician or other provider of the objection within sixty days after receipt of the reports and documents required by the administrative

director using an explanation of review. Any notice of objection shall include or be accompanied by all of the following:

(4) A statement pursuant to Labor Code section 4622(b)(1) that the physician may seek a second review by the claims administrator of the ~~reduction of~~ billing submitted for ~~of the~~ medical-legal expense under California Code of Regulations, title 8, section 9792.5.5.

The changes are recommended for accuracy and clarity.

(f) If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid pursuant to the fee schedule set forth in section 9795, unless a denial has previously been issued, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which shall also contain the following statements:

It is only necessary to issue a written denial of liability once.

(1) The physician may object to the denial of the medical-legal expense issued under this subdivision by notifying the claims administrator in writing of ~~their~~ his or her objection within ninety (90) days of the service of the explanation of review; and

This correction is suggested to address a minor grammatical error.

(2) If the physician does not file a written objection with the claims administrator within ninety (90) days of the service of the explanation of review challenging the denial of the medical-legal expense issued under this subdivision, neither the employer nor the employee shall be liable for the amount of the expense that was denied.

The objection must be made timely.

Adding "that" corrects a minor typographical error.

(i) Physicians shall keep and maintain for ~~three~~ five years, and shall make available to the administrative director by date of examination upon request, copies of all billings for medical-legal expense.

It appears that the Administrative Director intended to revise section (i) and not (k) to make the time required for physicians to retain medical-legal bills consistent with the five year retention period required for QMEs in section 39.5. The Initial Statement of Reasons states:

"The five year requirement in new subdivision (k) is necessary to make the retention of the bill for medical legal-services identical to the medical-legal retention requirement for QME's which appears at section 39.5 of these regulations."

(j) A physician may not charge, nor be paid, any fees for services in violation of Section 139.3 or 139.32 of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;

Section 139.32 of the Labor Code needs to be added here to conform to this new provision of Senate Bill 863.

(k) Claims administrator shall retain, for ~~five~~ three years, the following information for each comprehensive medical evaluation for which the claims administrator is billed:

….

It appears that the Administrative Director intended to revise section (i) and not (k) to make the time required for physicians to retain medical-legal bills consistent with the five year retention period required for QMEs in section 39.5. The Initial Statement of Reasons states:

"The five year requirement in new subdivision (k) is necessary to make the retention of the bill for medical-legalservices identical to the medical-legal retention requirement for QME's which appears at section 39.5 of these regulations."

Accordingly, it is not necessary to change the existing retention period for claims administrators.

Thank you for considering these comments.

Sincerely,

Brenda Ramirez
CWCI Claims & Medical Director

BR/pm

cc: Destie Overpeck, DWC Acting Administrative Director
Jacqueline Schauer, Industrial Relations Counsel

George Parisotto, Industrial Relations Counsel
CWCI Claims Committee
CWCI Medical Care Committee
CWCI Legal Committee
CWCI Regular Members
CWCI Associate Members
California Chamber of Commerce
California Coalition on Workers' Compensation
American Insurance Association