California Workers' Compensation Institute
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October 23, 2013

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

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

RE: 1st 15-Day Comments on Modifications to Proposed Permanent Sections 9792.5.1 - 9792.5.15 and 9793 - 9795

Dear Ms. Gray:

These comments on modifications to the regulations proposed for permanent adoption to implement Senate Bill 863 provisions relating to Independent Bill Review (IBR) are presented on behalf of the members of the California Workers' Compensation Institute (the Institute). Institute members include insurers writing 71% of California's workers' compensation premium, and self-insured employers with $46B of annual payroll (27% 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, Chevron Corporation, City and County of San Francisco, City of Santa Ana, 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 Permanente, 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 thanks the hard-working staff members of the Division of Workers' Compensation for their work on these regulations. Their effort and the sheer volume of work accomplished is impressive. 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.

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 XXX (effective date on/after the date the permanent 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:

> *As written, version 1.1 of the Medical Billing and Payment Guide appears to apply retroactive to October 15, 2011 ("Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011"). To avoid confusion, the Institute recommends clarifying that version 1.1 of this Guide applies to bills received by the claims administrator on or after the effective date of the permanent regulations and suggests listing here the effective dates for each rendition of the Guide.*

(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 XXX (effective date on/after the date the permanent 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:

There appears to be an inadvertent typographical error in the version of the Companion Guide proposed for permanent adoption in this subdivision. The version number of the Companion Guide proposed for permanent adoption is 1.2, not version 1.1.

As written, the Companion Guide proposed for permanent adoption appears to apply retroactively to October 15, 2011 ("Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011"). The Institute recommends clarifying that version 1.2 of this Guide will apply to bills received by the claims administrator on or after the effective date of these permanent regulations and suggests listing here the effective dates for each rendition of the Guide.

§ 9792.5.4 . Second Review and Independent Bill Review – Definitions

This section is applicable to billings received on or after January 1, 2013 for medical treatment services and goods rendered under Labor Code section 4600, or medical-legal expenses incurred under Labor Code section 4620 ~~on or after January 1, 2013~~.

Section 84 of Senate Bill 863 mandates that the provisions of the Bill apply to all pending matters unless a specific date is indicated. Senate Bill 863 provisions include 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.). Since these new requirements are also prerequisites for subsequent steps in the bill review and bill dispute process, these new requirements apply to billings received on and after January 1, 2013. The Institute believes that applying the regulations only to goods and services rendered on and after that date is overly broad and conflicts with Section 84 of SB 863.

Fee schedules are applied by date of service, however bill review timeframes and rules are triggered according to date of bill receipt. If these regulations and their future revisions are applied by date of service, separate sets of rules must be followed, depending on the date of service, and bill review systems must program and maintain different sets of timeframes and rules, creating unnecessary complexity, confusion, dispute and expense. If, on the other hand, the rules for bill review apply according to date of bill receipt, multiple sets of timeframes and rules will not be necessary and billing providers and payers can operate more efficiently under a single set of rules on a going-forward basis.

We urge the Administrative Director to apply these regulations by date of bill receipt.

(a)(1) Medical treatment services or goods rendered by a provider in accordance with Labor Code section 4600 that were authorized by Labor Code section 4610, and for which there exists an applicable fee schedule adopted by Statute or the Administrative Director for those categor~~y~~ies of services, including but not limited to those found at sections 9789.10 to 9789.111, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.

The Institute suggests including here an applicable fee schedule adopted by Statute as well as one adopted by the Administrative Director. For example, Labor Code section 5307.1(a)(2)(C) adopts a schedule of maximum reasonable fees for physician services and nonphysician practitioner services commencing January 1, 2014, and continuing until the Administrative Director has adopted such a schedule. If the Administrative Director did not adopt an RBRVS-based physician fee schedule that will be effective on January 1, 2014, the statutory fee schedule would have become applicable on that date. The Medi-Cal schedule of fees for pharmacy services and drugs that was promulgated by Labor Code section 5307.1(a) in 2004 is another example.

In addition, we note a minor typographical error.

(b) "Billing Code" means those codes for goods and services provided pursuant to Labor Code section 4600 and 4620 that include but are not limited to those adopted by the Administrative Director for use in the Official Medical Fee Schedule, located at sections 9789.10 to 9789.111, or in the Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).

SB 863 added the following language in Labor Code section 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 provided and the charge for each service…"*

The recommended additional language will cover codes for other fee schedule sections promulgated by statute or that may be adopted by the Administrative Director such as the schedule of interpreter fees that is currently in section 9795.3, a vocational expert fee schedule, home health care fee schedule, or copy service fee schedule.

(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 provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 4620.

We note a typographical omission.

(i) "Provider" means a provider of medical treatment services or goods, including a health care facility as defined in Section One of the California Division of Workers' Compensation Medical Billing and Payment Guide as incorporated by reference in section 9792.5.1, 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. A provider may utilize the services of a billing agent, a person or entity that has contracted with

the provider to ~~process~~ submit bills, a second bill review, or independent bill review under this article on the provider's behalf for services or goods rendered by the provider~~, to request a second bill review or independent bill review~~.

While a billing agent may contract with a provider to submit bills, second bill review requests, and requests for independent bill review on the provider's behalf, the billing agent is not entitled to receive payment from the claims administrator for goods or services rendered by a provider. We suggest this modification so that it is clear that an agent may submit on behalf of a provider. Without this recommended modification, the language may result in confusion and litigation over whether the language entitles a bill review agent to payment from the claims administrator.

§ 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 was received on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses ~~incurred~~ that was 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.

See comments on section 9792.5.4 regarding the conflict with Section 84 of SB 863 and the additional administrative burdens and expenses caused by the proposed language.

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

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

(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The second review bill shall be marked 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 Dental Claim Form (2006), or ADA Dental Claim Form (2012), 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.

(B) 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 supports a single method for paper medical treatment bills: specifically, attaching the Second Bill Review form (DWC Form SBR-1) to the modified standard billing form. This will provide both the necessary billing information and will prominently identify requests for second bill review for rapid processing so that second review bills are not delayed. One of the underlying principles of SB 863 was to reduce system friction by streamlining processes and this standard process will promote uniformity and efficiency within the IBR system.

§ 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:

- *"Goods and services" is the standard term used in the industry and is consistent with the language in the regulations*
- *To conform with the recommendation for section 9792.5.5(c) to attach the form to the second review bill (see comment on section 9792.5.5(c))*
- *The version number of the Companion Guide proposed for permanent adoption is 1.2, not version 1.1*
- *The instruction for when to apply is 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 bill for medical treatment goods or services 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 medical-legal bill submitted pursuant to Labor Code section 4622~~,for medical-legal expenses incurred~~ and received on or after January 1, 2013~~, 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. See comments on section 9792.5.4 regarding the conflict with Section 84 of SB 863 and the additional administrative burdens and expenses caused by the proposed language.

The Institute believes that adding a process to consolidate requests is an unauthorized 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.

(a)(1) For a bill for medical treatment services and goods, a dispute over the amount of payment for goods and services billed by a single provider involving one injured employee, one claims administrator, and either one date of service or discharge, ~~and one billing code under~~ in accordance with the applicable fee schedule adopted by Statute or 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.

"Goods and services" is the standard term used in the industry and is recommended here and elsewhere in the regulations to maintain consistency.

At a minimum, every independent bill review must encompass all goods and services provided on the same date of service 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.

See comments on section 9792.5.4(c)(1) regarding the addition of "Statute."

"Discharge" is added for accuracy and completeness.

(a)(2) For a bill for medical-legal expenses, 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 medical-legal evaluation including supplemental reports based on that same evaluation, if any.

See previous comment regarding the addition of "goods."

(d)(1)(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 and instructions 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.

The Maximus electronic form on the DWC web site differs materially from both the current emergency form and the proposed and modified versions. The Institute recommends 1) replacing it with an electronic version of the adopted form and 2) adding directions to the DWC IBR web pages on how a provider submitting an electronic IBR

request shall comply with the statutory and regulatory requirements in Labor Code section 4603.6(b) and CCR section 9792.5.7(f) to concurrently serve a copy of the request upon the claims administrator together with a copy of the supporting documents.

§ 9792.5.8. Request for Independent Bill Review Form

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

The Maximus electronic form on the DWC web site differs materially from both the current emergency form and the proposed and modified versions. The Institute recommends:

1) *replacing it with an electronic version of the adopted form and*
2) *adding directions on how a provider submitting an electronic IBR request shall comply with the statutory and regulatory requirements in Labor Code section 4603.6(b) and CCR section 9792.5.7(f) to concurrently serve a copy of the request upon the claims administrator with a copy of the supporting documents.*

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:

- *Prompts for addresses, are merged and reordered for clarity and to remain consistent with the Request for Second Review form to the extent feasible*
- *"Goods and services" is the standard term used in the industry and is consistent with the language in the regulations*
- *The Consolidation section has been deleted because the Institute believes that consolidations are not supported in SB 863*
- *Instruction to concurrently send a copy of the form and supporting documents to the claims administrator is necessary here so that it is clear that the instruction applies to both a paper and electronic submission*
- *See comments on section 9792.5.4(c)(1) regarding the addition of "Statute."*
- *The required Folsom mailing address on the form differs from the Sacramento address on the web; the address that is incorrect must be corrected because the instructions on both the form and the web site warn that applications not sent to that address will not be considered filed*
- *The Consolidation and Disaggregation paragraphs have been deleted for the reasons described above and in comments on section 9792.5.12.*

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

(b) If the request appears eligible for review, the Administrative Director, or his or her designee, shall, within ~~1~~5 days of the determination, notify the provider and the claims administrator 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 timelines to complete other steps in the process are necessarily short since Labor Code section 4603.6(d) requires the request to be assigned to an independent bill reviewer, and provider and employer notified, within 30 days of receipt of the request and fee. Since the notice can be provided when the Administrative Director or his or her designee makes the determination, there is no need to delay notice to the provider and longer than five days.

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

This corrects a minor typographical error.

(b)(3) A statement that the claims administrator may dispute both eligibility of the request for independent bill review under subdivision (a) and the provider's reason for requesting independent bill review 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.

Labor Code section 4603.6(d) requires the request to be assigned to an independent bill reviewer, and the provider and employer to be notified, within 30 days of receipt of the request and fee. To ensure this timeframe is met, it is necessary to count the fifteen days from the date the Administrative Director designated on the notification that the Request and fee was received.

(f)(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.

A minor typographical error is noted for correction.

§ 9792.5.11. Withdrawal of Independent Bill Review.

The provider may withdraw ~~their~~ a request for independent bill review at any time prior to the issuance of a final determination on the amount owed under section 9792.5.14 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.

This corrects a minor typographical error.

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.

(a) If the request is withdrawn prior to its assignment to an IBRO for an independent bill review under section 9792.5.9(f), the provider shall be reimbursed the ~~amount of $270.00~~$335.00 ~~from the~~ fee provided with the request under section 9792.5.7(d).

The Institute believes the fee should be returned if the request is withdrawn prior to its assignment to an IBRO. We question whether there is authority for retaining any portion of the fee if the request has not been assigned to the IBRO. Reviewing a request for eligibility is the responsibility of the Administrative Director, although she may choose to designate another entity to perform the review. No fee is retained for the review when the request is determined ineligible and we see no basis for retaining one when the request is determined eligible.

A $65.00 fee for withdrawal may also discourage a provider from withdrawing a request, even if the fee has been paid in full or settled, and therefore result in unnecessary independent medical reviews.

(b) If the request is withdrawn subsequent to its assignment to an IBRO for an independent bill review under section 9792.5.9(f), but prior to the issuance of a final determination on the amount owed under section 9792.5.14, the provider shall ~~not~~ be reimbursed the amount of $270.00 from the fee provided with the request under section 9792.5.7(d).

The Institute believes it is reasonable to return a portion of the fee if the request is withdrawn after assignment to an IBRO but prior to a final determination by the IBRO. It is not reasonable to pay an IBRO a full fee when it has not made a determination since it has not completed the contracted task.

~~§ 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) After consultation with the Administrative Director, the IBRO may allow the consolidation of requests for 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 Institute continues to believe that adding a process to consolidate requests is an unauthorized 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.

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

(b) Pursuant to Labor Code section 4603.6(f), the provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by filing a verified petition with the Workers' Compensation Appeals Board and serving a copy on interested parties within 20 days of serving the determination.

Since the specifics of Labor Code section 4610.6(f) have been deleted, it will be appropriate and helpful to include in this subdivision a citation to that section as well as the specific timeframe within which a verified petition must be filed.

Medical Billing and Payment Guide Version 1.1

3.0 Complete Bills

(c) For paper bills, if the required reports and supporting documentation are not submitted in the same mailing envelope as the bill, then a header or attachment cover sheet ~~as defined in Section One – 7.3 for electronic attachments~~ must be submitted that shall contain:~~.~~

(1) Unique Attachment Indicator Number

(2) Patient's name

(3) Claim Number (if assigned)

(4) Date of Service

(5) Date of Injury

(6) Social Security Number (if available)

(7) Date of Birth

The Institute recommends specifying here what a header or cover sheet must include for the convenience of the user and because Section 7.3 has been modified, and the information needed to match documentation with paper bills may differ from what is needed for electronic bills. A claim number is necessary here, or 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.

7.3 Electronic Bill Attachments

(b) 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.

Appendix B. Standard Explanation of Review

Paper Explanation of Review

The 3.0 Table for Paper Explanation of Review specifies use of the DWC Bill Adjustment Reason Codes and DWC Explanatory Messages as situational data elements (Data Items 39~~.1~~ and 51~~.1~~.) 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 utilize additional narrative explanatory language to supplement the DWC Bill Adjustment Reason Codes where necessary to fully explain why the bill is adjusted, denied, or considered incomplete.

We recommend either modifying as indicated or clarifying what is meant by 39.1 and 51.1.

1.0 California DWC Bill Adjustment Reason Code/CARC/RARC/ Matrix Crosswalk

The Institute recommends adding a description of the Issue, DWC Explanatory Message, and Payer Instruction for DWC Bill Adjustment Reason Code G53, as these are missing from the table.

Electronic Medical Billing and Payment Companion Guide Version 1.2

On behalf of its members, the Institute thanks the Division for replacing the term "clean bill" with "complete bill." This will prevent confusion, dispute and litigation over the term.

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