California Workers' Compensation Institute
1111 Broadway Suite 2350, Oakland, CA 94607 • Tel: (510) 251-9470 • Fax: (510) 251-9485

December 26, 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: 2nd 15-Day Comments on Modifications to Proposed Permanent Sections 9792.5.1 - 9792.5.15 and 9793 - 9795

Dear Ms. Gray:

These comments on additional 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 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

§ 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 reconsider and 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 categories of goods and 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. The Medi-Cal schedule of fees for pharmacy services and drugs that was promulgated by Labor Code section 5307.1(a) in 2004 is one such example.

§ 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 or goods ~~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. The DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider.

Since the Administrative Director has modified this section to require the DWC Form SBR-1 to be the first page of the request for second review, it appears that both (A) and (B) are required for a second review, it appears that the highlighted language was inadvertently retained and therefore can be deleted.

§ 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 with recommended changes identified by underscore and strikeout. The reasons for the recommended changes are summarized as follows:

- *"Code for" was inadvertently omitted (the instructions require the code, and a modifier can be included only in the service code)*
- *It would be helpful to clarify that supporting documentation should include the explanation of review (EOR)*

§ 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 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, ~~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 or goods, a dispute over the amount of payment for services or goods billed by a single provider involving one injured employee, one claims administrator, and either one date of service, ~~and one billing code~~or one hospital stay, under 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.

> *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."*

(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://www.dir.ca.gov/dwc/IBR.htm . 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*

3) *Correcting the mailing address: 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.*

See the attached Request for Independent Bill Review form with recommended changes identified by underscore and strikeout. The reasons for the recommended changes are summarized as follows:

- *The Consolidation section and references has been deleted because the Institute believes that consolidations are not supported in SB 863 and see comments on section 9792.5.12*
- *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."*

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

(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.

§ 9792.5.11. Withdrawal of Independent Bill Review.

The provider may, concurrent with written notice to the claims administrator, withdraw 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 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 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.

§ 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, with a maximum of twenty (20) for independent bill review 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.

Thank you for considering these comments.

Sincerely,

Brenda Ramirez
CWCI Claims & Medical Director

BR/pm
Attachments

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