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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: 1st Forum Comments on Draft Independent Bill Review Regulations Sections 9792.5.4 – 9792.5.15

Dear Ms. Gray:

These written comments on draft regulations to implement Senate Bill 863 provisions regarding Independent Bill Review (IBR) and utilization review 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, Meadowbrook Insurance Group, Pacific Compensation Insurance Company, Preferred Employers Insurance Company, SeaBright 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 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 wishes to acknowledge the remarkable effort expended by the staff of the Division of Workers' Compensation in drafting regulations to implement Senate Bill 863 in such a short period of time. The Institute generally 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 following recommendations and comments.

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.

The Institute wishes to emphasize the following areas:

RECOMMENDED CHANGES are indicated by and highlighted underscore and ~~strikeout~~.

CWCI COMMENTS are indicated by italicized and highlighted *text*.

> **Comment**: Preamble – Effective Date
> Sections 9792.5.4 . through 9792.5.15. apply to all medical treatment and medical-legal bills received on and after January 1, 2013, and to all medical treatment and medical-legal payment matters pending on January 1, 2013, but shall not be a basis to rescind, alter, amend, or reopen any final awards of medical treatment or medical-legal payments.

§ 9792.5.4 . Second Review and Independent Bill Review – Definitions

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

(1) Medical treatment services rendered by a provider in accordance with Labor Code section 4600 that was authorized by Labor Code section 4610, and for which there exists an applicable fee schedule located at sections 9789.10 to 9792.5.3, or 9795.3, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.

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

(b) "Billing Code" means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule, located at sections 9789.10 to 989.111, or in the Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).

(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.

> ***Comment:*** *Include in this definition other administrators of injured employee's claims, such as CIGA, SISF, 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 a good-faith issue that would defeat a provider's right to receive compensation for any of the medical treatment services provided in accordance with Labor Code section 4600 or ~~for~~ medical-legal expenses defined in Labor Code section 9720.

(e) "Consolidation" means 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.

(f) "Explanation of review" means the document described in Labor Code section 4603.3, or its electronic equivalent, provided by a claims administrator to a provider upon the payment, adjustment, or denial of a complete or incomplete itemization of medical services.

(g) "Independent bill review organization" or "IBRO" means the organization or the organizations designated by the Administrative Director pursuant to Labor Code section 139.5 to perform independent bill review under Labor Code section 4603.6.

(h) "Independent bill reviewer" means an individual retained by the IBRO and subject to the provisions of Labor Code section 139.5 to review a request for independent bill review, with supporting documentation, and issue a determination under the Article.

(i) "Provider" means a provider of medical treatment services whose billing processes are governed by Labor Code section 4603.2, or a provider of medical-legal services whose billing processes are governed by Labor Code sections 4620 and 4622~~, that has requested 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~~.

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.

§ 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 submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.

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

(1) The date of 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~~.~~,

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

(3) 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 that is five (5) calendar days after the date of the United States postmark stamped on the envelope in which the explanation of review was mailed., or

(4) The date of 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.

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

(1) For a medical treatment bill, the second review request shall be on either:

(A) The initially reviewed paper or electronically submitted bill, as modified by this subdivision. The 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

> ***Comment**: This is the currently required method of submitting a request for reconsideration of a medical treatment bill. There is no necessity to change it. This is the national standard for providers and their agents to request a second review of a medical bill and is mandatory under HIPAA. It is also included in the recently adopted medical billing and payment standards as the mandatory method in the California workers' compensation system, absent a mutual, written agreement to handle requests for reconsideration/second review otherwise.*
>
> *The Institute recommends maintaining this standard.*

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

***Comment**: If the Division decides to also adopt this alternate methodology for requesting a second review, the form can be used by mutual, written agreement that can be memorialized in the trading partner agreement.*

(2) For medical-legal bills, the second review shall be requested on the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6.

(d) The request for second review shall include:

(1) The original dates of service and the same itemized services rendered as the original bill. No new services or dates of service may be included.

(2) In addition to bill as modified in this subdivision, the second review request shall include, as applicable, the following:

(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.

(B) The item and amount in dispute.

(C) The additional payment requested and the reason therefor.

(D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

(e) If the only dispute is the amount of payment and the provider does not request a second review within the timeframes set forth in subdivision (b), the bill shall be deemed satisfied and neither the claims administrator nor the employee shall be liable for any further payment.

(f) Within 14 days 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. 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.

(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 45-day period described in Labor Code section 4603.2(b)(2) 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.~~

Comment: *This subdivision differs from the provisions in Labor Code sections 4603.2 and 4603.4. It omits, for example, the exceptions. Sections 9792.5.0, 9792.5.1 (including detail in the Guides that is relevant to payment) and 9792.5.2 cover those Labor Code provisions more accurately and completely. Either this subdivision is unnecessary and should be deleted or clarification is required.*

(g) Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review.

(h) If the provider contests the amount paid after receipt of the final written determination following a second review, the provider shall request an independent bill review pursuant to this Article.

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

§ 9792.5.6. Request for Second Review of Bill – Form

Request for Second Bill Review. DWC Form SBR-1.

§ 9792.5.7. Requesting Independent Bill Review.

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622, following the second review conducted under section 9792.5.5, the provider may request an independent bill review. Unless consolidated under section 9792.5.12, a request for independent bill review shall resolve:

(1) For a bill for medical treatment services, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, and one date of service~~, and one billing code~~ under the applicable fee schedule(s) 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.

Comment: *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.*

(2) For a bill for medical-legal expenses, a dispute over the amount of payment 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 and associated costs and expenses.

Comment: *The same rationale noted in subdivision (1), above, applies here as well.*

(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 reasonable fee for services where that category of services is not covered by a fee schedule adopted by the Administrative Director or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11.

Comment: *This restriction is unfortunate. 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.

(2) The proper selection of an analogous code or formula where no fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, exists for that category of services unless the fee schedule or contract allows for such analogous coding.

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

(1) The date of 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.

(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) If the final written determination is sent by mail and if in the absence of a proof of service or documentation of receipt, 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.

(4) The date of resolution in favor of the provider of any issue of contested liability.

(5) The date of service of an order of the Workers' Compensation Appeal Board resolving in favor of the provider any threshold issue that would preclude a provider's right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 9720.

> ***Comment**: Either subdivision (4) **or** subdivision (5) is required, as they address the same issue. One subdivision should be deleted.*

(d)(1) The request for independent bill review shall be either by:

(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 http://www.dir.ca.gov/caibr/htm. Electronic payment of the required fee of $325.00 [subject to change] shall be made at the time the request is submitted. Electronic copies of the documents listed in section 9792.5.9(f)(4)(A) may be submitted by the provider with the electronic request form.

> ***Comment:** This fee is more than a hundred times greater than the fee typically paid for the initial bill review.*

(B) Mailing the Request for Independent Bill Review form, DWC Form IBR-1, located in section 9792.5.8, and simultaneously paying the required fee of $325.00 [subject to change]. Copies of the documents listed in 9792.5.9(f)(4)(A) may be submitted by the provider with the request form.

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

> ***Comment:** The regulation needs to state to whom the fee must be paid and the procedure for payment.*

(A) The original billing ~~itemization~~;

(B) Any supporting documents that were furnished with the original billing;

(C) If applicable, the contract for reimbursement rates under Labor Code section 5307.11.

(D) The explanation of review that accompanied the claims administrator's response to the original billing;

(E) The provider's request for second review of the claims administrator's original response to the billing;

(F) Any supporting documentation submitted to the claims administrator with that request for second review;

(G) The final written determination of the second review issued by the claims administrator to the provider.

(e) The provider may request that two or more disputes that would constitute a separate request for independent bill review be consolidated for a single determination under section 9792.5.12.

> ***Comment:*** *At a minimum, the review should encompass all the goods and services with the same date of service, so that the provider cannot manipulate the process in order to obtain payment for unbundled services, and to evade fee schedule and other rules leaving the claims administrator without recourse. Also, the appropriate payment for a particular service on a bill often depends on the payment made for other services. If only one service code is reviewed, rules that are interdependent with others won't be applied and the review will be defective. If a provider's goal is to sidestep the rules to maximize profits, the provider is unlikely to request this type of consolidation*

(f) The provider shall concurrently serve a copy of the request of independent bill review upon the claim administrator with a copy of the supporting documents submitted under subdivision (d). Any document that was previously provided to the claims administrator or originated from the claims administrator need not be served if a written description of the document and its date is served.

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.

§ 9792.5.8. Request for Independent Bill Review Form

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

§ 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) If a second request for review of the bill was completed;

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

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

(5) Any previous, overlapping or duplicate requests for independent bill review of the same bill for medical treatment services or bill for medical-legal expenses.

(6) If the dispute between the provider and the claims administrator is ineligible under section 9792.5.7(b) or contains any other issue than the amount of payment of the bill.

(7) Other reasons, if any, that the application may be ineligible for independent bill review.

(b) If the request appears eligible for review, the Administrative Director, or his or her designee, shall 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:

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

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

(3) A statement that within fifteen (15) calendar days of the date the request was received by the Administrative Director ~~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 Administrative Director, or his or her designee, must receive from the claims administrator any document indicating that the provider's request is incomplete, inaccurate, or ineligible for independent bill review under subdivision (a).

(~~c~~4) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(4) must be 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.

Comment: *Is there a procedure by which the claims administrator can verify that it was served the all of the information provided to the Administrative Director?*

(c) Upon receipt of the documents requested in subdivision (b)(4), or, if no documents or not all documents have been received, upon the expiration of fifteen (15) days of the date the Administrative Director received the request ~~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).

(d) If the review conducted under either subdivision (a) or subdivision (c) finds that the request is ineligible for independent bill review, the Administrative Director shall, within fifteen (15) days following receipt of the documents requested in subdivision (b)(4) or, if no documents or not all documents are received, the expiration of the time period indicated above, issue a written determination informing the provider and claims administrator that the request is not eligible for independent bill review and the reasons therefor.

(1) If a request is deemed ineligible under this section, the provider shall be partially reimbursed the fee provided with the request.

Comment: *What are the procedures for reimbursement?*

(2) The provider or the claims administrator may appeal an eligibility determination by the Administrative Director by filing a petition with the Workers' Compensation Appeals Board and serving a copy on all interested parties, including the Administrative Director, within 30 days of receipt of the determination.

(e) If the Administrative Director determines from the review conducted under subdivision (c) that the request is eligible for independent medical review, the Administrative Director shall assign the request to an IBRO for an independent bill review within 30 days from the date the request was received by the Administrative Director. Upon assignment of the request, the IBRO shall immediately notify the parties in writing that the request has been assigned to that organization for review. The notification shall contain:

(1) The name and address of the IBRO;

Comment: *Advise how this information can be found.*

(2) A independent bill review case or identification number;

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

(f) After the assignment to the IBRO, it shall immediately assign an independent bill reviewer who does not have any material professional, familial, or financial affiliation with any of the individuals, institutions, facilities, services or products as described in Labor Code section 139.5 (c) (2) to review and resolve the dispute.

(g) If in course of conducting an independent bill review it is determined that the bill reviewer assigned to the dispute has a prohibited interest as described in in Labor Code Section 139.5 (c) (2), the IBRO shall immediately reassign the matter to a different independent bill reviewer.

(h) Upon reassignment under subdivision (h), the IBRO shall immediately notify the Administrative Director, the provider, and claims administrator of the reassignment of the dispute to a different independent bill reviewer.

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.

§ 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 the documents with the independent bill reviewer at the address listed in the correspondence in Section 9792.5.9(e) within ~~35~~ 30 days of the request~~, 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.

***Comment**: Advise how this information can be found.*

(C) Except for the documents submitted under this section, and those requested under section 9792.5.12, neither the provider nor the claims administrator shall file any additional documents with the independent bill reviewer.

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.

§ 9792.5.11. Withdrawal of Independent Bill Review

(a) Either before or f~~F~~ollowing 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. If the claims administrator pays the disputed amount and the filing fee 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.

(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).

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.

§ 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 or a claims administrator may recommend 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.

(c) Two or more requests for independent bill review by a single provider may be aggregated 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 or set of billing codes 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 upcoding or downcoding; underpayment or overpayment by a provider or claims administrator for specific billing codes. Requests to be consolidated under the subdivision shall involve multiple injured employees, ~~one~~ multiple claim administrators, ~~one~~ multiple billing codes, ~~one~~ and 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 $325.00 [subject to change], specify all of the requests for independent bill review sought to be aggregated with a description of how the requests involve common issues of law and fact or delivery of similar or related services. The claims administrator may also recommend such consolidation.

(e) The decision to grant or deny consolidation shall be immediately communicated in writing by the IBRO to the provider and the claims administrator. ~~Once consolidation has been granted no other disputes shall be added to the consolidated disputes.~~

(f) 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 provided that services provided on the same date of service shall not be disaggregated. 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 separation, 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.

(g) 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.

§ 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 as defined in Labor Code section 4600, the independent bill reviewer shall apply the provisions of sections 9789.10 to 9792.5.3, and other applicable rules to determine the additional amounts, if any, that are to be paid to or by the provider.

> ***Comment:*** *One example of an "other applicable rule" is the 24 visit cap.*

(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 other applicable rules to determine the additional amounts, if any, that are to be paid to the provider.

(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 other applicable rules to determine the additional amounts, if any, that are to be paid to the provider.

(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, as if the bill is being reviewed for the first time.

> ***Comment:*** *While the independent medical reviewer should make their own determination, the reviewer must also consider all the explanations in the initial EOR and the final determination of the second review because the standard explanations may indicate some additional rules and factors to consider that will not otherwise be evident.*

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.

§ 9792.5.14. Independent Bill Review - Determination

(a) Within sixty (60) days of the assignment of a dispute to an independent bill reviewer under section 9792.5.9(f), the reviewer shall issue a written determination, in plain language, if any additional amount of money is owed to or by the provider under the request for independent bill review. The determination shall state the reasons for the determination and the information received and relied upon by the independent bill reviewer in rendering the determination.

(b) If the independent bill reviewer finds any additional amount of money is owed to or by the provider, the determination shall also order as applicable the provider to refund the overage; and the claims administrator to reimburse the provider the amount of the filing fee in addition to any additional payments for services found owing.

(c) The independent bill reviewer shall serve the determination on the provider, the claims administrator and the Administrative Director.

(d) The determination issued by the independent bill reviewer shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.

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.

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

(a) Upon receiving the determination of the Administrative Director that an additional amount of money is owed to the provider on a bill for medical treatment services submitted pursuant to Labor Code section 4603.2, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622, the claims administrator shall, unless appealed under subdivision (b), pay the additional amounts set forth in the determination per the timely payment requirements set forth in Labor Code sections 4603.2 and 4603.4.

(b) 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 all interested parties, including the Administrative Director, within 20 days of mailing of the determination.

(c) The determination of the Administrative Director shall be presumed to be correct and shall be set aside by the Workers' Compensation Appeals Board only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The Administrative Director acted without or in excess of his or her powers.

(2) The determination of the Administrative Director was procured by fraud.

(3) The independent bill reviewer was subject to a material conflict of interest that is in violation of Labor Code section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review and not a matter that is subject to expert opinion.

(e) If the final determination of the Administrative Director is reversed on the basis of the criteria set forth in subdivision (c), the dispute shall be remanded to the Administrative Director. The Administrative Director shall:

(1) Submit the dispute to independent medical review by a different IBRO, if available;

(2) If a different IBRO is not available after remand, the Administrative Director shall submit the dispute to the original IBRO for review by a different reviewer in the organization.

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.

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