

**STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION**

FINAL STATEMENT OF REASONS

**Subject Matter of Regulations: Independent Bill Review; Standardized Paper
Billing and Payment; Electronic Billing and Payment**

California Code of Regulations, title 8, Article 5.5.0
Sections 9792.5.1, 9792.5.4, 9792.5.5, 9792.5.6, 9792.5.7, 9792.5.8, 9792.5.9,
9792.5.10, 9792.5.11, 9792.5.12, 9792.5.13, 9792.5.14, and 9792.5.15.

California Code of Regulations, title 8, Article 5.6
Sections 9793, 9794, and 9795

The Acting Administrative Director of the Division of Workers' Compensation (hereinafter "Acting Administrative Director"), pursuant to the authority vested in her by Labor Code sections 111, 133, 138.2(b), 4903.05, 4903.06 and 5307.3, has amended or adopted the following regulations:

Amend section 9792.5.1.	Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides
Amend section 9792.5.3.	Medical Treatment Bill Payment Rules
Adopt section 9792.5.4.	Second Review and Independent Bill Review – Definitions
Adopt section 9792.5.5.	Second Review of Medical Treatment Bill or Medical-Legal Bill
Adopt section 9792.5.6.	Provider's Request for Second Bill Review – Form
Adopt section 9792.5.7.	Requesting Independent Bill Review
Adopt section 9792.5.8.	Request for Independent Bill Review Form
Adopt section 9792.5.9.	Initial Review and Assignment of Request for Independent Bill Review to IBRO
Adopt section 9792.5.10.	Independent Bill Review - Document Filing
Adopt section 9792.5.11.	Withdrawal of Independent Bill Review
Adopt section 9792.5.12.	Independent Bill Review - Consolidation or Separation of Requests
Adopt section 9792.5.13.	Independent Bill Review – Review
Adopt section 9792.5.14.	Independent Bill Review – Determination
Adopt section 9792.5.15.	Independent Bill Review – Implementation of Determination and Appeal
Amend section 9793.	Definitions
Amend section 9794.	Reimbursement of Medical-Legal Expenses
Amend section 9795.	Reasonable Level of Fees for Medical-Legal Expenses, Follow-up Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony

REQUEST AND GOOD CAUSE FOR EFFECTIVE DATE UPON FILING WITH THE SECRETARY OF STATE

This rulemaking revises the emergency regulations. Changes have been made to the regulatory text since the emergency regulations became effective on January 1, 2013. It is important and necessary that these regulations are effective upon filing with the Secretary of State so that there is clarity and consistency for the public.

UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

As authorized by Government Code §11346.9(d), the Acting Administrative Director hereby incorporates by reference the entire Initial Statement of Reasons prepared in this matter. Unless a specific basis is stated below for any modification to the regulations as initially proposed, the necessity for the amendments to existing regulations and for the adoption of new regulations as set forth in the Initial Statement of Reasons continues to apply to the regulations as now adopted. All modifications from the initially proposed text of the regulations are summarized below.

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

Subdivision (a) was modified to add subdivisions (a)(1), (a)(2) and (a)(3) listing the titles and effective dates of the three versions of the Medical Billing and Payment Guide, which are documents incorporated by reference.

Subdivision (b) was modified to add subdivisions (b)(1), (b)(2) and (b)(3) listing the titles and effective dates of the three versions of the Electronic Medical Billing and Payment Companion Guide, which are documents incorporated by reference.

Reason for Change

Modification to subdivisions (a) and (b) was necessary to clarify that each version of the guide will be incorporated by reference, and to clarify the effective dates of the versions. Subdivisions (a)(1) and (b)(1) are the original codified versions of the guides; Subdivisions (a)(2) and (b)(2) are the versions of the guides adopted as “emergency regulations” and effective January 1, 2013; Subdivisions (a)(3) and (b)(3) are the versions of the guides as modified in the certificate of compliance action, effective date of the regulation to be inserted by OAL. These changes are necessary to add clarity and to avoid unintended retroactivity.

Medical Billing and Payment Guide (incorporated by reference): Purpose and Necessity for Changes

Amendment was made to the cover to specify version 1.2 which is necessary to distinguish the Guide from the version 1.1 which is the “emergency regulation” version.

The Table of Contents was updated so the Section One – Business Rules, 6.0 reads: “Bill Processing and Payment Requirements for Non-Electronically Submitted Medical

Treatment Bills”. This amendment was necessary to conform to change in the heading in the body of the guide.

Amendments were made throughout the document to improve reference to the electronic ASC X12 transaction standards by conforming to standard nomenclature by adding the applicable addenda version (either “A1” or “A2”) as follows:

ASC X12N/005010X222 Health Care Claim: Professional (837)	ASC X12N/005010X222A1
ASC X12N/005010X223 Health Care Claim: Institutional (837)	ASC X12N/005010X223A2
ASC X12N/005010X224 Health Care Claim: Dental (837)	ASC X12N/005010X224A2
ASC X12N/005010X231 Implementation Acknowledgment (999)	ASC X12N/005010X231A1
ASC X12N/005010X221 Health Care Claim Payment/Advice (835)	ASC X12N/005010X221A1

The amendments were necessary to conform to the version reference protocol for these HIPAA-compliant national transaction standards that are copyrighted by the Accredited Standards Committee.

The Introduction was modified to add a table of version references and effective dates, and to provide the website address to download the guides. The amendments were necessary to provide easily accessible version and access information at the beginning of the Guide.

Section One – Business Rules, 1.0 Standardized Billing/Electronic Billing Definitions:

1.0(z)(2): Amend to modify the definition of the “CDT Codes”. The amendments were necessary to conform to the nomenclature used by the American Dental Association to identify its copyrighted dental codes.

1.0(z)(7): Amend to add definitions of ICD-10-CM and ICD-10-PCS. Amend to re-number remaining definitions. It is necessary to add definitions of the ICD-10 diagnosis and procedure codes, as these new code sets are being added to the list of requirements for a “complete bill” in Business Rules, section 3.0 Complete Bill.

Section One – Business Rules, 2.0 Standardized Medical Treatment Billing Format:

2.0(a)(1): Amend to add the “(08/05)” version number to the CMS 1500 form definition.

2.0(a)(1): Amend to add a definition for the new CMS 1500 form: “Form CMS-1500 (02/12)”

2.0(a)(3): Amend to clarify the title of the dental claim form and to add a definition for the new dental claim form: “American Dental Association Dental Claim Form, Version 2012”. It was necessary to adopt the new CMS 1500 form in order to align with the broader health care industry which will use the 1500 version 02/12 exclusively beginning April 1, 2014. Use of the CMS 1500 form version 02/12 will be necessary in order to report the ICD-10 code beginning in October 2014, since the CMS 1500 form version 08/05 was structured to use the ICD-9. Amendment was also necessary to adopt the updated American Dental Claim Form version 2012 in order to align with the national usage of the updated form.

Section One – Business Rules, 3.0 Complete Bills:

3.0(a)(2): Amend to specify that a complete bill includes use of the correct ICD code as specified in Section 3.1.0 – 3.2.1.

3.0(b)(12): Amend regarding supporting documentation for a claim to provide rules specific to pharmacy claims in order to comply with statutory changes made by Senate Bill 146 (Statutes of 2013, Chapter 129.)

3.0(c): Amend to specify that for paper bills, required supporting documentation that are not submitted in the same mailing envelope shall contain a header or attached cover sheet that shall contain the patient name, claims administrator name, date of service, date of injury, social security number (if available), claim number (if known), and unique attachment indicator number.

3.1.0, 3.1.1, and 3.2.1: Adopt new sections to incorporate by reference the International Classification of Diseases 10th Revision Clinical Modification (ICD-10-CM) and related documents, to incorporate by reference the International Classification of Diseases 10th Revision Procedure Coding System (ICD-10-PCS) and related documents, to specify the effective dates for usage of the ICD-10, and to inform the public of where to obtain the documents.

The amendment to 3.0 complete bills subdivision (b)(12) was necessary to carry out the provision of Senate Bill 146 (Statutes of 2013, Chapter 129). In order to implement the statute it was necessary to add language to (b)(12) to provide an exception to the requirement to submit a prescription if the treatment or services were performed by other than the primary treating physician. The exceptions are: if there is a written agreement to provide the prescription; an employer et al may request a copy of the prescription during a review of records. A pharmacy bill may be resubmitted by 3/31/2014 if denied after 1/1/2013 due to lack of submitting a prescription.

The amendment to 3.0 (c) was necessary in order to approve the clarity of the section. Previously, the section required the header or attachment cover sheet to be in conformity with the header or attachment for documents sent in conjunction with an electronic bill as set forth in Section 7.3 for electronic bill attachments. It was necessary to put the substance of the requirements in the 3.0 to eliminate the need for the public to look to the cross referenced section for the requirements.

The amendments to 3.0(a)(2), 3.1.0, 3.1.1, and 3.2.1 was necessary in order to adopt the ICD-10 diagnosis and procedure codes in conformity with the timeframe mandated by the Secretary of the Dept. of Health and Human Services for use in Health Insurance Portability and Accountability Act (HIPAA) - covered transactions. Although workers' compensation is exempt from HIPAA, the many advantages of using the ICD-10 codes instead of the ICD-9 codes have led to the decision to adopt the ICD-10 effective for services/inpatient discharges on or after October 1, 2014. The ICD-10 incorporates much greater clinical detail, reduces the need for additional narrative descriptions of illnesses/injuries, streamlines communication, provides increased detail that can be used in conducting research and developing policy, and allows greater ability to prevent and detect fraud and abuse. In addition to these advantages, the workers' compensation system will benefit by aligning with the general health care industry. In order to effectively adopt the ICD-10 it was necessary to adopt the related tables and mappings between the ICD-9 and ICD-10, and to specify the CMS website address to access the documents.

Section One – Business Rules, 6.5 Timeframes: Treatment Bills that are Submitted as a Request for Second Review:

This section was amended to specify that the time frames for responding to a request for second review and for making a payment may be extended by mutual written

agreement. The section also added a cross reference to the California Code of Regulations for further rules relating to second review of medical bills.

It was necessary to amend the provision relating to timeframes for responding to a request for second review and for payment in order to be consistent with title 8 CCR section 9792.5.5 subdivisions (g) and (h) which were amended to allow extension of the timeframes upon mutual written agreement. It was determined that the bill review and payment system would result in fewer disputes if willing parties were allowed to agree to extend the timelines.

Section One – Business Rules, 7.3 Electronic Bill Attachments:

7.3(a): The subdivision was amended to add cross-reference to the Electronic Medical Billing and Payment Companion Guide section 2.4.7 for documentation/attachment identification rules, and to delete substantive provisions detailing the attachment identification.

7.3(b): The subdivision, which had required identifiers on the attachment or on a cover sheet, was deleted.

7.3(c): The subdivision was amended to meld the provisions of (c) into (b).

7.3(d): The subdivision was amended to re-number as “(c)”.

7.3(e): The subdivision was amended to re-number as “(d)”. The subdivision was amended to delete a list of attachment types and to add language providing that attachment types are specified in 005010X222A1, 005010X223A2, and 005010X224A2 and in the Appendix B of the California Electronic Medical Billing and Payment Guide: Jurisdictional Report Type Codes.

The amendments to section 7.3 Electronic Bill Attachments were necessary in order to avoid duplication with provisions of the Electronic Medical Billing and Payment Companion Guide which also govern documentation/attachment rules for electronic billing. In order to streamline the rules and to reduce the possibility of conflicting provisions, it was necessary to eliminate the substantive requirements from 7.3 and utilize the section to cross-reference to the relevant provisions in the Companion Guide.

Section One – Business Rules, 7.4 Timeframes: Treatment Bills that are Submitted as a Request for Second Review:

The section was amended to specify that the time frames for responding to a request for second review and for making a payment may be extended by mutual written agreement. The section was also amended to add a cross reference to the California Code of Regulations for further rules relating to second review of medical bills.

It was necessary to amend the provision relating to timeframes for responding to a request for second review and for payment in order to be consistent with title 8 CCR section 9792.5.5 subdivisions (g) and (h) which were amended to allow extension of the timeframes upon mutual written agreement. It was determined that the bill review and payment system would result in fewer disputes if willing parties were allowed to agree to extend the timelines.

Section One – Business Rules, 8.0 Request for Second Review of a Paper or Electronic Bill:

The section was amended to add language allowing the 90-day time limit for requesting a second review to be extended by mutual written agreement between the provider and claims administrator.

The amendment was necessary to conform to the amendment made to title 8 CCR section 9792.5.5(b)(3) which allows the 90 day time limit for requesting a second review to be extended by mutual written agreement. It was determined that the billing and payment system would be more efficient if willing parties were allowed to agree to extend the timeframe to request a second review.

Appendices for Section One: Appendix A. Standard Paper Forms

1.0 CMS 1500: The section was amended to incorporate by reference new CMS 1500 Claim Form (version 02/12) and to adopt the new 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 02/12, Version 1.1 06/13. The section was amended to add the “1500 Instructions Change Log – as of 11/2003: 1500 Health Insurance Claim Form, Reference Instruction Manual Version 1.1 6/13 for the 02/12 1500 Claim Form Change Log” as part of the Instruction Manual for 02/12 Manual.

The section was amended to specify the dates for usage of the new form and instruction manual. Language was deleted in order to reorganize section to provide the form and manual versions in a table format for greater clarity. The section was amended to update information about where to obtain the CMS 1500 form and manual.

1.1 Field Table CMS 1500: The title of the table was amended to specify the version (08/05) and the effective date.

1.1 Field Table CMS 1500 Field 19: The California workers’ compensation instruction column was amended to add language stating that Field 19 may be left blank if supporting documentation is sent in the same envelope/package with the bill.

It was necessary to add to the title of the 1.1 Field Table CMS 1500 08/05 in order to differentiate it from the new 1500 form. Field 19 instruction was amended to clarify that the field may be left blank if the supporting documentation is sent in the same envelope/package as the bill.

1.2: The Appendix was amended to adopt a new Field Table CMS 1500 (02/12) to specify data requirements (required, situational, optional, not applicable) for the data fields of the new CMS 1500 form, and to provide California workers’ compensation-specific instructions where needed. The table also specifies dates of usage.

It was necessary to update the Guide to adopt the CMS 1500 Form version 02/12 in order to align with the broader health care industry that will be using the new version 02/12 exclusively beginning April 1, 2014. An important feature of the new CMS 1500 form is a format change to accommodate the ICD-10. It was necessary to adopt a new

1.2 Field Table CMS 1500 02/12 in order to provide the requirements and workers’ compensation instructions for the new form since there are new fields and revised field usage. It was necessary to provide a dual usage period beginning with the effective date of the regulations (to be inserted by OAL) through April 1, 2014 to align with the implementation period in general health care and Medicare.

2.0 UB-04: The section was amended to incorporate by reference new National Uniform Billing Committee Official UB-04 Data Specifications Manual 2014, Version 8.0, July 2013. The section was amended to specify the dates for usage of the new specifications manual as the date of the regulations, to be inserted by OAL. Language was deleted in order to reorganize the section to provide the form and manual versions in a table format for greater clarity.

The amendment was necessary to adopt the most recent UB-04 Data Specifications Manual in order to keep current with industry standards for usage of the form. It was

necessary to reorganize the section to include the table format to provide greater clarity on the Form and Data Specifications Manual versions, and the effective dates.

2.1 Field Table UB-04: The Field Table was amended to add language to the California Workers' Compensation Instructions for Form Locator 66 and 67 to cross reference to Section One – Business Rules, 3.1.0 – 3.2.1 for dates of usage of ICD-9 or ICD-10 codes.

In light of the adoption of the ICD-10, it was necessary to amend the Field Table to provide reference to the rules that determine whether the ICD-9 or ICD-10 code is required in each of the Fields.

3.0 National Council for Prescription Drug Programs “NCPDP” Workers' Compensation/Property & Casualty Universal Claim Form (“WC/PC UCF”): The section was amended to incorporate by reference the new NCPDP Manual Claims Form Reference Implementation Guide Version 1.3, October 2013, and specified the effective date of the updated manual to be the effective date of the regulations, the date to be inserted by OAL. Language was deleted in order to reorganize section to provide the form and manual versions in a table format. The section was amended to update information about where to obtain the NCPDP WC/PC Claim Form and implementation guide.

The amendment was necessary to adopt the most recent NCPDP Manual Claim Form Reference Implementation Guide in order to keep current with industry standards for usage of the WC/PC UCF. It was necessary to reorganize the section to include the table format to provide greater clarity on the Form and Manual versions, and the effective dates.

3.1 Field Table NCPDP:

Field 76 (Re-numbered 77) Product Strength: was amended to specify that the data field is optional rather than required.

The amendment was necessary to reduce administrative burden caused by mandating data entry in the field. Product strength is included in the structure of the National Drug Code; therefore “product strength” is duplicative and should be optional.

4.0 ADA 2006: The section was amended to delete “2006” and add “Dental Claim Form” to the section title. The section was amended to incorporate by reference new American Dental Association Dental Claim Form and dental coding book; the effective date of the new form and book will be the effective date of the regulations, the date to be inserted by OAL.. Language was deleted in order to reorganize the section to provide the form and manual versions in a table format.

It was necessary to amend the title of the section since to more accurately reflect the content of the section. The amendment was necessary to adopt the most recent ADA Dental Claim Form and the updated CDT 2014: Dental Procedure Codes book in order to keep current with industry standards. It was necessary to reorganize the section to include the table format to provide greater clarity on the ADA Dental Claim Form and Instruction Manual versions, and the effective dates.

4.1 Field Table ADA 2006: The title was amended to add “Dental Claim Form”.

The amendment was necessary to more accurately identify the name of the dental claim form.

4.2 Field Table ADA Dental Claim Form 2012: The amendment adopted a new Field Table to specify data requirements (required, situational, optional, not applicable) for the data fields of the new ADA Dental Form 2012, and to provide California workers' compensation-specific instructions where needed.

It was necessary to adopt a separate field table for the new ADA Dental Claim Form 2012 since the 2006 and 2012 forms do not have identical fields.

Appendices for Section One: Appendix B. Standard Explanation of Review:

The section was amended to add language stating that when a bill is paid in full or in part, the EOR also serves as a remittance advice. Amendments also added "remittance advice" in the title and subtitles for paper and electronic EORs. The language regarding Paper Explanation of Review was amended to correct two erroneous references, and changed the word "Field" to "Data Items".

It was necessary to add language that an explanation of review is a "remittance advice" when the bill is paid in full in order to clarify the function of the EOR, and so that the public would not think that the EOR is restricted to situations in which the bill is adjusted. Labor Code section 4603.2 subdivision (b)(1) states in pertinent part: "Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate, itemization of medical services...." And Labor Code section 4603.3 states in part: "Upon payment, adjustment, or denial of a complete or incomplete itemization of medical services and employer shall provide an explanation of review..." Also, the electronic equivalent of the paper EOR is the ASC X12/005010X221A1 Health Care Claim Payment/Advice (835) which serves as a remittance advice if the bill is paid in full. The language changes from "field" to "data items" was necessary to be consistent with the language in the 3.0 Table for Paper Explanation of Review.

1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk: The table was amended in the row for DWC Bill Adjustment Reason Code G53 to add the "issue" and "explanatory message" as follows: "Prescription is incomplete or not current". The table was amended to add the payer instruction to "Indicate specific deficiencies in the prescription".

The amendment was necessary to correct an erroneous omission of instructions for DWC Bill Adjustment Reason Code G53.

3.0 Table for Paper Explanation of Review: The table was amended to add clarifying language to Data Items 39 and 51 (DWC Bill Adjustment Reason Codes and explanatory language) to specify that the situational data is required if an adjustment is made to the bill, if there is a denial of billed charges, or there is a need to communicate the messages represented in the codes.

The amendment was necessary to improve clarity regarding what situations give rise to a need to provide the DWC Bill Adjustment Reason Code and Explanatory Messages. There are no codes or messages in Table 1.0 to state "paid in full". The new language

regarding the situational usage of the Data Item will help clarify that Data Items No. 39 and No. 51 will not be used where the EOR is a remittance advice on a bill paid in full.

Electronic Medical Billing and Payment Companion Guide (incorporated by reference):
Purpose and Necessity for Changes

Amendments were made throughout the document to improve reference to the electronic ASC X12 transaction standards by conforming to standard nomenclature by adding the applicable addenda version (either “A1” or “A2”):

ASC X12N/005010X222 Health Care Claim: Professional (837)	ASC X12N/005010X222A1
ASC X12N/005010X223 Health Care Claim: Institutional (837)	ASC X12N/005010X223A2
ASC X12N/005010X224 Health Care Claim: Dental (837)	ASC X12N/005010X224A2
ASC X12N/005010X231 Implementation Acknowledgment (999)	ASC X12N/005010X231A1
ASC X12N/005010X221 Health Care Claim Payment/Advice (835)	ASC X12N/005010X221A1

The amendments were necessary to conform to the version reference protocol for these HIPAA-compliant national transaction standards that are copyrighted by the Accredited Standards Committee.

Preface: Amended to provide a placeholder for the Change Control Table to insert new web links for the public to access the rulemaking documents that will reflect all changes adopted, and to provide the effective date of Version 1.2 to be inserted by OAL.

The amendment was necessary to update the table of companion guide version references and effective dates, and to provide the website address to download the companion guides. The change control table provides easily accessible version and access information at the beginning of the Companion Guide, and is less unwieldy than inserting detailed document change information into the Companion Guide itself.

Table of Contents: The amendment changed the headings relating to “Clean Bill” to “Complete Bill” to conform to text of the guide.

The change was necessary for consistency in referring to a “complete bill” rather than a “clean bill”.

Section 2.4.7: The section was amended to add cross reference to the Medical Billing and Payment Guide Section 7.3 relating to electronic bill attachments. It was also amended to modify the requirement to provide the claim number by adding the words “if known”.

The amendment was necessary to draw the reader’s attention to the provisions of the Medical Billing and Payment Guide which relate to electronic bill attachments. The addition of the words “if known” is necessary for consistency with other portions of the regulations which require the medical provider to list the claim number “if known.”

Chapter 9 Companion Guide Acknowledgments: Amendments were made throughout the chapter to replace “clean bill” with “complete bill”.

The amendment was necessary for consistency with the term “complete bill” adopted in the Medical Billing and Payment Guide in place of “clean bill”. The Division determined that “complete bill” was a more descriptive and appropriate term.

Section 9.2: The section was amended in two places to refer to an “otherwise complete” bill instead of a “clean bill”.

The amendment is necessary in the context :1) to utilize the term “complete” rather than “clean” for consistency, and 2) to highlight that the circumstance describes a bill that is complete *except for* the missing claim number.

2. Section 9792.5.4. Second Review and Independent Bill Review – Definitions

Preface: Amend to provide that the section is applicable to 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.

(a)(1): Amend to specify that “amount of payment” includes the amount of money paid by the claims administrator for 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 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.

(a)(2): Amend to specify that “amount of payment” includes the amount of money paid by the claims administrator for medical-legal expenses, as defined by Labor Code section 4620, where the payment is determined in accordance with sections 9793-9795 and 9795.1-9795.4.

(d): Amend to insert “of” between “existence” and “good-faith issue.”

(i): Amend to include 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, within the definition of provider. Further amend to provide that a provider may use a billing agent, a person or entity that has contracted with the provider to process bill under article 5.5.0, for services or goods rendered by the provider, to request a second bill review or independent bill review.

Reasons for Changes

Based on comments, subdivisions (a)(1) and (a)(2) were amended to clarify the definition of “amount of payment,” by standardizing the terminology to “goods and services,” as this is the term used in general practice, and to specify that category of goods and services provided must be covered under a fee schedule adopted by the Administrative Director. Subdivision (d) was amended to correct a grammatical error. Subdivision (i) was amended to align the definition of provider with that set forth in the

California Division of Workers' Compensation Medical Billing and Payment Guide, and to acknowledge the common use of billing agents in the medical billing process.

3. Section 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill

(a): Deletion of comma after reference to section 4603.2. Amend to insert "or goods" between "medical treatment services" and "rendered."

(b)(3): Addition of new subdivision providing that the 90-day time limit for requesting a second review may be extended by mutual written agreement between the provider and the claims administrator.

(c)(1): Amend to change "bills" to "bill"; provide that the second review shall be requested on the forms listed under subdivision (c)(1)(A) or (c)(1)(B).

(c)(1)(A): Amend to clarify that the second review bill shall be modified with the appropriate second review code. Amend to clarify reference to the American Dental Association Dental Claim Form (2006) and to add reference to the new ADA Dental Claim Form (2012).

(c)(1)(B): Substitute "the" for "requested on the." Amend to add the following sentence: "The DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider."

(c)(2): Amend to singular electronic medical treatment bill.

(d)(1): Amend to provide that no additional billing codes may be included with a second bill review.

(f): Addition of subdivision to provide that a claims administrator may respond to a request for second bill review that does not comply with the requirements of subdivision (d). Any response to such a request is not subject to the requirements of subdivisions (g) and (h).

(f): Re-letter former subdivision (f) as subdivision (g). Amend to specify that the 14-day response requirement applies to a request for a second bill review that complies with subdivision (d). Relocate former subdivision (f)(1) into text of new subdivision (g).

(f)(1) and (f)(2): Deleted.

(g): Re-letter former subdivision (g) as subdivision (h). Amend to provide that based on the results of the second review, payment of any balance no longer in dispute, or payment of any additional amount determined to be payable, shall be made within 21 days of receipt of the request for second review. The 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator.

(h): Re-letter former subdivision (h) as subdivision (i).

Reasons for Changes

Typographical and/or grammatical errors were corrected in subdivisions (c)(1), (c)(2), The section was amended as necessary to standardize terminology to “goods and services,” as this is the general term used in practice.

Subdivision (b)(3) was amended to allow the parties, by mutual agreement, to extend the 90-day timeframe for requesting a second bill review (SBR). An extension may allow the parties an additional opportunity to resolve the billing dispute.

Subdivision (c)(1)(A) was amended to clarify that the second review bill shall be modified with the appropriate second review code, and to update the reference to standardized dental forms.

Subdivision (c)(1)(B) was amended to delete unnecessary language and to expressly provide that the DWC Form SBR-1, if used, must be the first page of the request for SBR. This change was made based on comments that providers were submitting requests where the form was placed in the middle of supporting documents. To avoid any confusion, and to reduce the possibility of a request for SBR being mistaken for a duplicate bill, a requirement that the form be the first page of the request is reasonable.

Subdivision (d)(1) was amended to ensure that a request for SBR would not be used as a means to submit a new billing codes for review.

Subdivision (f) was added to allow a claims administrator the option of reviewing a non-compliant request for SBR without being bound to the response requirements. This will allow the parties an additional opportunity to resolve the billing dispute.

Subdivisions (f)(1) and (f)(2) were deleted. The former was moved to new subdivision (g). The latter was deleted because the Administrative Director was not given statutory authority to impose penalties and interest during the SBR process.

Subdivision (g) (formerly subdivision (f)) was amended to expressly state that a claims administrator is not bound by the 14-day response deadline if the request for SBR is not complete. The subdivision was further amended to allow the parties, by mutual agreement, to extend the 14-day timeframe for the claims administrator response. An extension may allow the parties an additional opportunity to resolve the billing dispute.

Subdivision (h) (formerly subdivision (g)), was amended to clarify that, following a second review, a claims administrator must pay any balance no longer in dispute or additional amounts determined to be payable. Expanding the circumstances for which additional amounts are paid should reasonably cover most billing disputes. The subdivision was further amended to allow the parties, by mutual agreement, to extend the 21-day timeframe for payment, as authorized by Labor Code section 4603.2(e)(3).

4. Section 9792.5.6. Provider’s Request for Second Bill Review – Form

- a. The version of the form is “01/2014.”
- b. The form was amended as necessary to standardize terminology to “goods and services.”

- c. Employee Information
 - Delete Social Security Number.
 - Relocate Claim Number and add Employer Name.
- d. Provider Information: Delete separate fields for City, State, and Zip Code.
- e. Claims Administrator Information
 - Delete separate fields for City, State, and Zip Code
 - Delete E-Mail Address and Employer Name.
- f. Bill Information
 - Delete row for Was Bill Authorized?
 - Substitute “items” for “goods” in row beginning with “List of disputed....”
 - Substitute “procedure” for “treatment” in second column.
 - Add column for “Procedure/Service/Item Authorized?”
 - Deletion of “Additional” and Information” in last column and following row.
- g. Signature: Add “Provider.”
- h. Instructions
 - In the second paragraph of instruction page, “How to Apply,” delete “version 1.1” following reference to the billing guides.
 - Bill Information is amended to conform to form changes. Amend the first sentence to read: “Complete all fields in this section for each disputed service or good, or medical-legal service.” Amend the first sentence of the fourth bullet point to read: “State the service or good for which payment is in dispute.”
 - Replace “physician” with “provider” under the signature instructions

Reasons for Changes

The form was amended as necessary to standardize terminology to “goods and services,” as this is the general term used in practice. Separate fields for City, State, and Zip were deleted as these could be combined in the Address field. Fields for “Claim Number” and “Employer Name” were moved to the more appropriate “Employee Information.” The “Social Security Number” field was deleted as it was found to be unnecessary for identification purposes. The “Bill Information” section was slightly reorganized (the authorization field was moved into the table) and unnecessary words deleted. In the instructions, the website address was corrected and versions of the billing guides removed to acknowledge that more than one version may apply. See section 9792.5.1. Additional language was simplified or added to conform to changes on the first page of the form.

5. Section 9792.5.7. Requesting Independent Bill Review

(a): Amend to insert “or goods” between “medical treatment services” and “rendered.”

(a)(1): Amend to provide that an independent bill review shall resolve, 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 the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.

(a)(2): Amend to specify that an independent bill review shall resolve, for a bill for medical-legal expenses, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, and one comprehensive, follow-up, or supplemental medical legal evaluation report as defined in section 9794.

(c): Amend to specify that a request for independent bill review must be made within 30 calendar days of the stated conditions.

(c)(5): Amend to insert “or goods” following the word “services” on the third line.

(d)(1)(A): Amend to correct the website link: delete <https://ibr.dir.ca.gov> and replace with <http://www.dir.ca.gov/dwc/IBR.htm>.

(d)(2): Amend to provide that the provider shall include the listed documents with the application for independent bill review, which shall be indexed and arranged so that each category of documents can be separately identified:

Reasons for Changes

The section was amended as necessary to standardize terminology to “goods and services,” as this is the general term used in practice.

Subdivision (a)(1) was amended to expressly provide that a request for independent bill review (IBR) can include one hospital stay. This inclusion acknowledges inpatient facilities as providers and provides the most expedient, cost-efficient means of resolving billing disputes for those facilities.

Subdivision (a)(2) was amended to specify that IBR is available for resolving medical-legal billing disputes regarding the reports expressly defined in section 9794 (a comprehensive, follow-up, or supplemental medical legal evaluation report).

Subdivision (c) was amended to clarify that a request for IBR must be made within 30 calendar days. See Labor Code section 4603.6(a).

Subdivision (d)(1)(A) was amended to correct the website link for the IBR application.

Subdivision (d)(2) was amended to require that providers index and arrange the documents submitted in support of their IBR application. Experience with the IBR program over the past year has shown that many providers do not organize or separate the supporting documents they provide with their application. To determine whether an IBR is eligible, it has taken an extensive amount of time and effort by Division staff to separate, identify, organize, and analyze the documents. If the “mechanical” portion of this process is performed by providers, the IBR process can be conducted in a more efficient and timely manner.

6. Section 9792.5.8. Request for Independent Bill Review Form

- a. The version of the form is "01/2014."
- b. The form was amended as necessary to standardize terminology to "goods and services."
- c. Employee Information
 - o Delete Social Security Number.
 - o Relocate Claim Number and add Employer Name.
- d. Provider Information
 - o Delete fields for "City," "State," and "Zip Code"
 - o Under "Provider Type," add "Other Practitioner – specify" box.
- e. Claims Administrator Information
 - o Delete fields for "City," "State," and "Zip Code"
 - o Delete Employer Name.
- f. Bill Information
 - o Under "Applicable Fee Schedule(s)," add "Other – specify" box" and Insert "or" before Contract for Reimbursement Rates."
 - o Substitute "Decision" for "Outcome."
 - o Insert "Reduction or" prior to "Denial of Full Payment."
- g. Consolidation: Insert "Reduction or" prior to "Denial of Full Payment."
- h. Documents to Accompany Request
 - o Add "Must by Indexed and Separated" to heading line.
 - o Add "Concurrently send a copy of this request to the Claims Administrator."
 - o Add "Provider" in signature line.
- i. Instructions
 - o Amended to conform to changes on the face of the form.
 - o Delete "please" as it occurs.
 - o Update the website link to <http://www.dir.ca.gov/dwc/IBR.htm>.
 - o Under last bullet point, substitute "must" for "should" and add "You must index and arrange the documents so that each category of documents can be separately identified." Substitute "concurrently sent to" for "served on."
 - o Under "Consolidation" on the instruction page, insert "up to a maximum of twenty (20)" following "Two or more requests for IBR."
 - o Under "Fee," substitute "must" for "should"
 - o Under "How to Apply by Mail," add the last sentence "Concurrently send a copy of this request and supporting documents to the Claims Administrator."

Reasons for Changes

The form was amended as necessary to standardize terminology to “goods and services,” as this is the general term used in practice. Separate fields for City, State, and Zip were deleted as these could be combined in the Address field. Fields for “Claim Number” and “Employer Name” were moved to the more appropriate “Employee Information.” The “Social Security Number” field was deleted as it was found to be unnecessary for identification purposes. Provider type and specialty were added to assist the IBRO in selecting an appropriate reviewer for the dispute. Adding “reduction to” in “Reason for Disputing Denial of Full Payment” accounts for disputes where a bill was reduced rather than denied in full. In the instructions, the website address was corrected and language simplified as necessary (i.e., “decision” for “outcome”). Additions for indexing and arranging documents, and for consolidating a maximum of 20 IBR requests, conform to regulatory changes.

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

(a)(2): Amend to clarify that the Administrative Director shall consider as a factor for eligibility the date the medical treatment services or goods were rendered or the medical-legal expenses incurred.

(a)(3): Include as an additional consideration whether the second request for review of the bill under section 9792.5.5 was timely requested by the provider.

(a)(4): Include as an additional consideration whether the second review of the bill under section 9792.5.5 was timely completed by the claims administrator.

(a)(3)-(6): The former subdivisions are re-numbered as (a)(5) through (8). The word “not” is deleted from new subdivision (a)(6).

(a)(5): Amend to insert “goods” following “medical treatment services.”

(a)(6): Amend subdivision to read: “If the required fee for the review was not paid pursuant to section 9792.5.7(d)(1)(A) or (B).”

(b): Amend to provide that the notification required by the subdivision be made within fifteen (15) days of the eligibility determination.

(b)(1): Correct typographical error, “An” for “A.”

(b)(3): Amend to provide that the claims administrator, in submitting documentation challenging the request for independent bill review, may dispute both eligibility of the request under subdivision (a) of the section and the provider’s reason for requesting independent bill review.

(c): Amend to provide the documents filed by the claims administrator must be concurrently served on the provider. Amend to substitute “provider” for “other party” in two places.

(f): Amend to delete reference to subdivision (a).

(f)(2): Amend to replace “A” with “An.”

(f)(3): Amend to provide that the notification sent by the independent bill review organization must include identification of the claim and the disputed amount of payment. Replace comma at the end of the sentence with a period.

Reasons for Changes

Typographical and/or grammatical errors were corrected in subdivisions (b)(1), (f)(2), and (f)(3). The section was amended as necessary to standardize terminology to “goods and services,” as this is the general term used in practice.

Subdivisions (a)(2), (3), and (4) were amended to clarify that the Administrative Director will specifically consider the date services were rendered, and whether a second bill review was completed under the necessary timeframes. Both factors are critical in determining the eligibility of an IBR request. See Labor Code section 4603.6(a), section 9792.5.4.

Subdivision (a)(6) was amended to specify the regulatory section, 9792.5.7(d)(1)(A) or (B), the requires the payment of an IBR filing fee at the time of application.

Subdivision (b) has been amended to provide that the notification required by the subdivision be made within fifteen (15) days of the eligibility determination. Upon receipt of a request for IBR, the Administrative Director has 30 days to assign the request to the IBRO. Labor Code section 4603.6(d). A 15 day period is reasonable for notifying the parties after a decision is made that an IBR request is eligible for review.

Subdivision (b)(3) has been amended to allow a claims administrator the opportunity to submit evidence regarding the provider’s reasons for requesting IBR. Labor Code section 4603.6 does not contain an express provision allowing a claims administrator to submit documents disputing the IBR request. However, subdivision (e) of that section provides that the IBR reviewer shall consider “the materials submitted by the parties.” The proposed regulation will allow a claims administrator to exercise its due process rights and submit evidence on its behalf.

Subdivision (c) was amended to provide the documents filed by the claims administrator must be concurrently served on the provider. The notification provide under subdivision (b) neither requires nor requests the provider to submit documents to the Administrative Director. Only the claims administrator is asked to submit evidence showing the IBR request is either ineligible or without merit.

Subdivision (f) is amended to delete an unnecessary reference to subdivision (a). A determination can only be made following the submission of documents by the claims administrator.

Subdivision (f)(3) was amended to provide that the notification sent by the IBRO must include identification of the claim and the disputed amount of payment. This will allow claims administrators to more easily identify claims where a request for IBR has been filed.

8. Section 9792.5.10. Independent Bill Review - Document Filing

(b): Amend to specify that the documents requested under subdivision (a) must be received within 35 days of the request, if the request is made by mail, or 32 days of the request, if the request is made electronically. The subdivision is further amended to provide that the filing party shall concurrently serve the non-filing party with the documents requested by the independent bill reviewer.

Reasons for Changes

Subdivision (b) has been amended to clarify for the parties that: (1) documents must be received within 35 days of the request by the IBR reviewer; and (2) the documents must be concurrently served on the non-filing party. The language complies with the language of Labor Code section 4603.6(e) and takes into consideration Code of Civil Procedure section 1013.

9. Section 9792.5.11. Withdrawal of Independent Bill Review

Amend to expressly provide that 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 of payment owed under section 9792.5.14.

(a): The existing subdivision is deleted and replaced with a provision providing that if the request is withdrawn prior to its assignment to an Independent Bill Review Organization for an independent bill review under section 9792.5.9(f), the provider shall be reimbursed the amount of \$270.00 from the fee provided with the request under section 9792.5.7(d).

(b): Amend to provide that if the request is withdrawn subsequent to its assignment to an IBRO for an independent bill review under section 9792.5.9(f), the provider shall not be reimbursed the fee provided with the request under section 9792.5.7(d).

Reasons for Changes

The section was amended to require that a provider, when withdrawing an IBR request, concurrently provide the claims administrator with written notice. This will inform the claims administrator that the request is no longer pending and no further action will be taken by the IBRO. The section was also amended to allow a reimbursement of \$270 of the filing fee to the provider if the withdrawal is made prior to the assignment of the request to the IBRO. This will allow a provider to withdraw an erroneous filing, or a filing that has been quickly resolved, without incurring the total amount of the fee. The point of assignment for incurring the entire fee is reasonable. If the only action necessary on a request is for the reviewer to issue a determination after completing an analysis, the IBRO will be penalized if the request is withdrawn and \$270 is reimbursed to the provider. To set the line at the assignment of the request ensures that the IBRO will be compensated for their work and acts as an incentive for the parties to resolve their dispute.

10. Section 9792.5.12. Independent Bill Review - Consolidation or Separation of Requests

(a): Amend to provide that a maximum of twenty (20) requests for independent bill review can be consolidated for the purpose of having the payment reductions contested in each request resolved in a single determination. Deletion of the word “together.”

(b)(2): Amend definition of “Delivery of similar or related services” to replace “items” with “goods” and to include medical-legal services within the definition.

(b)(3): The first sentence is amended to read “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.”

(c): Amend to provide that a maximum of twenty (20) requests for independent bill review can be consolidated for a single determination.

(c)(1) Amend to include as eligible for consolidation, subject to the express conditions, separate requests for medical-legal services.

Reasons for Changes

The section was amended as necessary to standardize terminology to “goods and services,” as this is the general term used in practice.

Subdivisions (a) and (c) were amended to limit request for consolidation to 20 separate IBR requests. The Division finds that a reasonable maximum number of IBR requests that can be consolidated into one determination is necessary to ensure that the resources of the IBRO are not strained in reviewing these types of request and that the IBRO will be adequately compensated for their work. Combining 20 requests should allow the IBRO to conduct a sufficient review of the challenged billing practices.

Subdivision (c)(1) is amended to expressly allow separate requests for medical-legal services, which was inadvertently omitted in the emergency regulations.

Subdivision (c)(3) was amended to allow the IBRO to consolidate requests after consultation with the Administrative Director rather than having to show good cause. The purpose of IBR is to allow medical billing experts to resolve disputes over the amount paid on a bill. The IBRO, medical billing experts, can reasonably identify a practice and practice of underpayment without having to provide good cause to the Division.

11. Section 9792.5.13. Independent Bill Review – Review

(d): Amend to add the sentence: “The independent bill review shall also apply as necessary all billing, payment, and coding rules adopted under this Article.

Reasons for Changes

The subdivision was amended to specify that when applying the provisions of the applicable fee schedule, the IBR reviewer must also apply as necessary all billing, payment, and coding rules adopted by the Division. This is to ensure that all decisions comply with the California billing rules.

12. Section 9792.5.15. Independent Bill Review – Implementation of Determination and Appeal

(b): Amend to begin subdivision with “Pursuant to Labor Code section 4603.6(f), the provider or the claims administrator may appeal....”

(b)(1): Amend to substitute “bill” for “medical.”

Reasons for Changes

Subdivision (b) is amended to specify that any appeal of an IMR determination must be based on Labor Code section 4603.6(f). Rules for such an appeal are established by the Workers’ Compensation Appeals Board. Subdivision (b)(1) corrects an error in terms.

13. Section 9793. Definitions

(c)(2): Correct citation to subdivision (h).

(e): Punctuation changes in definition of “disputed medical fact” for clarity.

Reasons for Changes

The section was amended to correct a citation that has changed and to improve clarity.

14. Section 9794. Reimbursement of Medical-Legal Expenses

(i): Amend to require that physicians keep and maintain for five years copies of all billings for medical-legal expense.

(k): Amend to add statutory reference to Labor Code section 139.32.

Reasons for Changes

Subdivision (i) was amended to: (1) be consistent with the record retention period required of claims administrators (section 9794(k)); and (2) align with the period of time that a Qualified Medical Evaluator (QME) must retain a copy of all comprehensive medical-

legal reports (section 39.5). Subdivision (k) was amended to acknowledge the specified prohibitions against payment that physicians are subject to under Labor Code section 132.32.

JUSTIFICATION FOR INCORPORATION BY REFERENCE

As specifically identified above, numerous documents have been incorporated by reference into the regulations. Incorporation by reference is necessary because all of the documents incorporated by reference are voluminous (amounting to hundreds of pages) and it would be cumbersome and otherwise impractical to publish the entire publications in the California Code of Regulations. (1 CCR § 20(c)(1), (c)(2)) Moreover, many of the documents incorporated by reference are documents that are copyrighted intellectual property of private entities and may not be published in the California Code of Regulations. The regulations specify how each of the documents incorporated by reference may be obtained.

UPDATE OF MATERIAL RELIED UPON AND DOCUMENTS INCORPORATED BY REFERENCE ADDED TO THE RULEMAKING FILE

The following additional documents beyond those identified in the Initial Statement of Reasons were relied upon by the Acting Administrative Director and added to rulemaking file after close of the 45 day comment period. They were identified in the "Notice of Modification to Text of Proposed Regulations and Forms and Notice of Addition of Documents to the Rulemaking File" (1st 15-Day Comment Period) and were available for 15-day public review and comment from October 7, 2013 through October 23, 2013.

Documents Incorporated by Reference

- CMS 1500 Health Insurance Claim Form (version 02/12)
- NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, June 2013 Version 1.1 06/13
- National Uniform Billing Committee Official UB-04 Data Specification Manual 2014, Version 8.0, July 2013
- NCPDP Manual Claim Forms Reference Implementation Guide Version 1.1, March 2012, except for pages 13-35 relating to the Universal Claim Form
- CDT 2014: Dental Procedure Codes
- ADA Dental Claim Form 2012

ICD-10-CM

- 2014 Code Descriptions in Tabular Order [ZIP, 1MB]
- 2014 Code Tables and Index [ZIP, 16MB]
- 2014 ICD-10-CM Duplicate Code Numbers [ZIP, 64KB]

- 2014 General Equivalence Mappings (GEMs) – Diagnosis Codes and Guide [ZIP, 623KB]
- 2014 ICD-10-CM Present On Admission (POA) Exempt List [ZIP, 4MB]

ICD-10-PCS

- 2014 Official ICD-10-PCS Coding Guidelines [PDF, 71KB]
- 2014 Version – What’s New [PDF, 39KB]
- 2014 Code Tables and Index [ZIP, 5MB]
- 2014 PCS Long and Abbreviated Titles [ZIP, 1MB]
- 2014 Development of the ICD-10 Procedure Coding System (ICD-10-PCS) [PDF, 245KB]
- 2014 ICD-10-PCS Reference Manual [ZIP, 709KB]
- 2014 Addendum [ZIP, 64KB]
- PCS Slides for 2014 [ZIP, 689KB]
- 2014 General Equivalence Mappings (GEMs) – Procedure Codes and Guide [ZIP, 721KB]

Documents Relied Upon

- 1500 Health Insurance Claim Form Change Log 6/17/2013
- NUCC 02/12 1500 Claim Form Map to X12 Health Care Claim: Professional (837)
- ADA Dental Claim Form (2012 © American Dental Association) Completion Instructions
- Federal Register, Vol. 74, No. 11, January 16, 2009, page 3328 et seq. Final Rule: HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards To Adopt ICD–10–CM and ICD–10–PCS
- Federal Register, Vol. 77, No. 172, September 5, 2012, page 54664 et seq. Final Rule: Administrative Simplification: Adoptions of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data code Sets
- CMS ICD-10 Transition Focus on Non-Covered Entities September 2012

The following documents added to the rulemaking file after the close of the first 15-day comment period were identified in the “Notice of Modification to Text of Proposed Regulations and Forms and Notice of Addition of Documents to the Rulemaking File” (2nd 15-Day Comment Period) and were available for 15-day public review and comment from December 11, 2013 through December 26, 2013.

Documents Incorporated by Reference

- Manual Claim Forms Reference Implementation Guide Version 1.3, October 2013, National Council for Prescription Drug Programs
- 1500 Instructions Change Log – as of 11/2003: 1500 Health Insurance Claim Form, Reference Instruction Manual Version 1.1 6/13 for the 02/12 1500 Claim Form Change Log

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed amendments do not apply to any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments do not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Acting Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts.

The public comment period was as follows:

Initial 45-day comment period on proposed regulations:

February 24, 2013 through April 9, 2013

First 15-day comment period on modifications to proposed text:

October 9, 2013 – October 23, 2013

Second 15-day comment period on modifications to proposed text:

December 12, 2013 – December 26, 2013