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

INITIAL 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.

1. Introduction.

This Initial Statement of Reasons ("ISOR") describes the purposes, rationales, and necessity of the Division of Workers' Compensation's (DWC) proposed amendments to existing medical treatment billing and payment regulations and existing medical-legal expenses regulations, and proposed new regulations to implement the statutorily mandated independent bill review (IBR) program, which went into effect on January 1, 2013. The purpose of the IBR program as established by the proposed regulations is to ensure that billing disputes in workers' compensation cases will be resolved by a conflict-free medical billing and payment expert utilizing fee schedules adopted by DWC's Administrative Director. This Initial Statement of Reasons (ISOR) fulfills the requirements of California's Administrative Procedure Act (see Government Code section 11340 et seq.).

In passing Senate Bill 863 (Statutes of 2012, Chapter 363), the Legislature found that that the current system of resolving disputes over medical treatment billing and medical-legal billing offers no avenue for resolution short of litigation. Section 1(h) of SB 863 declared that prior to the bill's enactment there was no requirement that medical billing and payment experts, those with specialized knowledge regarding the application of complex fee schedules and billing standards, reviewed and resolved disputes, which were immediately submitted to workers' compensation administrative law judges without the benefit of independent and unbiased findings on such billing issues. Based on SB 863's mandate, for dates of service occurring on or after January 1, 2013, the IBR program as established by the proposed regulations will be used to decide disputes regarding medical treatment and medical-legal billing disputes in workers' compensation cases.

The authorizing statutes, Labor Code sections 139.5, 4603.2, 4603.3, 4603.6 and 4622, require DWC to contract with an independent bill review organization (IBRO) and institute a procedure whereby a medical provider and claims administrator must first attempt to resolve billing disputes through a second bill review process, then, if the amount of the bill remains in dispute after this process, submit the dispute to an independent bill reviewer assigned by the IBRO. Following a review of billing documents designated by statute, the bill reviewer must issue a decision as to whether any additional amount is owed to the medical provider. By statute, the bill reviewer's decision

is an order of DWC's Administrative Director, and cannot be appealed to either the Workers' Compensation Appeals Board (WCAB) or civil courts as to the issue of payment.

To implement the second bill review and IBR programs mandated by SB 863, DWC proposes to amend Article 5.5.0 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, section 9792.5.1, and adopt Article 5.5.0 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 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. Further, DWC proposes to amend Article 5.6 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9793, 9794, and 9795. These regulations were initially adopted under the emergency regulatory process on December 31, 2012 (see OAL File No. 2012-1219-02E). These proposed emergency regulations are substantially similar to those enacted on December 31, 2012 under the emergency rulemaking process.

DWC welcomes comments on the ISOR and on the proposed regulations that the ISOR describes. Please see the accompanying Notice of Rulemaking for instructions on how to submit comments electronically, on paper, and orally at the DWC hearing on the proposed regulations.

2. Technical, Theoretical, or Empirical Studies, Reports, or Documents.

DWC relies on the following documents in proposing the regulations. They are available for public review and comment in the rulemaking file.

- Department of Industrial Relations' contract (DIR Agreement # 41230041) with Maximus Federal Services, Inc. to provide Independent Bill Review Services.
- Workers' Compensation Insurance Rating Bureau's (WCIRB) Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012.
- The California Commission on Health and Safety and Workers' Compensation Liens Report dated January 5, 2011.
- IAIABC Workers' Compensation Electronic Billing and Payment National Companion Guide, Based on ASC X12 005010 and NCPDP D.0, Release 2.0, July 2, 2012

3. Problem Addressed with this Rulemaking.

This rulemaking allows the Division to establish and administer the second bill review and IBR program in compliance with SB 863's mandate, as reflected in Labor Code sections 4603.2, 4603.3, 4603.6 and 4622, by detailing the procedures by which a dispute regarding the amount paid on a bill for medical treatment or medical-legal expenses is resolved by a bias-free medical billing and payment expert assigned by the IBRO designated by the Administrative Director. The rules first establish a second bill review process for medical treatment billing using standardized forms, electronic billing, and medical-legal billing. The rules then set forth the timeframes under which to request IBR, the mandatory form that must be used by a medical provider, and the procedure that must be followed by the parties and the review organization in order to ensure that

the timely, efficient IBR program envisioned by the Legislature is realized. The rulemaking addresses the need to make updates, corrections, and clarifications to the rules for electronic and standardized paper medical treatment billing.

4. Specific Technologies or Equipment.

None.

5. Reasonable Alternatives to the Proposed Regulations and Reasons for Rejecting Those Alternatives.

The Administrative Director has not identified any effective alternative, or any equally effective and less burdensome alternative to the regulation at this time. The public is invited to submit such alternatives during the public comment process.

6. Duplication or Conflicts with Federal Regulations (Gov. Code section 11346.2(b)(7)

The proposed regulations do not duplicate or conflict with any federal regulations. There are no federal regulations that prescribe rules for workers' compensation medical billing and bill review.

7. The Specific Purpose, Rationale, and Necessity of Each Section of the Proposed Amendments (Government Code section 11346.2(b)(1))

The specific purpose, rationale, and necessity of each section of the proposed amendments, in accordance with Government Code section 11346.2(b)(1), is provided below.

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

Text of subdivisions (a) and (b)

Specific Purpose:

The text of subdivision (a) is amended to change the reference to the California Division of Workers' Compensation Medical Billing and Payment Guide. The purpose is to change the designation of the guide from "dated 2011" to "version 1.1."

The text of subdivision (b) is amended to change the reference to the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide. The purpose is to change the designation of the guide from "dated 2012" to "version 1.1."

Necessity:

The changes in subdivision (a) and (b) are necessary in order to improve the clarity of the designation of the version of the guides. Use of a date to designate the guides may be confusing because updated versions of the guides may not correlate with a particular

year. Using a version number will improve clarity as the guides are periodically updated, but not necessarily on an annual basis as more frequent updates may be needed.

Text of subdivisions (c), (d), (e), (f), (g), (h) and (i)

Specific Purpose:

The text of subdivisions (c), (d), (e), (f), (g), (h) and (i) is deleted for the purpose of eliminating duplication. Subdivisions (c), (d), (e), (f), (g), (h) and (i) which set forth a variety of documents incorporated by reference including: medical treatment billing and payment electronic transaction standards, medical treatment paper billing forms and instruction manuals/implementation guides for those paper forms are duplicative. All of the documents specified as incorporated in subdivisions (c), (d), (e), (f), (g), (h) and (i) are also incorporated by reference into either the California Division of Workers' Compensation Medical Billing and Payment Guide or the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.

Necessity:

It is necessary to delete subdivisions (c), (d), (e), (f), (g), (h) and (i) in order to eliminate duplication in the regulation and improve clarity. Since the medical billing and payment guide and the electronic companion guide already incorporate the standards, forms and manuals by reference there is no need to have those documents incorporated by reference into the regulation text. Furthermore, having the documents incorporated by reference in two places may create confusion and additional work for the public as they attempt to discern whether the document lists are the same.

Subdivision (a) Document Incorporated by Reference: California Division of Workers' Compensation Medical Billing and Payment Guide

Specific Purpose:

SB 863 adopted several changes related to medical treatment billing and payment that impact the paper and electronic billing rules. The Medical Billing and Payment Guide (Guide), which is incorporated by reference into subdivision (a), is amended to address the provisions in SB 863. The Guide specifies the manner in which a medical provider may request a "second review" of its medical bill if the provider disputes the amount paid by the claims administrator or disputes the denial of the bill, including instruction on designating a bill as a request for second review on the paper field tables. The Guide adds language relating to the "Explanation of Review" (EOR) to conform to statutory amendments. This includes new mandatory language that must appear on the EOR to inform the provider of the time limits for requesting a second review and for requesting independent medical review. The Guide specifies that the EOR is required to be used for communicating the results of both the original bill review and the review conducted upon a request for second review. Submission of a duplicate bill is prohibited after issuance of the explanation of review. The list of documents required to be submitted as a component of a "complete bill" is amended to add: any evidence of authorization for the services, and the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician. The provisions relating to the timeframes for payment of a paper bill and objection to a paper

bill are amended to delete the word “working” from “45 working days” (“60 working days” for governmental entity) and “30 working days”.

In addition to the SB 863 amendments, there are amendments to the Guide to update and clarify the rules. Sections 6.0 – 6.2 are added to clarify the timeframes for processing and paying bills submitted on paper. Section 7.3 Electronic Bill Attachments is amended for the purpose of avoiding duplication, to improve clarity and to streamline the billing process. 7.3 (b) is revised in order to provide a narrowed list of identifiers, and to require that those identifiers be on the body of the attachment or inscribed on the attachment. The purpose of the amendment is to ensure that attachments submitted to support electronic bills can be easily matched with the bills. Updates include adoption of new implementation guides/manuals for: the paper CMS 1500 form for professional billing, the paper UB-04 form for facility billing, the American Dental Association form for dental billing and the National Council on Prescription Drug Programs Workers’ Compensation/Property and Casualty Universal Claim Form (NCPDP WC/PC UCF) for pharmacy billing. These updated implementation guides/manuals are incorporated by reference. In addition, the regulation is amended to include the adopted NCPDP WC/UCF version 1.1 - 05/2009 in place of the NCPDP WC/UCF version 1.0 - 05/2008 which was a draft version that was never in production. The regulations add language to specify the effective date of the manuals/guides and forms. The Guide adds language specifying the provider types that should use each type of billing form. For each form the Guide has a “field table” setting forth special instructions where that is needed for workers’ compensation. Each of the field tables is modified to change the instruction regarding the date to be entered for the “date of injury” for an occupational disease in order to align with the Labor Code section 5412 definition. The field table for the NCPDP WC/PC UCF is amended to give instructions for new field No. 68, to renumber subsequent fields, and to provide corrections/additions to field descriptions and to the column crosswalking to the electronic NCPDP D.0 data element. The Appendix B, Table 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk is amended to add language to the “Issue” and “DWC Explanatory Message” columns for many of the DWC Bill Adjustment Reason Codes. The table is also amended to correct a RARC that has changed numbers and to correct RARC language. Throughout the document, the source to obtain the electronic transaction standards (other than pharmaceutical standard) is changed from the Data Interchange Standards Association to the Accredited Standards Committee (ASC) X12. Language regarding payment time frames and penalties is amended and reorganized. The Guide is amended for grammatical accuracy.

Necessity:

Amendments and additions to the Guide are necessary to carry out many of the provisions of SB 863, and to conform Guide language to statutory changes. It is necessary for the Guide to specify the procedure for a provider to request that a claims administrator conduct a “second review” of the bill if a dispute remains after the first review. Prior to SB 863, it was possible for a provider to submit multiple bill “appeals” or “requests for reconsideration.” SB 863 limits “appeal/reconsideration” with the claims administrator to one, and specifies that the remedy thereafter is “independent bill review” (IBR). It is necessary for the guide to be amended to specify second review and IBR as the procedures for resolving billing disputes, and to reference the text of regulations that lay out details of these procedures. In order to streamline communication between payers and providers, it is necessary to adopt standardized language to be inserted on

EORs relating to a provider's second review and IBR remedies. It is necessary to adopt updated standardized billing form manuals and implementation guides to keep the workers' compensation billing system current with the general health care system.

Subdivision (b) Document Incorporated by Reference: California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide

Specific Purpose:

SB 863 prohibits submission of a duplicate bill after issuance of an EOR, and provides that the claims administrator does not need to respond to a duplicate submitted after the issuance of the EOR. In order to implement SB 863, the Electronic Medical Billing and Payment Companion Guide (Companion Guide) is amended to prohibit the submission of duplicates after issuance of the electronic remittance advice ASC X12 0050X221, unless the time for responding to the bill has passed without issuance of the remittance advice. In addition, clarifications are made to how duplicate bills are identified in electronic billing. Provisions are added to designate the ASC X12 005010221 Health Care Claim Remittance Advice as the EOR required by SB 863. In order to comply with SB 863's requirement that the EOR notify the medical provider of the way to dispute the amount paid and the time frames to submit a request for second review or request for independent review, the Companion Guide adopts a jurisdictional code to represent the remedies notification. This is called the "Claim Level California Jurisdictional EOR Statement." The language is revised to delete the former statement regarding liens for medical treatment bills and replace it with new language to comply with SB 863. The Companion Guide is revised in order to implement the provisions of SB 863 that limit a medical bill "appeal" with the claims administrator to only one "request for second review." Provisions are revised to add the "request for second review" to the phrase "appeal/reconsideration." The Guide is revised to specify that an electronic "second review" bill submitted utilizing the ASC X12 transaction, utilizing the National Uniform Bill Committee Condition Code W3 (First Level Appeal). The Companion Guide specifies which loops and segments of the transaction are used to transmit the W3 code. Corollary changes are made for all of the ASC X12 billing transaction types: physician, institutional, dental. The NCPDP transaction does not use the NUBC W3 appeal code, so provisions are inserted into the Companion Guide to specify that trading partners may make agreements on how to identify second review bill transmissions. And as an alternative, the Companion Guide specifies the use of the paper Request for Second Review form that may be used to request second review for pharmaceutical claims.

In addition to the changes related to SB 863, changes are made to the Companion Guide for the purpose of updating the guide to current standards, to be as consistent with HIPAA as possible, to be as consistent as possible with the national electronic billing standards, to make corrections, to eliminate duplicative language and to improve the clarity of the Companion Guide. The ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277) and errata are adopted in order to provide a medical practitioner an electronic method to initiate a request for information on the status of a claim and for the claims administrator to respond.

Throughout the document, the source to obtain the electronic transaction standards (other than pharmaceutical standard) is changed from the Data Interchange Standards Association to the Accredited Standards Committee (ASC) X12. Many references to loops, segments, and elements in the electronic billing transactions are revised, added or deleted to conform to the ASC X12 standards. The purpose of some of the deletions is to eliminate material that duplicates material in the ASC X12 transaction standards. Changes are made to clarify that certain billing rules are related to California workers' compensation requirements rather than AXC X12 requirements. For example, revised language clarifies that for California workers' compensation billing the injured employee is identified by social security number. Language is added to specify that the date sent and date received are determined by the Interchange Control Head ISA Segment Interchange Date, which must be the actual date the transmission is sent. In order to provide clarity, language is added to identify the location of the paid date in the remittance advice. Provisions relating to use of Loop 2100 Other Claim Related Information REF is amended to conform to ASC X12 requirements. The tables with workers' compensation instructions for professional, institutional, dental, and pharmaceutical billing are each modified to change the instruction regarding the "date of injury" for an occupational disease in order to align with the Labor Code section 5412 definition. Appendix B Code Set References is deleted for a variety of reasons; it is duplicative of codes lists in other applicable provisions including in the ASC X12 guides, and in the official medical fee schedule, and it setting forth code sets in multiple places could be confusing and could increase the risk of inadvertent inconsistencies. The Appendix C, Jurisdiction Report Type Codes, is re-lettered as Appendix B. Revisions are made to clarify the descriptions of the Report Type Codes. One code is deleted from the list as it is not used (J3 Medical Permanent Impairment Report.) Seven other codes are deleted from the Companion Guide because they inappropriately duplicate ASC X12 Report Type Codes and are not "Jurisdiction Report Type Codes."

Necessity:

Amendments and additions to the Companion Guide are necessary to implement many of the provisions of SB 863 so the public will have clear rules relating to billing, payment and remittance advice. In order to maintain the efficiency of the electronic process for physician, institutional and dental billing, it is necessary to specify that the "form" to request a second bill review is the original electronic bill transaction standard with a NUBC W3 code, rather than a paper form. The NCPDP pharmaceutical telecommunication standard does not accommodate the transmission of the NUBC W3 appeal code. Therefore it is necessary to specify that the parties may agree upon a method to identify bill transmissions that are a request for second review, and to allow a paper request for second review, so that if parties are unable to agree, there is still a specified method to request second review. The electronic billing transactions do not allow the transmission of narrative text so it is necessary to specify a method by which the payer can comply with the statutory directive to notify the provider of the time limits and methods to dispute the amount paid on a bill (remedies language). The notification is accomplished by transmitting the "Claim level California Jursidictional EOR Statement ID Qualifier" from the payer to provider in the ASC X12 005010X221 Health Care Claim Remittance Advice. This method conforms to national standards recommended by the International Association of Industrial Accident Boards and Commissions (IAIABC) in its model ebilling guide. It is necessary to adopt language that replaces the obsolete language regarding liens under Labor Code section 4903.5 and insert new remedies language that conforms to changes made by SB 863 and that conforms to new language

required for the paper EORs. This is necessary to ensure providers receiving paper and electronic EORs both have the remedies language as any dispute must be raised within the statutory timeframes.

Many changes are necessary throughout the Companion Guide to conform to requirements of the ASC X12. The copyrighted ASC X12 standards set forth in the Type 3 Technical Reports (TR3) are the basis for the electronic physician, institutional and dental billing. Generally, the ASC X12 does not allow duplication of the TR3 material in a companion guide. The companion guide can provide clarification where there is a need for workers' compensation application/instructions, but "duplication" of TR3 material is to be avoided. Therefore, various changes in the Companion Guide are necessary to avoid duplication of TR3 material. Some changes are also necessary to conform to ASC X12 protocols regarding naming of loops, segments and data elements. The IAIABC Workers' Compensation Electronic Billing and Payment National Companion Guide has been approved by the ASC X12 and has been relied upon as a model for the California Companion Guide. It is necessary to look to the IAIABC national model in order to provide efficiencies for providers and payers that result from standards across multiple jurisdictions. It is necessary for the Companion Guide to set forth rules that are as consistent with HIPAA as feasible in order to comply with Labor Code section 4603.4. To carry out the Labor Code directive the Companion Guide adds the ASC X12 005010X212 Health Care Claim Status Request and Response, which is a HIPAA standard, and which will improve the communication between provider and payer.

Section 9792.5.3. Medical Treatment Bill Payment Rules.

Specific Purpose:

The authority and reference are amended to add Labor Code section 4603.3.

Necessity:

The regulation specifies that claims administrators are required to adhere to the Guide and the Companion Guide. It is necessary to add Labor Code section 4603.3 as reference to notify the public that the regulation is implementing that Labor Code section, which requires the issuance of an explanation of review in the manner prescribed by the administrative director of DWC upon the payment, adjustment or denial of a bill. It is necessary to add Labor Code section 4603.3 as authority because that Labor Code section states that the administrative director of DWC may adopt regulations requiring the use of electronic explanations of review.

Section 9792.5.4. Second Review and Independent Bill Review – Definitions

Specific Purpose:

This section lists and defines the key terms used in the second bill review and IBR regulations. The terms include: "amount of payment," "billing code," "claims administrator," "contested liability," "consolidation," "explanation of review," independent bill review organization," "Independent bill reviewer," and "provider." The purpose of the definitions is to implement, interpret, and make specific Labor Code sections 4603.2, 4603.3, 4603.6, and to ensure that the meanings of the terms are clearly understood by the workers' compensation community.

Necessity:

It is necessary to define each of the key terms used in the second bill review and IBR regulations to ensure that their content and meaning are clearly understood by the workers' compensation community.

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

Specific Purpose:

The purpose of this section is to set forth the timeframe, procedures and notices required in the second bill review process mandated by Labor Code sections 4603.2(e) and 4622(b). The section advises that if a medical provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services rendered on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill. The section advises of the 90-day timeframe in which to request a second review, and the procedure that must be followed for non-electronic medical treatment bills, electronic medical treatment bills for professional, institutional or dental services, electronic pharmacy bills, and medical-legal bills. Subdivision (d) advises of the required elements needed for a second review, while subdivision (e) advises that if a second review is not requested, the bill shall be deemed satisfied and neither the claims administrator nor the employee shall be liable for any further payment. Claims administrators are advised in subdivision (f) of the timeframe and manner of response to a second bill review request.

Necessity:

This section implements Labor Code sections 4603.2(e) and 4622(b)'s mandate regarding the procedure by which a medical provider requests a second bill review following an initial determination that medical treatment bill or medical-legal bill – for services on or after January 1, 2013, should not be paid in full. It is necessary to set forth different second bill review processes for all formats of medical billing in the workers' compensation system – including the use of standardized billing forms and electronic billing – to ensure consistency with and to accommodate all formats whose use are either mandated by regulation (use of standard medical treatment billing forms) or optional (electronic billing). The section in part restates the provisions of Labor Code sections 4603.2(e) and 4622(b), which is necessary for the purpose of clarity in that the statute establishes a comprehensive and detailed procedure for initiating requesting a second bill review. Rather than simply delegating to the Division authority to establish this program, the Labor Code provisions specify that a form prescribed by the Administrative Director must be filed by the provider, the timeline for filing, and the required elements of a second request. Since the second review and IBR programs are entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules.

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

Specific Purpose:

This section sets forth the form. The DWC Form SBR-1, by which a medical provider requests a second bill review under Labor Code sections 4603.2(e) and 4622(b). The form contains identifying information regarding the employee, the providing physician, the claims administrator, and specific information as to the dispute over the amount billed and paid. The form is signed by the medical provider and sent to the claims administrator to initiate the second bill review.

Necessity:

The DWC Form SBR-1 is necessary to conform to Labor Code sections 4603.2(e)(1)'s and 4622(b)(1)'s mandate that the Administrative Director prescribe a form for a medical provider to initiate the second bill review process. The form contains all elements required by statute; the requested information is reasonable and will allow the claims administrator to efficiently identity the billing dispute.

Section 9792.5.7. Requesting Independent Bill Review.

Purpose of this Section:

The purpose of this section is to describe the procedure by which a medical provider initiates the IBR process upon a second bill review decision by the claims administrator that fails to resolve a dispute over the amount of payment made on a bill for medical treatment services or a bill for medical legal services. Subdivision (a) of the section first advises of the billing disputes which can be resolved through IBR. For a bill for medical treatment services rendered on or after January 1, 2013, IBR is available for a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, one date of service, and one billing code 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. For a bill for medical-legal expenses, a dispute over the amount of payment for services (rendered on or after January 1, 2013) 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. Conversely, subdivision (b) advises of billing disputes for which IBR cannot be used: if the dispute involves any issue other than the amount of payment; if the billed category of services is not covered by a fee schedule adopted by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11; and if the determination of the fee necessitates the use of an analogous code (e.g., using a shoulder surgery procedure code to pay for a knee procedure), unless such analogous coding is authorized. The section further sets forth the 30-day deadline for a medical provider to seek IBR and the manner in which the request is made (i.e., mailing the mandatory DWC Form IBR-1 or completing it online), including the set IBR fee of $335.00. In regard to the IBR request, subdivision (d)(2) advises the medical provider as to the documents that must accompany the IBR request form, while subdivision (e) expressly provides that the provider may request that two or more billing disputes may be consolidated for a single IBR determination.

Necessity:

This section implements Labor Code section 4603.6(b) and (c)'s mandate regarding the procedure by which a medical provider initiates the IBR procedure and is necessary to inform the workers' compensation community of the dispute resolution process applicable to medical billing disputes. IBR is appropriately limited to services rendered on or after January 1, 2013. This limitation harmonizes Labor Code section 139.5(a)(2) which allows the Administrative Director to contract with an IBRO to "enable the independent review program to go into effect for injuries occurring on or after January 1, 2013….", and Section 84 of SB 863, which provides that the act shall apply to all pending matters, regardless of the date of injury. The limitation is also necessary to allow claims administrators to establish their second bill review programs, and for the Division to contract with and designate an independent bill review organization to conduct IBR services, and still comply with the statutory timeframes for conducting a second bill review and initiating IBR. Subdivision (a)(1) and (a)(2)'s description of the types of disputes subject to IBR's resolution procedure – generally limited to one employee, one date of service, and one billing code under a fee schedule adopted by the Administrative Director - is necessary to define the scope and nature of the IBR, and correlate the service to be provided by the IBRO with the fee that must be paid by the provider to initiate IBR. The provisions in Subdivision (b) limiting IBR to disputes over the amount owed to a provider 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, is necessary to reduce the possibility that IMR decisions will be affected by subjective considerations or bias, or rely on findings made by the reviewer that are beyond the scope of their expertise. Further, limiting IBR to established fee schedules ensures that bill reviewers will not unilaterally establish informal billing standards in the absence of public input and comment.

Regarding the IBR application, the $335.00 fee for providers to initiate IBR is necessary to comply with the mandate of Labor Code section 4603.6(c), which expressly provides that the provider shall pay a fee to cover no more than the reasonable estimated cost of IBR and the administration of the IBR program. Further Labor Code section 139.5(a)(2) provides that to implement IBR by January 1, 2013, the Administrative Director is authorize to contract – on substantially the same terms and without competitive bidding – with a review organizations providing IBR under contract with the Department of Managed Health Care (DMHC). The Department of Industrial Relations has contracted (DIR Agreement No. 41230041) with Maximus Federal Services, Inc. (Maximus), to provide IBR services under the Labor Code mandates. The fees set forth in the regulation are taken from the terms of the contract and are considered by the Administrative Director to be reasonable for the services provided. The payment procedure set forth in the regulation is necessary to ensure that Maximus is promptly and efficiently compensated for the dispute resolution services they are providing to the Division.

The requirement in subdivision ((d)(2) for the provider to submit documentation with the IBR request is necessary to efficiently and expeditiously determine if a billing dispute is eligible for IBR and to conserve the resources of the parties in providing documentation. The subdivision effectively resolves an internal contradiction in Labor Code section 4603.6(b). The first sentence of the statute's subdivision expressly provides that an IMR request "shall be made on a form prescribed by the administrative director, and shall include copies of the originally billing itemization, any supporting documents that were

furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final explanation of the second review." The last two sentences of the subdivision, however, indicate that only the form and proof of payment be filed with the administrative director and that the supporting documents be provided to the IBRO within 10 days from the notice of assignment for IBR. Defining an IBR request and then bifurcating the application process is untenable in view of the statute's overall goal of quickly resolving billing disputes.

Section 9792.5.8. Request for Independent Bill Review Form.

Specific Purpose.

This section sets forth the mandatory form by which a medical provider requests IBR under Labor Code section 4603.6. The DWC Form IBR-1 contains identifying information regarding the employee, the providing physician, the claims administrator, and the bill which is the subject of the dispute. The form further includes a section to be completed if the provider wishes to consolidate their request with another disputed billed service, and lists the documents that must accompany the IBR request.

Necessity:

The DWC Form IBR-1 is necessary to conform to Labor Code section 4603.6(b)'s mandate that the Administrative Director prescribe a form for a medical provider to initiate IBR. The information requested on the form is reasonable and will allow the Administrative Director to expediently and accurately make a determination that the billing dispute is subject to IBR.

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

Specific Purpose:

The purpose of this section is to advise the workers' compensation community of the procedure by which the Administrative Director conducts a preliminary review of an IBR request and submitted documentation to determine whether the identified billing dispute is eligible for IBR. In making this determination, the Administrative Director shall consider the timeliness and completeness of the request, the date of the services provided and whether a second bill review was conducted, whether the billed medical treatment services was authorized under Labor Code section 4610, if the provider paid the required IBR fee, if there were any previous or duplicate IBR requests for the same services, and whether the dispute contains any other issue than the amount of payment of the bill or is not covered under an applicable fee schedule or negotiated contract. If a request is eligible, the section advises that the IBRO shall send a notification to the medical provider and claims administrator stating the provider's IBR request has been submitted and appears eligible for assignment to an IBRO. The notification must also state that the claims administrator may submit evidence indicating that the request is ineligible for IBR and that such evidence must be submitted within a specific timeframe. Upon the receipt the evidence, or if no evidence is received within the specified timeframe, the Administrator Director must either: (a) issue a decision finding the IBR request ineligible and refunding the provider the amount of $270.00; or (b) assign the

request for IBR. Upon assignment, the IBRO must notify the parties of the IBRO's contact information, the IRB case number, and the billing dispute subject to determination. The IBRO must then assign the request to a conflict-free independent bill reviewer. If it is subsequently found that the bill reviewer has a conflict as described in in Labor Code Section 139.5 (c) (2), the IBRO must reassign the matter to a different independent bill reviewer.

Necessity:

The section is necessary to implement Labor Code section 4603.6's mandate that only the amount of payment on medical treatment bill or bill for medical-legal expenses is subject to resolution through IBR, and section 4603.6(b) and (d)'s requirements regarding the processing of an IBR application. To provide for the workers' compensation community the factual and legal considerations that may preclude IBR, the regulation lists the various factors the Administrative Director must take into consideration in making an eligibility determination. If an IBR request by a provider appears eligible for review, subdivision (b) requires that a notice be sent to the parties with the opportunity for the claims administrator to provide a statement disputing eligibility; this notice is necessary to ensure that the claims administrator has an opportunity to be heard during the IBR process. If, following a review of all submitted documents, the IBR request is found to be ineligible, a decision by the Administrative Director is issued and the provider is reimbursed a portion of the filing fee in the amount of $270.00. The $65.00 cost for the initial review, determined through consultation between the Division and the current IBRO (Maximus Federal Services, Inc.) is a reasonable estimate of the cost and administration of the preliminary review.

Section 9792.5.10. Independent Bill Review - Document Filing.

Specific Purpose:

The purpose of this section is to allow the independent bill reviewer to request additional information from the medical provider or the claims administrator if the information previously provided by the parties is insufficient to decide the billing dispute. The section advises that in response to such a request, the parties must file the documents with the independent bill reviewer 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.

Necessity:

The section implements the provisions of Labor Code section 4603.6(e), which allows the independent bill reviewer to request additional documents from the parties. A restatement in this section is necessary for the purpose of clarity; since the IBR program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules.

Subdivision (b) provides that if additional documents are requested by the independent reviewer, the parties shall file the requested documents with the reviewer "within 35 days of the request" if by mail, or "32 days of the request" if the request was made electronically. This language appears inconsistent with Labor Code section 4603.6(e), which provides "If additional documents are requested, the parties shall respond with the

documents requested within 30 days and shall provide the other party with copies of any documents submitted to the independent reviewer."

The timeframes set forth in the proposed regulation takes into consideration Code of Civil Procedure sections 1010.6 and 1013(a), which extend certain deadlines to act or respond to documents that are served by mail (5 additional days) or by an electronic method (2 additional days). The Division feels this extension is necessary to obviate any prejudice resulting from a delay in the receipt of a request for additional documents.

Section 9792.5.11. Withdrawal of Independent Bill Review.

Specific Purpose:

The section advises medical providers and claims administrator of the procedure by which to withdraw a request for IBR following the settlement of the billing dispute. The section expressly provides that a medical provider shall not be reimbursed the IBR filing fee if a withdrawal is made under this section.

Necessity:

Given the comprehensive IBR procedure set forth in Labor Code section 4603.6 and the adopted emergency regulations, it is necessary to advise the parties of the process to be used to withdraw an IBR request should the parties settle the billing dispute prior to the issuance of an IBR determination. To assist in the settlement process, it is further necessary to expressly state that the IBR filing fee will not be reimbursed if a request is withdrawn.

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

Specific Purpose:

The purpose of this section is to set forth the circumstances by which: (a) individual, separate requests for IBR may be consolidated into a single request; or (b) one request for IBR may be disaggregated into multiple IBR requests. The section first lists and defines the key terms used in consolidation/disaggregation: "common issues of law and fact," "delivery of similar or related services," and "pattern and practice." Subdivision (c) of the section then advises of the three circumstances for which the consolidation of IBR requests that involve common issues of law and fact or the delivery of similar or related services.is appropriate. These circumstances involve a single disputed billing code over multiple days of service, multiple disputed codes on a single day of service, and a pattern and practice of underpayment by a claims administrator. Subdivision (d) advises medical providers seeking the consolidation if IBR requests that, in addition to the filing fee of $335.00, the initial IBR request must specify how the possible consolidated requests involve common issues of law and fact or delivery of similar or related services. Subdivision (e) advises that a single IBR request submitted by a provider can be disaggregated should the standards of subdivision (c) not be met. A separate filing fee for each disaggregated request must then be paid by the provider for IBR to continue.

Necessity:

This section implements Labor Code section 4603.6(c), which provides that the Administrative Director "may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation…." The consolidation of IBR requests is necessary to ensure that IBR is effective as a dispute resolution mechanism as envisioned by the Legislature: requiring a medical provider to pay a separate filing fee for each billing code in dispute on one day of service, regardless of whether the same service is provided over multiple days or whether other related services are provided on the same day, would act as a disincentive for providers to initiate IBR over relatively small billing disputes. (The $4,000 cap in subdivisions (c)(1) and (c)(3) is reasonable to encourage the consolidation of lesser disputes that would likely not be taken to IMR based on the filing fee, and distinguish between larger disputes where the filing fee would not serve as a disincentive.) Further allowing the consolidation of IBR requests allowing common issues of law and fact – whether multiple disputed billing codes on a single date of service or a single disputed code on multiple dates of service would serve to eliminate the possibility of inconsistent decisions on essentially an identical fact pattern made by different independent bill reviewers. The consolidation of "pattern and practice" IBR requests, those disputes involving one provider, one claims administrator, one disputed billing code, and multiple injured employees, is necessary to address those instances when a claims administrator may improperly reimburse a specific billing code as a general practice; a single IBR determination with one filing fee could serve to resolve multiple requests. Conversely, the authority to disaggregate a single request for IBR into multiple requests is necessary to discourage medical providers from amassing dissimilar billing disputes into a single IMR request for the sole purpose of avoiding the payment of a larger IBR filing fee. Dissimilar billing disputes hiding under the umbrella of a single IBR request could require that an independent bill reviewer issue a finding beyond the scope of their expertise.

Section 9792.5.13. Independent Bill Review – Review.

Specific Purpose:

This section describes for the regulated community the fee schedules or standards that must be used by an independent bill reviewer to decide if any additional amounts are owed to a medical provider on a disputed medical treatment or medical-legal bill. If the IMR involves a medical treatment bill, the reviewer must apply the Official Medical Fee Schedule. If the IMR involves medical treatment and the provider and the claims administrator have agreed to contract for reimbursement rates under Labor Code section 5307.11, the terms of the contract must be applied. If the IMR involves a medical-legal bill, the reviewer must apply the Medical-Legal Fee Schedule. The section further advises that the reviewer shall apply the fee reimbursement schedules as if the bill is being reviewed for the first time.

Necessity:

This section is necessary to describe and clarify for the public the standards that will be used by an independent bill reviewer to resolve billing disputes under the IMR program. The use of adopted fee schedules, essentially objective standards, will reduce the

possibility that IMR decisions will be affected by subjective considerations or bias, or rely on findings made by the reviewer that are beyond the scope of their expertise.

Section 9792.5.14. Independent Bill Review – Determination.

Specific Purpose:

This section describes for the regulated community the obligations of the independent review organization upon receipt of all information necessary to conduct an independent bill review. The section advises of the requirements for an IBR determination by a independent bill reviewer: it must be in plain language, where possible, and the reasons for the determination and the information received and relied upon in rendering the determination. The section further advises that if the independent bill reviewer finds any additional amount of money is owed to the provider, the determination shall order the claims administrator to reimburse the provider the amount of the filing fee in addition to any additional payments for services found owing.

Necessity:

This section restates the express statutory requirements of Labor Code section 4610.6, subdivisions (e) and (f). A restatement in this section is necessary for the purpose of clarity in that Labor Code section 4603.6 establish comprehensive and detailed procedures for the IBR program. Rather than simply delegating to the Division authority to implement an IBR program, the Labor Code provision specifies the timeframe in which an IBR determination must issue and the contents of that determination. Further the statute expressly provides that the determination shall be deemed to be the determination of the Administrative Director and shall be binding on all parties. Since the IBR program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules.

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

Specific Purpose:

The purpose of this section is to: (1) set forth the obligations of the claims administrator upon an IBR determination that an additional amount of money is owed to the medical provider on either a bill for medical treatment services or a bill for medical-legal expenses submitted; and (2) advise the parties to IBR that the Administrative Director, upon a reversal of an IBR determination by the Workers' Compensation Appeal Board, with either refer the case to a different review organization designated by the Administrative Director to provide IBR services, or, if there is only one review organization, to a different IBR reviewer within that organization.

Necessity:

This section restates the express statutory requirements of Labor Code section 4603.6, subdivisions (f) through (h). A restatement in this section is necessary for the purpose of clarity in that Labor Code section 4603.6 establishes comprehensive and detailed procedures for the IBR program. Rather than simply delegating to the Division authority

to implement an IBR program, the Labor Code provision specifies the obligations of a claims administrator upon the issuance of an IBR determination that finds additional amounts owing to a medical provider and also the procedure that must be followed by the Administrative Director upon the reversal of an IBR decision. Since the IBR program is entirely new to workers' compensation in this state, a restatement of statutory provision is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of rules.

Section 9793. Definitions.

Specific Purpose:

This section lists and defines the key terms used in the medical-legal expenses and medical-legal evaluation regulations. The amended terms include "disputed medical fact," "explanation of review," and "supplemental medical-legal evaluation." The purpose of the definitions is to implement, interpret, and make specific Labor Code sections 4061, 4062, 4610.5, and 4622, and to ensure that the meanings of the terms are clearly understood by the workers' compensation community

Necessity:

Based on the establishment of the independent medical review process set forth in Labor Code section 4610.5, it is necessary to amend section 9793(e)(3) to set forth the periods of time during which a Qualified Medical Evaluator (QME) may resolve a disputed medical fact (i.e., for injuries that occurred before January 1, 2013, if the utilization decision is communicated to the requesting physician on or before June 30, 2013). It is necessary to add a definition for "explanation of review" as it is a necessary component of the second bill review process now mandated by Labor Code section 4622. The amendment of "supplemental medical-legal evaluation" in new subdivision (m) is necessary to account for the new factual correction procedure allowed for in Labor Code section 4061(d)(1).

Section 9794. Reimbursement of Medical-Legal Expenses.

Specific Purpose:

This section sets forth the billing and reimbursement procedures for medical-legal expenses authorized under Labor Code section 4620 et seq. The section is amended to require that a claims administrator use an explanation of review as described in Labor Code section 4603.3, when contesting a bill, and that the explanation of review provide notice of the second bill review procedure mandated by Labor Code section 4622(b). The section advises that a medical-legal provider who contests the amount of the payment of the bill after receipt of the explanation of review must request a second bill review under section 9792.5.5. The section further advises of the dispute resolution procedure for issues other than the payment of the bill, as mandated by Labor Code section 4622(c) through (e). The new subdivision (k) is amended to change the obligation to retain documents from three years to five years.

Necessity:

This section is necessary to implement Labor Code sections 4622(b)'s mandate that the second bill review process be used to should a medical-legal provider dispute the amount paid by a claims administrator on a medical-legal bill. The five year requirement in new subdivision (k) is necessary o make the retention of the bill for medical legal-services identical to medical-legal retention requirement for QME's which appears at section 39.5 of these regulations.

Section 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

Specific Purpose:

The purpose of section 9795 is to set forth the parameters for different types of medical-legal evaluation, and the fees to be allowed for the evaluations. Code ML 103, complexity factor (6) has been amended to delete "or if a bona fide issue of medical causation is discovered in the evaluation." Code ML 103, complexity factor (8), addressing the issue of "medical monitoring" of an injured worker following of several named types of occupational exposures, has been deleted. In addition, complexity factor (10) is renumbered to (9) and is amended to limit evaluations concerning a utilization review decision to injured workers whose injuries occurred before January 1, 2013 if the utilization review decision was communicated to the employee's requesting physician before June 30, 2013.

Necessity:

The amendments to this section are necessary to conform to the requirements of Labor Code section 4062 as amended by SB 863. The deletion of the complexity factor for medical causation discovered by the QME is because the parties define issues through objections to made to medical determinations made by the injured worker's primary treating physician or through the request of a party to address a particular issue. See Labor Code sections 4060, 4061 and 4062; and section 9785 of these regulations. Further, addressing the issue of compensability is the basic function of a Labor Code section 4060 evaluation, and therefore does not warrant enhanced fees. Medical monitoring of an injured worker for various occupational exposures is deleted as a complexity factor because it is a consequence of a medical treatment disputes which after July 1, 2013 will no longer be the subject of QME examination. The new complexity factor (9) under Code ML 103 accounts for the limited period during which QME may still conduct an evaluation following an adverse utilization review decision.

8. Economic Impact Analysis

Evidence Supporting Finding of No Significant Statewide Adverse Impact Directly Affecting Business.

The Administrative Director has determined that the proposed regulations will not have a significant adverse impact on business. Last year, over 400,000 liens seeking payment for medical expenses were filed were filed with the Workers' Compensation Appeals Board. Approximately 80,000 of these liens had billing issues that could have been

candidates for IBR if it had been in effect. (Based on CHSWC Liens Report finding 17% of liens were solely for billing issues and another 20% had multiple issues, some of which could become candidates for IBR depending on the outcomes of the other issues). The cost of IBR – the fee paid by medical providers to initiate the process - will probably deter both groundless billing disputes by the medical providers and small-dollar medical disputes. Approximately 10,000 to 20,000 billing disputes per year will go to IBR, and the cost of IBR payable by the medical provider will be in most cases $335.00. The number of disputes will vary according to the provider's share of the $6 billion annual medical spending in Workers' Compensation system.

Creation or Elimination of Jobs within the State of California

The regulations establish an independent bill review program, a system that shifts the dispute resolution process for disputes over the amount of payment made on a medical treatment bill or a bill for medical-legal expenses from workers' compensation judges to conflict-free payment and billing experts applying fee schedules adopted by the Administrative Director. Accordingly, the Administrative Director has determined that the proposed regulations will not have a significant adverse impact on jobs within the State of California.

Creation of New or Elimination of Existing Businesses Within the State of California, or the Expansion of Business Within the State of California

Annual ongoing costs for a typical business to comply with the IBR regulations will be approximately $1,200 to $1,500 per year. Most of the affected businesses are medical providers – such as physicians – with fewer than 100 employees. The measurable increase in cost for medical providers will be partially offset by more rapid and accurate payment of accounts receivable, however those offsetting savings cannot be adequately estimated. Accordingly, the Administrative Director has determined that the proposed regulations will not create, eliminate, or expand businesses within the State of California.

Benefits of the Regulations

Unquantifiable benefits will result from the deterrence of frivolous disputes on the part of either providers or payers and from the swift resolution of legitimate billing disputes. Eventual savings for California employers from the reduction in lien litigation are estimated to be similar to the $106 million that the WCIRB attributed to the lien filing fee. (WCIRB Evaluation of the Cost Impact of Senate Bill No. 863, Updated October 12, 2012.) Local government employers will likely experience savings of approximately $15 million annually based on the reduction in lien litigation while the state may experience savings of approximately $4 million beginning Fiscal Year 2013-14 for the same reason.