Independent Bill Review Regulations

Title 8, California Code of Regulations
Chapter 4.5 Division of Workers' Compensation
Subchapter 1 Administrative Director – Administrative Rules

Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011

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

(a) The *California Division of Workers' Compensation Medical Billing and Payment Guide,* versions listed below, ~~version 1.1,~~ which set~~s~~ forth billing, payment and coding rules for paper and electronic medical treatment bill submissions, ~~is~~ are incorporated by reference. ~~It~~ They may be downloaded from the Division of Workers' Compensation through the Department of Industrial Relations' website at www.dir.ca.gov or may be obtained by writing to:

DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
ATTN: MEDICAL BILLING AND PAYMENT GUIDE
P.O. BOX 71010
OAKLAND, CA 94612

(1) California Division of Workers' Compensation Medical Billing and Payment Guide 2011, for bills submitted on or after October 15, 2011.
(2) California Division of Workers' Compensation Medical Billing and Payment Guide, Version 1.1, for bills submitted on or after January 1, 2013.
(3) California Division of Workers' Compensation Medical Billing and Payment Guide, Version 1.2, for bills submitted on or after [OAL to insert effective date of regulations], 2014.

(b) The *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide,* versions listed below, ~~version 1.1,~~ which set~~s~~ forth billing, payment and coding rules and technical information for electronic medical treatment bill submissions, ~~is~~ are incorporated by reference. ~~It~~ They may be downloaded from the Division of Workers' Compensation website at www.dir.ca.gov or may be obtained by writing to:

DIVISION OF WORKERS' COMPENSATION
MEDICAL UNIT
ATTN: MEDICAL BILLING AND PAYMENT COMPANION GUIDE
P.O. BOX 71010
OAKLAND, CA 94612

(1) California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.0, dated 2012, for bills submitted on or after October 18, 2012.
(2) California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.1, for bills submitted on or after January 1, 2013.
(3) California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, Version 1.2, for bills submitted on or after [OAL to insert effective date of regulations], 2014.

~~(c) The HIPAA-approved Technical Reports Type 3 for billing listed in subdivision (c)(1) through (3) are incorporated by reference. They may be obtained for a fee from the ASC X12*'s* Secretariat, the Data Interchange Standards Association (DISA):~~

~~Data Interchange Standards Association (DISA) at http://store.x12.org~~

~~(1)(A) ASC X12N/005010X222~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Professional (837)~~
~~MAY 2006~~

~~(B) ASC X12N/005010X222E1~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Professional (837)~~
~~Errata~~
~~January 2009~~

~~(C) ASC X12N/005010X222A1~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Professional (837)~~
~~Errata~~
~~June 2010~~

~~(2)(A) ASC X12N/005010X223~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Institutional (837)~~
~~MAY 2006~~

~~(B) ASC X12N/005010X223A1~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Institutional (837)~~
~~Errata Type 1~~
~~OCTOBER 2007~~

~~(C) ASC X12N/005010X223E1~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Institutional (837)~~
~~Errata~~
~~JANUARY 2009~~

~~(D) ASC X12N/005010X223A2~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Institutional (837)~~
~~Type 1 Errata~~
~~June 2010~~

~~(3)(A) ASC X12N/005010X224~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Dental (837)~~
~~MAY 2006~~

~~(B) ASC X12N/005010X224A1~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Dental (837)~~
~~Errata Type 1~~
~~OCTOBER 2007~~

~~(C) ASC X12N/005010X224E1~~
~~Based on Version 5, Release 1~~
~~ASC X12 Standards for Electronic Data Interchange~~
~~Technical Report Type 3~~
~~Health Care Claim: Dental (837)~~

Errata
JANUARY 2009

(D) ASC X12N/005010X224A2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim: Dental (837)
Errata
June 2010

(d) The HIPAA-approved implementation guides for pharmacy billing listed in subdivision (d)(1) and (2) are incorporated by reference. They may be obtained for a fee from the National Council for Prescription Drug Programs (NCPDP), 9240 E. Raintree Drive, Scottsdale, AZ 85260; Telephone (480) 477–1000; and FAX (480) 767–1042. They may also be obtained through the Internet at *http://www.ncpdp.org*.

(1) Telecommunication Standard Implementation Guide Version D.0, August 2007, National Council for Prescription Drug Programs.

(2) The Batch Standard Implementation Guide, Version 1.2, 2006, National Council for Prescription Drug Programs.

(e) The following HIPAA-approved Technical Report Type 3 and errata, for acknowledgment and remittance are incorporated by reference:
(1)(A) ASC X12C/005010X231
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Implementation Acknowledgment for Health Care Insurance (999)
June 2007

(B) ASC X12C/005010X231A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Implementation Acknowledgment for Health Care Insurance (999)
June 2010

(2)(A) ASC X12N/005010X214
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange

Technical Report Type 3
Health Care Claim Acknowledgment (277)
January 2007

(B) ASC X12N/005010X214E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Acknowledgment (277)
April 2008

(C) ASC X12N/005010X214E2
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Acknowledgment (277)
January 2009

(3)(A) ASC X12N/005010X221
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
APRIL 2006

(B) ASC X12N/005010X221E1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
JANUARY 2009

(C) ASC X12N/005010X221A1
Based on Version 5, Release 1
ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3
Health Care Claim Payment/Advice (835)
Errata
June 2010

They may be obtained for a fee from the Data Interchange Standards Association (DISA) at: http://store.x12.org

(f) The *National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version*, Version 6.0 07/10, and the 1500 Form (revised 08-05) are incorporated by reference. The manual can be obtained directly from the National Uniform Claim Committee at:
http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42 .

(g) The *National Uniform Billing Committee Official UB-04 Data Specifications Manual 2011, Version 5.0, July 2010*, including the UB-04 form, is incorporated by reference. The manual can be obtained from the National Uniform Billing Committee at http://www.nubc.org/become.html by becoming a UB-04 committee paid subscriber.

(h) The *Manual Claim Forms Reference Implementation Guide Version 1.Ø*, October 2008, National Council of Prescription Drug Programs (NCPDP) Data Specifications Manual including the NCPDP paper WC/PC Universal Claim Form Version 1.1 – 05/2009, except pages 13-36, is incorporated by reference. The manual can be obtained from the NCPCP's vendor at:
www.communiform.com/ncpdp.

(i) The CDT 2011-2012: ADA Practical Guide to Dental Procedure Codes, including the ADA 2006 Dental Claim Form, is incorporated by reference. The manual can be obtained from the American Dental Association at:

AMERICAN DENTAL ASSOCIATION
http://www.ada.org/
211 East Chicago Ave.
Chicago, IL 60611-2678

Or on the web at:

http://www.ada.org/

Authority: Sections 133, 4603.4, 4603.5 and 5307.3, Labor Code.
Reference: Section 4600, 4603.2 and 4603.4, Labor Code.

Section 9792.5.3 – Medical Treatment Bill Payment Rules.

(a) On and after October 15, 2011, claims administrators shall conform to the payment, communication, penalty, and other provisions contained in the *California Division of Workers' Compensation Medical Billing and Payment Guide*, except that the provisions relating to the payment of electronic medical bills shall become effective on October 18, 2012. This subdivision does not apply to processing or payment of bills submitted before October 15, 2011.

(b) On and after October 18, 2012, claims administrators shall conform to the payment, communication, penalty, and other provisions contained in the *California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.*

Authority: Sections 133, 4603.3, 4603.4, 4603.5 and 5307.3, Labor Code.
Reference: Section 4600, 4603.2, 4603.3 and 4603.4, Labor Code.

§ 9792.5.4 . Second Review and Independent Bill Review – Definitions

This 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) "Amount of payment" means the amount of money paid by the claims administrator for either:

(1) Medical treatment services or goods rendered by a provider or goods supplied in accordance with Labor Code section 4600 that ~~was~~ 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 ~~located~~ at sections 9789.10 to 9789.111, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.

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

(b) "Billing Code" means those codes adopted by the Administrative Director for use in the Official Medical Fee Schedule, located at sections 9789.10 to 9789.111, or in the Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).

(c) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(d) "Contested liability" means the existence of a good-faith issue which, if resolved against the injured worker, would defeat the right to any workers' compensation benefits or the existence of a good-faith issue that would defeat a provider's right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 4620.

(e) "Consolidation" means combining two or more requests for independent bill review together for the purpose of having the payment reductions contested in each request resolved in a single determination.

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

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

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

(i) “Provider” means a provider of medical treatment services or goods, including a health care facility as defined in Section One of the California Division of Workers’ Compensation Medical Billing and Payment Guide as incorporated by reference in section 9792.5.1, whose billing processes are governed by Labor Code section 4603.2 or 4603.4, or a provider of medical-legal services whose billing processes are governed by Labor Code sections 4620 and 4622, that has requested a second bill review and, if applicable, independent bill review to resolve a dispute over the amount of payment for services according to either a fee schedule established by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11. A provider may utilize the services of a billing agent, a person or entity that has contracted with the provider to process bills under this article for services or goods rendered by the provider, to request a second bill review or independent bill review.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

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

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services or goods 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.

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

(1) The date of service of the explanation of review provided by a claims administrator in conjunction with the payment, adjustment, or denial of the initially submitted bill, if a proof of service accompanies the explanation of review.

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

(B) If the explanation of review is sent by mail and if in the absence of a proof of service or documentation of receipt, the date of service is deemed to be five (5) calendar days after the date of the United States postmark stamped on the envelope in which the explanation of review was mailed.

(2) The date of service of an order of the Workers' Compensation Appeal Board resolving any threshold issue that would preclude a provider's right to receive compensation for the submitted bill.

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

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

(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The second review bill shall be marked using the National Uniform Billing Committee (NUBC) Condition Code Qualifier "BG" followed by NUBC Condition Code "W3" in the field designated for that information to indicate a request for second review, or, for the ADA Dental Claim Form 2006 ~~form~~, or ADA Dental Claim Form (2012), the words "Request for Second Review" will be marked in Field 1, or for the NCPDP WC/PC Claim Form, the words "Request for Second Review" may be written on the form.

(B) ~~Requested on the~~ The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6. The DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider.

(2) For an electronic medical treatment bills for professional, institutional or dental services, the request for second review shall be submitted on the correct electronic standard format, utilizing the National Uniform Billing Committee (NUBC) Condition Code Qualifier "BG" followed by NUBC Condition Code "W3" as specified in the Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.

(3) For an electronic pharmacy bill that used either the NCPDP Telecommunications D.0 or the NCPDP Batch Standard Implementation Guide 1.2, the method for identifying a request for second review may be addressed in the trading partner agreement, or the second review may be requested on the DWC Form SBR-1.

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

(d) The request for second review shall include:

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

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

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

(B) The item and amount in dispute.

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

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

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

(f) 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) of this section.

~~(f)~~(g) Within 14 days of receipt of a request for second review that complies with the requirements of subdivision (d), the claims administrator shall respond to the provider with a final written determination on each of the items or amounts in dispute by issuing an explanation of review. The determination shall contain all the information that is required to be set forth in an explanation of review under Labor Code section 4603.3, including an explanation of the time limit to raise any further objection regarding the amount paid for services and how to obtain independent bill review under Labor Code section 4603.6. The 14 day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the claims administrator.

~~(1) The 14-day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the claims administrator.~~

~~(2) Any properly documented itemized service provided and not paid within the timeframes described in Labor Code section 4603.2(b)(2) and (3) shall be paid at the rates then in effect and increased by fifteen (15) percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the provider's initial itemized billing, if the claims administrator untimely communicates the final written determination under this section.~~

~~(g)~~ (h) Based on the results of the second review, ~~P~~payment of any balance no~~t~~ 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)~~(i) If the provider further contests the amount paid after receipt of the final written determination following a second review, the provider shall request an independent bill review pursuant to this Article.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

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

Provider's Request for Second Bill Review. DWC Form SBR-1.
[Please print Form DWC Form SBR-1 here]

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.7. Requesting Independent Bill Review.

(a) If the provider further contests the amount of payment made by the claims administrator on a bill for medical treatment services or goods rendered on or after January 1, 2013, submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses incurred on or after January 1, 2013, submitted pursuant to Labor Code section 4622, following the second review conducted under section 9792.5.5, the provider shall request an independent bill review. Unless consolidated under section 9792.5.12, a request for independent bill review shall only resolve:

(1) For a bill for medical treatment services or goods, a dispute over the amount of payment for services or goods billed by a single provider involving one injured employee, one claims administrator, and either one date of service, and one billing code or one hospital stay, under the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.

(2) 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.

(b) Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review. Issues that are not eligible for independent bill review shall include:

(1) The determination of a reasonable fee for services where that 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.

(2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.

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

(1) The date of service of the final written determination issued by the claims administrator under section 9792.5.5(f), if a proof of service accompanies the final written determination.

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

(3) The date that is five (5) calendar days after the date of the United States postmark stamped on the envelope in which the final written determination was mailed if the final written determination is sent by mail and there is no proof of service or documentation of receipt.

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

(5) The date of service of an order of the Workers' Compensation Appeal Board resolving in favor of the provider any threshold issue that would have precluded a provider's right to receive compensation for medical treatment services or goods provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 4620.

(d)(1) The request for independent bill review shall be made in one of the following manners:

(A) Completing and electronically submitting the online Request for Independent Bill Review form, which can be accessed on the Internet at the Division of Workers' Compensation's website. The website link for the online form can be found at ~~https://ibr.dir.ca.gov.~~ http://www.dir.ca.gov/dwc/IBR.htm. Electronic payment of the required fee of $335.00 shall be made at the time the request is submitted.

(B) Mailing the Request for Independent Bill Review form, DWC Form IBR-1, set forth in section 9792.5.8, and simultaneously paying the required fee of $335.00 as instructed on the form.

(2) The provider ~~will~~ shall include with the request form submitted under this subdivision, either by electronic upload or by mail, a copy of the following documents which shall be indexed and arranged so that each of the following categories of documents can be separately identified:

(A) The original billing itemization;

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

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

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

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

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

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

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

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

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.8. Request for Independent Bill Review Form

Request for Independent Bill Review. DWC Form IBR-1.
[Please print Form DWC Form IBR-1 here]

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

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

(a) Upon receipt of the Request for Independent Bill Review under section 9792.5.7, the Administrative Director, or his or her designee, shall conduct a preliminary review to determine whether the request is ineligible for review. In making this determination, the Administrative Director shall consider:

(1) The timeliness and completeness of the request;

(2) The date the medical treatment services or goods were rendered or the medical-legal expenses incurred ~~If a second request for review of the bill was completed~~;

(3) Whether the second request for review of the bill under section 9792.5.5 was timely requested by the provider;

(4) Whether the second review of the bill under section 9792.5.5 was timely completed by the claims administrator;

~~(3)~~(5) Whether, for a bill for medical treatment services or goods, the medical treatment was authorized by the claims administrator under Labor Code section 4610.

~~(4)~~(6) If the required fee for the review was ~~not~~ paid pursuant to section 9792.5.7(d)(1)(A) or (B);

~~(5)~~ (7) Any previous or duplicate requests for independent bill review of the same bill for medical treatment services or bill for medical-legal expenses.

~~(6)~~ (8) If the dispute between the provider and the claims administrator is ineligible under section 9792.5.7(b) or contains any other issue than the amount of payment of the bill.

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

(b) If the request appears eligible for review, the Administrative Director, or his or her designee, shall within fifteen (15) days of the determination, notify the provider and the claims administrator by the most efficient means available that request for independent bill review has been submitted and appears eligible for assignment to an IBRO. The notification shall contain:

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

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

(3) A statement that the claims administrator may dispute both eligibility of the request for independent bill review under subdivision (a) and the provider's reason for requesting independent bill review by submitting a statement with supporting documents, and that the Administrative Director or his or her designee must receive the statement and supporting documents within fifteen (15) calendar days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically.

(c) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(3) must be concurrently served on the ~~other party~~ provider. Any document that was previously provided to the ~~other party~~ provider or originated from the ~~other party~~ provider need not be served if a written description of the document and its date is served.

(d) Upon receipt of the documents requested in subdivision (b)(3), or, if no documents have been received, upon the expiration of fifteen (15) days of the date designated on the notification, if the notification was provided by mail, or within twelve (12) days of the date designated on the notification if the notification was provided electronically, the Administrative Director, or his or her designee, shall conduct a further review in order to make a determination as to whether the request is ineligible for independent bill review under subdivision (a).

(e) If the review conducted under either subdivision (a) or subdivision (d) finds that the request is ineligible for independent bill review, the Administrative Director shall, within fifteen (15) days following receipt of the documents requested in subdivision (b)(3) or, if no documents are received, the expiration of the time period indicated above, issue a written determination informing the provider and claims administrator that the request is not eligible for independent bill review and the reasons therefor.

(1) If a request is deemed ineligible under this section, the provider shall be reimbursed the amount of $270.00.

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

(f) If the Administrative Director or his or her designee determines from the review conducted under subdivision ~~(a) or~~ (d), ~~whichever applies,~~ that the request is eligible for independent bill review, the Administrative Director shall assign the request to an IBRO for an independent bill review. Upon assignment of the request, the IBRO shall notify the

parties in writing that the request has been assigned to that organization for review. The notification shall contain:

(1) The name and address of the IBRO;

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

(3) Identification of the claim and disputed amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622,

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

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

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

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.10. Independent Bill Review - Document Filing.

(a) The independent bill reviewer assigned the request shall review all information provided by the parties to determine if any additional information is necessary to resolve the dispute. If the independent bill reviewer determines that additional information is necessary, the independent bill reviewer shall contact the claims administrator and the provider in writing to request the information.

(b) If the independent bill reviewer requests information from either the claims administrator or the provider, or both, the party shall file the documents with the independent bill reviewer at the address listed in the correspondence in Section 9792.5.9(f). The requested documents 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 filing party shall concurrently serve the non-filing party with the documents requested by the independent bill reviewer.

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

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.11. Withdrawal of Independent Bill Review.

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) Following the submission of all required documents under section 9792.5.10 or 9792.5.12, the provider may withdraw his or her request for independent bill review, before a determination on the amount of payment owed, if the provider and claims administrator settle their dispute regarding the amount of payment of the medical bill. If the provider and claims administrator settle their dispute, they shall make a written joint request for withdrawal and serve it on the independent bill reviewer~~.

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

(b) If ~~a~~ the request ~~for independent bill review~~ is withdrawn ~~under this section~~ 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).

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

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

(a) With a request for independent bill review submitted under section 9792.5.7, a provider may request combining two or more requests, with a maximum of twenty (20), for independent bill review ~~together~~ for the purpose of having the payment reductions contested in each request resolved in a single determination issued under section 9792.5.14.

(b) In applying this section, the following definitions shall be used:

(1) "Common issues of law and fact" means the denial or reduction of the amount of payment in each request was made for similar reasons and arose from a similar fact pattern material to the reason for the denial or reduction.

(2) "Delivery of similar or related services" means like or coordinated medical treatment services or ~~items~~ goods, or medical-legal services, provided to one or more injured employees.

(c) Two or more requests, with a maximum of twenty (20), for independent bill review by a single provider may be consolidated if the Administrative Director or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services.

(1) Requests for independent bill review by a single provider involving multiple dates of medical treatment or medical-legal services may be consolidated and treated as one single independent bill review request if the requests involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, and the total amount in dispute does not exceed $4,000.00.

(2) Requests for independent bill review by a single provider involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service.

(3) ~~Upon a showing of good cause and~~ ~~a~~After consultation with the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Requests to be consolidated under the subdivision shall involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service, and aggregated amounts in dispute up to $4,000.00 or individual amounts in dispute less than $50.00 each.

(d) Upon filing a request for independent bill review under section 9792.5.7, the provider, if requesting the consolidation of separate requests, shall, in addition to providing the filing fee of $335.00, specify all of the requests for independent bill review sought to be consolidated with a description of how the requests involve common issues of law and fact or delivery of similar or related services. Once consolidation has been granted no other disputes shall be added to the consolidated disputes.

(e) The IBRO may disaggregate into separate independent bill review requests a single request that does not meet the standards set forth in subdivision (c) of this section. For any independent bill review request that must be disaggregated, the same fee shall be charged for each additional independent bill review request as charged for one independent bill review request.

(1) If an independent bill review request must be separated, the IBRO shall immediately provide notice in writing to the provider and claims administrator stating the reasons for disaggregation, and shall inform the provider of the additional fee or fees required to perform the independent bill review.

(2) Within ten (10) days following receipt of the notification informing the provider of the separation of requests, the provider shall submit to the IBRO any additional fee or fees necessary to conduct independent bill review. The failure to provide the additional fee or fees shall subject the request to a determination of ineligibility under section 9792.5.9.

(f) Nothing in this section shall extend the time for issuing a determination required by Labor Code section 4603.6 (e).

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.13. Independent Bill Review – Review.

(a) If the request for independent bill review involves the application of the Official Medical Fee Schedule (OMFS) for the payment of medical treatment services or goods as defined in Labor Code section 4600, the independent bill reviewer shall apply the provisions of sections 9789.10 to 9789.111 to determine the additional amounts, if any, that are to be paid to the provider.

(b) If the request for independent bill review involves the application of a contract for reimbursement rates under Labor Code section 5307.11 for the payment of medical treatment services as defined in Labor Code section 4600, the independent bill reviewer shall apply the contract to determine the additional amounts, if any, that are to be paid to the provider.

(c) If the request for independent bill review involves the application of the Medical-Legal Fee Schedule (M/L Fee Schedule) for services defined in Labor Code section 4620, the independent bill reviewer shall apply the provisions of sections 9793-9795 and 9795.1 to 9795.4 to determine the additional amounts, if any, that are to be paid to the provider.

(d) In applying this section, the independent bill reviewer shall apply the provisions of the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, as if the bill is being reviewed for the first time. The independent bill review shall also apply as necessary all billing, payment, and coding rules adopted under this Article.

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

§ 9792.5.14. Independent Bill Review - Determination

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

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

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

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

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.

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

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

(b) Pursuant to Labor Code section 4603.6(f), ~~T~~the provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by filing a ~~verified~~ petition with the Workers' Compensation Appeals Board ~~and serving a copy on all interested parties, including the Administrative Director, within 20 days of mailing of the determination~~.

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

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

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

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

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

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

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

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

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

Authority: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code.
Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6, Labor Code.