

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|--|---|-----------------------------|
| 9792.5.5 | <p>Commenter states that under this section there are two methods for requesting a second bill review on a non-electronic medical treatment bill: (1) submitting the initially reviewed bill on a CMS 1500 or UB04; or (2) submitting a Request for Second Bill Review form (DWC Form SBR-1). Commenter recommends that the DWC adopt a single method. Specifically, the DWC should require the Second Bill Review form (DWC Form SBR-1) to be attached to either the modified CMS 1500 or UB04 forms. Commenter states that this would provide both the necessary billing information and prominently distinguish request for second bill reviews. Commenter opines that having one standard process will promote uniformity and efficiency within the IBR process.</p> | <p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, the Administrative Director has been tasked with the responsibility to ensure that all health providers and facilities submit medical bills for payment on standardized forms. Labor Code section 4603.4(a). An SBR request on a standardized form should streamline billing processes and assist in the expedient second review of a medical bill.</p> | <p>No action necessary.</p> |
| 9792.5.5(b)(3) | <p>Commenter appreciates the Division clarifying that the 90-day time limit for requesting a second review may be extended by mutual agreement. This will give both parties additional time to resolve disputes.</p> | <p>Diane Przepiorski Executive Director California Orthopaedic Association December 23, 2013 Written Comment</p> | <p>The Division appreciates the comment.</p> | <p>No action necessary.</p> |
| General Comment | <p>Commenter requests that the Division convene a work group to evaluate the Independent Bill Review process. Commenter states that some providers</p> | <p>Diane Przepiorski Executive Director California Orthopaedic</p> | <p>The Division is considering this suggestion.</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|---|--|--|-----------------------------|
| | <p>have filed an IBR in June, 2013 and they have yet to have a resolution of their claim. Commenter opines that this is unreasonable and will unfairly discourage providers from filing an IBR if their claims are not resolved in a more timely manner. Just as payors are concerned about the mounting costs of IMR, providers are concerned about the mounting costs of collecting legitimate reimbursements due to them.</p> | <p>Association December 23, 2013 Written Comment</p> | | |
| <p>General Comment?</p> | <p>Commenter would like to know if there be any clarification or language on corrected billings (bill type 137) as they relate to 2nd review and IBR, as well as timelines. The billing guidelines indicate that 137 type bills go out without a condition code "w3" so this would indicate that they are not considered 2nd review, but claims administrators(not all) are taking the stance that any billing that they receive is considered a review. Therefore, a corrected bill is being determined to be a 2nd review even though it does not fit within the language of a 2nd review request (ie-it is not submitted with a W3 condition code, it is not submitted with a DWF Form SBR-1, it may include</p> | <p>Marko Vucurevic Supervisor A/R Analytics</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|--|--|---|---|----------------------|
| | additional billing codes, it is not submitted with an EOR/item in dispute/etc as required if a request for 2nd review). Commenter would guess that this does not constitute a request for 2nd review; however, this is not addressed in the regs. Commenter would like to know how and if this affects the timeline requirements for SBR/IBR is open for debate, but some guidance would be greatly appreciated. | | | |
| General Comment | Commenter would like to know that if a claims administrator makes no payment and sends an EOR requesting additional information, if this specifically requires a 2nd review request form effectively eliminating a 2nd review request if there is an actual dispute of the amount paid once an actual payment is made. There would be no recourse but to pursue IBR, adding \$335 to the cost of the claim. | Marko Vucurevic Supervisor A/R Analytics | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | No action necessary. |
| General Comment: Second Review and IBR | Commenter states that a lot of insurance companies do not respond to a second bill review and that this needs to be addressed. Commenter states that he cannot proceed to the IBR without the insurance company response. Commenter recommends that the matter be allowed to go to | Anonymous December 13, 2013 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. A billing dispute not eligible for IBR can be resolved before the WCAB. | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------------|--|---|--|----------------------|
| | IBR but that the insurance company pay the fee or alternatively, this be disputed before a WCAB judge. | | | |
| General Comment: IBR | <p>Commenter opines that it is too costly to fight over each fee reduction from the doctor’s standpoint and that about 33% of time, the insurance company refuses to pay for review of ame/qme report. Commenter states that under code 99358 (payment is 36.34 for 1/4 hour) and that he usually charges for 1/4 or 1/2 hour. Commenter is a psychologist and many of his patients find it medically necessary to call in between appointments .These charges for phone consultations range from 11.70 to 66.72. They are denied about 20 % of the time. It is not really cost effective for him to spend his time and his staff time to request a second review, but he does so. The time and cost risk of IBR is not worth it.</p> <p>Commenter request that the Division allow the doctor to appeal all disputes at the end of the case so they can just spend time only once fighting fees paid incorrectly rather than fighting each instance.</p> | Anonymous December 13, 2013 Written Comment | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> <p>In addition, in regard to commenter’s request to “appeal all disputes at the end of the case”, the Labor Code prescribes the periods for “appeal” (second review within 90 days of service of EOR, and IBR within 30 days of service of EOR) and does not allow the dispute resolution request to be delayed to the “end of the case.”</p> | No action necessary. |
| General Comment: E-billing | Commenter opines given the lack of preparedness by claims administrators | Catherine Montgomery | The comment does not address the substantive changes made | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|---|--|--|--------|
| | <p>for the new RBRVS physician fee schedule, commenter fears that the impending changes in reimbursement will force providers to dispute incorrect reimbursements arising from the new fee schedule by submitting exponentially more requests for second reviews and filing subsequent IBRs.</p> <p>Commenter sees a problem with lack of compliance by claims administrators with e-billing payment; claims administrators routinely ignore their duties as required by Administrative Director's Medical Billing Guideline, including but not limited to the following egregious and systematic violations:</p> <ol style="list-style-type: none"> 1) Not processing compliant requests for second review. 2) Incorrectly denying compliant requests for second review. 3) Issuing non-compliant EORs 4) A large number of claims administrators continue to refuse to process e-bills but providers have no recourse to force claims administrators to comply with the Administrative Director's rules | <p>DaisyBill December 26, 2013 Written Comment</p> | <p>to the proposed regulations during the 2nd 15-day comment period. Commenter provides a list of perceived difficulties with the e-billing process, all of which allege non-compliance of system participants with the existing ebilling rules. Commenter does not make suggestions directed at the regulatory proposal that is pending in this comment period.</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|---|--|----------------------|
| | or the enacted Labor Code. | | | |
| General Comment: IBR | Commenter opines that it is critical that IBR decisions are issued in 30 days or less of initial filing. | Catherine Montgomery DaisyBill December 26, 2013 Written Comment | Labor Code section 4603.6(e) allows IBRO up to 60 days to issue a decision upon assignment from the Administrative Director. | No action necessary. |
| 9792.5.5(c)(1)(B) | Commenter is in support of the change made indicating “first” page. Sifting through paper can lead to processing errors and delays in responding. | Lisa Anne Forsythe, Senior Compliance Consultant Coventry Workers’ Compensation Services December 26, 2013 Written and Oral Comment | The Division appreciates the comment. | No action necessary. |
| 9792.5.6 DWC Form SBR-1 | Commenter recommends that the Division ensure that this remains a one page form. | Diane Przepiorski Executive Director California Orthopaedic Association December 23, 2013 Written Comment | The Division intends to keep the form to one page. | No action necessary. |
| 9792.5.8 DWC Form IBR-1 | Commenter recommends that the Division ensure that this remains a one page form. Commenter notes that the city/state/zip fields have been deleted; however, the claims administrator’s address is being retained. Commenter | Diane Przepiorski Executive Director California Orthopaedic Association December 23, 2013 Written Comment | The address for the provider and claims administrator, including the city, state, and zip, should be provided on the address line. The requirements of the form are reasonable; all information | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|---|--|----------------------|
| | <p>speculates that this information was inadvertently overlooked when revising the form and should also be deleted.</p> <p>Commenter questions the necessity of the “contact person” field under the Claims Administrator area. Commenter opines that this field is redundant and unnecessary.</p> <p>Commenter opines that the providers should only be required to complete all fields under the Claims Administrator section if this information is known and that one incompleted field should not make the request invalid.</p> | | requested should be within the possession of the provider. | |
| 9792.5.1 | Commenter has issue with, “the date to be inserted by OAL.” Commenter opines that it is easier to plan with specific effective dates. | Lisa Anne Forsythe, Senior Compliance Consultant Coventry Workers’ Compensation Services December 26, 2013 Written and Oral Comment | The Division balanced the benefits of inserting a “specific” effective date against the benefits of adopting the new guides as soon as possible by the mechanism of OAL inserting the effective date. The Division determined that benefits weigh in favor of adopting the new guides as soon as possible, which entails OAL inserting the date. | No action necessary. |
| 9792.5.11 | Commenter appreciates the revised | Jeremy Merz | The comment does not address | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|--|--|--------|
| | <p>language that allows a provider to withdraw their request at any time prior to a final determination being made.</p> <p>Commenter is disappointed that his previous recommendation that a claims administrator be allowed to unilaterally withdraw in a situation where the disputed amount is paid in full prior to a final determination was not incorporated in this revision. § 9792.5.11 (a) provides for the reimbursement of \$270 to the requesting provider. Commenter states that in a situation where the disputed amount is paid in full prior to a final determination the requesting provider has no incentive to withdraw the IBR request because they would receive an additional \$65 if the process is completed and the claims administrator has to reimburse the IBR fee. Commenter opines that the incentives are aligned in a way that perpetuates disputes that have already been resolved and that allowing a claims administrator to unilaterally withdraw an IBR request under these limited circumstances would help to resolve disputes more quickly.</p> | <p>California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation December 20, 2013 Written Comment</p> | <p>the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, allowing a claims administrator to unilaterally withdraw an IBR request offers no assurance or guarantee that any dispute over the reimbursement of filing fee has been resolved.</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|---|--|---|------------------------|
| 9792.5.11 | <p>Commenter recommends the following revised language:</p> <p>“The provider may, concurrent with written notice to the claims administrator, withdraw a request for independent bill review at any time prior to the issuance of a final determination on the amount owed under section 9792.5.14 <u>If the claims administrator pays the disputed amount to the provider before the determination, the claims administrator will notify the provider, Administrative Director, IBRO and/or reviewer and the request will be withdrawn.</u>”</p> <p>Commenter opines that it is important that the claims administrator notify the Administrative Director, IBRO and independent bill reviewer as applicable, if it pays the disputed amount prior to the determination, otherwise a determination and order of the Administrative Director may unnecessarily require a duplicate payment.</p> | Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute (CWCI) December 26, 2013 Written Comment | See response to comment by the California Chamber of Commerce regarding this section. | No response necessary. |
| 9792.5.11 | Commenter is in support of the change to include concurrent notice when a provider files a request to withdraw a | Lisa Anne Forsythe, Senior Compliance Consultant | The Division appreciates the comment. | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|---|---|---|----------------------|
| | pending IBR as it ensures that all parties are informed. | Coventry Workers' Compensation Services December 26, 2013 Written and Oral Comment | | |
| 9792.5.12 | Commenter does not object to the Division setting a limit on the number of claims that can be consolidated under one IBR, but commenter opines that it is too narrow to restrict the claims to a particular claims administrator. Commenter states that a company may, and that some have, adopted a policy to deny payment for a particular service. | Diane Przepiorski Executive Director California Orthopaedic Association December 23, 2013 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said, consolidation applies to IBR requests against one claims administrator, which aligns with the language of Labor Code section 4603.6, which only references a single provider and a single employer. It is hoped that a consolidated IBR determination on specific billing practice will educate the public and act as a deterrent against those who would engage in the same practice. | No action necessary. |
| 9792.5.12 | Commenter recommends deleting the entire section. Commenter continues to believe that adding a process to consolidate | Brenda Ramirez Claims and Medical Director California Workers' Compensation | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|---|--|--------|
| | <p>requests is an unauthorized expansion of Statute that thwarts its purpose. Commenter is also concerned that neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.</p> | <p>Institute (CWCI) December 26, 2013 Written Comment</p> | <p>That said, 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 an efficient, cost-effective means of resolving multiple IBR requests involving similar issues and can reasonably be considered an “other criteria” affecting the amount of the filing fee. To require that disputes over a single billing code on multiple dates of service, or multiple billing codes on a single date of service, or a regular practice of downcoding billing codes, be treated as separate requests with separate filing fees would be punitive on providers and act as a disincentive for providers to seek IBR.</p> <p>IBR is requested by providers, who pay a filing fee that is</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|--|---|----------------------|
| | | | only reimbursed by the claims administrator if the provider prevails in an IMR determination. As consolidation looks to give providers greater access to IBR through reasonable fees to determining similar disputes in a single determination, allowing the procedure to serve as a vehicle for claims administrators to pursue claims of physician misconduct is inappropriate. | |
| 9792.5.12 | Commenter opines that consolidation of a single issue across multiple second reviews is unworkable. | Catherine Montgomery DaisyBill December 26, 2013 Written Comment | The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. | No action necessary. |
| 9792.5.15 | Commenter recommends the following revised language: “(b) Pursuant to Labor Code section 4603.6(f), the provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by filing a verified petition with the Workers' Compensation Appeals Board <u>and serving a copy on interested parties within 20 days of</u> | Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute (CWCI) December 26, 2013 Written Comment | The Division does not have authority to formally establish procedures for the WCAB. The parties should look to the rules and procedures of the WCAB for the manner in which to appeal an IBR determination. | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|--|--|-----------------------------|
| | <p><u>servicing the determination.”</u></p> <p>Commenter believes that since the specifics of Labor Code section 4610.6(f) have been deleted, it will be appropriate and helpful to include in this subdivision a citation to that section as well as the specific timeframe within which a verified petition must be filed.</p> | | | |
| 9792.5.4(i) | <p>Commenter states that at times, a billing agent does not submit a bill for second review and independent bill review in the original form as submitted by the provider. This is not in compliance with the California DWC Medical Billing and Payment Guide which requires that a bill being submitted for second review or independent bill review must accordingly be sent in its original paper or e-billing form.</p> <p>Commenter recommends that the division require agents who submit a bill for second review or independent bill review to send the bill accordingly in its original paper or e-billing form as previously submitted by the provider. Commenter states that agents also be required to include in</p> | <p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund December 24, 2013 Written Comment</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> <p>The DWC Form SBR-1, the alternative method of requesting IBR, and DWC Form IBR-1 should sufficiently identify the provider and a copy of the agreement letter would be unnecessary to process the request.</p> <p>Additionally, these regulations are about bill review, not about specifying payment of liens covered by Labor Code section 4903.8.</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|---|--|-----------------------------|
| | <p>the submission a copy of the agreement letter from provider indicating the agent who is representing the provider, for the purpose of expeditiously and correctly processing the request. Commenter opines that this section should specify that any payment due as a result of the review must be made to the provider, not the agent, in line with the intent of §4903.8.</p> | | | |
| 9792.5.4 | <p>Commenter recommends the following revised language:</p> <p>“This section is applicable to <u>billings received on or after January 1, 2013</u> for medical treatment services and goods rendered under Labor Code section 4600, or medical-legal expenses incurred under Labor Code section 4620 on or after January 1, 2013.”</p> <p>Commenter opines that Section 84 of Senate Bill 863 mandates that the provisions of the Bill apply to all pending matters unless a specific date is indicated. Senate Bill 863 provisions include new billing and payment requirements that include additional documentation that must be</p> | <p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute (CWCI) December 26, 2013 Written Comment</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. See response to April 9, 2013 comment by the American Insurance Association regarding this section.</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|--------------------------------|----------|--------|
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| | <p>submitted with billings, new payment timeframes, and new content for explanations of review and for explanations of second review (Labor Code section 4603.2 et. al.). Since these new requirements are also prerequisites for subsequent steps in the bill review and bill dispute process, these new requirements apply to billings received on and after January 1, 2013. Commenter believes that applying the regulations only to goods and services rendered on and after that date is overly broad and conflicts with Section 84 of SB 863.</p> <p>Fee schedules are applied by date of service, however bill review timeframes and rules are triggered according to date of bill receipt. If these regulations and their future revisions are applied by date of service, separate sets of rules must be followed, depending on the date of service, and bill review systems must program and maintain different sets of timeframes and rules, creating unnecessary complexity, confusion, dispute and expense. If, on the other hand, the rules for bill review apply</p> | | | |
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| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|--------------------------------|----------|--------|
| | <p>according to date of bill receipt, multiple sets of timeframes and rules will not be necessary and billing providers and payers can operate more efficiently under a single set of rules on a going forward basis. Commenter would like the regulations to apply by date of bill receipt.</p> <p>Commenter recommends the following revised language:</p> <p>“(a)(1) Medical treatment services or goods rendered by a provider in accordance with Labor Code section 4600 that were authorized by Labor Code section 4610, and for which there exists an applicable fee schedule adopted by <u>Statute</u> or the Administrative Director for those categories of goods and services, including but not limited to those found at sections 9789.10 to 9789.111, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.”</p> <p>Commenter suggests including an applicable fee schedule adopted by Statute as well as one adopted by the Administrative Director. The Medi-</p> | | | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|---|---|---|----------------------|
| | Cal schedule of fees for pharmacy services and drugs that was promulgated by Labor Code section 5307.1(a) in 2004 is one such example. | | | |
| 9792.5.5 | <p>Commenter recommends the following revised language:</p> <p>“(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services <u>or goods rendered that was received</u> on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred that was received on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.”</p> <p>Commenter suggests applying these regulations to bills received on and after January 1, 2013.</p> <p>Commenter recommends the following revised language:</p> <p>“(c) The request for second review</p> | <p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute (CWCI) December 26, 2013 Written Comment</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> <p>The Division administers IBR. Labor Code sections 139.5 and 4603.6. Further, Labor Code section 139.5(a)(1) provides that “[t]he [AD] shall contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews.” In turn, section 139.5(a)(2) provides that “[t]o enable the independent review program to go into effect for injuries occurring on or after January 1, 2013, ... independent review organizations under contract with the Department of Managed Health Care ... may be designated by the [AD]</p> | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|--------------------------------|--|--------|
| | <p>shall be made as follows: (1) For a non-electronic medical treatment bill, the second review shall be requested on either.”</p> <p>Commenter points out that it appears the suggested change was inadvertently retained.</p> | | <p>to conduct reviews.” Read together, these provisions imply a legislative intent that IBR is inapplicable to injuries prior to January 1, 2013 (see Stats. 2012, ch. 363, § 84 [stating that SB 863 “shall apply to all pending matters, regardless of date of injury, unless otherwise specified in this act”]. 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.</p> <p>Regarding the language of the subdivision, while appearing redundant, specifies that either method can be used to request a second bill review. The Division may delete unnecessary language in future rulemaking.</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|--|--|-----------------------------|
| 9792.5.5 | <p>Commenter recommends the following revised language:</p> <p>“(c)(1)(B) The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6. The <u>completed</u> DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider.”</p> | <p>Steven Suchil Assistant Vice President American Insurance Association December 26, 2013 Written Comment</p> | <p>While the form should be completed, it is not necessary to state that for the purpose of this subdivision.</p> | <p>No action necessary.</p> |
| 9792.5.5 | <p>Commenter opines that effective January 1, 2014, a vastly more complicated RBRVS-based fee schedule replaces California’s current, comparatively simpler, fee schedule for workers’ compensation. To code commenter’s RBRVS Calculator for this new reimbursement system, commenter’s team spent hundreds of hours of intensive reading and analysis to learn all the ins and outs, the calculations and the exceptions, and all the new acronyms and what to do with them. Commenter has hosted dozens of webinars over the last 30 days.</p> <p>Commenter recommends a recourse for providers when claims administrators do not comply with second review guidelines.</p> | <p>Catherine Montgomery DaisyBill December 26, 2013 Written Comment</p> | <p>The Division does not have statutory authority to impose additional penalties and interest beyond that mandated by Labor Code section 4603.2(b)(1).</p> | <p>No action necessary.</p> |
| 9792.5.7 | <p>Commenter recommends the</p> | <p>Brenda Ramirez</p> | <p>Regarding the effective date of</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|--|--|--------|
| | <p>following revised language:</p> <p>“(a) If the provider further contests the amount of payment made by the claims administrator on a bill <u>for medical treatment or services submitted pursuant to Labor Code sections 4603.2 or 4603.4 and, for medical treatment services rendered received on or after January 1, 2013, submitted pursuant to Labor Code sections 4603.2 or 4603.4, or medical-legal bill submitted pursuant to Labor Code section 4622, for medical legal expenses incurred and received on or after January 1, 2013, submitted pursuant to Labor Code section 4622,</u> 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 <u>A</u> request for independent bill review shall only resolve:”</p> <p>Commenter suggests applying these regulations to bills received on and after January 1, 2013. Commenter believes that adding a process to consolidate requests is an unauthorized expansion of the scope</p> | <p>Claims and Medical Director California Workers’ Compensation Institute (CWCI) December 26, 2013 Written Comment</p> | <p>the IBR process, the comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> <p>Regarding consolidation of IBR requests, the comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> <p>Regarding the review of multiple codes in IBR, the Division finds that the “one date of service” and “one billing code” limit will cover essentially all billing disputes will allow IBR to be conducted in an efficient, cost-effective manner. To open up the review process to multiple billing codes may tax the resources of the IBRO and result in possibly higher filing fees. As an option, a provider is allowed to consolidate related requests for IBR under section</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|--------------------------------|---|--------|
| | <p>of the statute that thwarts its purpose. As a practical matter, commenter is also concerned that neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.</p> <p>Commenter recommends the following revised language:</p> <p>“(a)(1) For a bill for medical treatment services or goods, a dispute over the amount of payment for services or goods billed by a single provider involving one injured employee, one claims administrator, and either one date of service, and one billing code or one hospital stay, under the California Code of Regulations, title 8, section 9792.5.4 – 9792.5.15 5 (Proposed Regulation – 010113) applicable fee schedule adopted by <u>Statute or by the Administrative Director</u> or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.”</p> <p>Commenter opines that every</p> | | <p>9792.5.12.</p> <p>The Division agrees that the form and its instructions as presented on its website should match the paper form. The Division will work with its IBRO to ensure that they correspond.</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|--------------------------------|----------|--------|
| | <p>independent bill review must encompass all goods and services provided on the same date of service billed by a single provider on a single claim. If not, a provider can easily manipulate the process and evade fee schedule rules and the Correct Coding Initiative (CCI) edits in order to obtain undeserved payment, leaving the claims administrator without recourse. Payment for a particular single service on a bill often depends on the payment for other services provided on the same day. If only one service code is reviewed, a provider will be able to evade the CCI edits and other rules that apply when certain other codes are billed. Such behavior will negatively impact the injured employee's quality of care and result in higher costs.</p> <p>Commenter recommends the following revised language:</p> <p>“(d)(1)(A) Completing and electronically submitting the online Request for Independent Bill Review form, which can be accessed on the Internet at the Division of Workers’ Compensation’s</p> | | | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|---|---|----------------------|
| | <p>website. The website link for the online form <u>and instructions</u> can be found at https://www.dir.ca.gov/dwc/IBR.htm . Electronic payment of the required fee of \$335.00 shall be made at the time the request is submitted.”</p> <p>Commenter believes that the Maximus electronic form on the DWC web site differs materially from both the current emergency form and the proposed and modified versions. Commenter recommends 1) replacing it with an electronic version of the adopted form and 2) adding directions to the DWC IBR web pages on how a provider submitting an electronic IBR request shall comply with the statutory and regulatory requirements in Labor Code section 4603.6(b) and CCR section 9792.5.7(f) to concurrently serve a copy of the request upon the claims administrator together with a copy of the supporting documents.</p> | | | |
| 9792.5.8 DWC Form IBR | Commenter states that clarification is needed on the mailing address for Maximus to use for an IBR App. The form instructions state to mail it to: | Jeremy Merz California Chamber of Commerce | DWC will ensure that the address for Maximus Federal Services on the DWC Form IBR-1 is correct and that it will | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|--|---|--|----------------------|
| | <p>DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. The instructions further state, “Forms that are not sent to this address will be returned by DWC and not considered filed.” However, the IBR section of the DWC website states the IBR App should be mailed to a PO Box address in Sacramento for Maximus. Commenter would like to know that if the IBR App is mailed to the PO Box in Sacramento if it be considered filed. Commenter states that the suite address for Maximus’ physical address on the website is listed as Suite 150, not 100.</p> | <p>Jason Schmelzer California Coalition on Workers’ Compensation December 20, 2013 Written Comment</p> | <p>correspond on the DWC website.</p> | |
| 9792.5.8 | <p>Commenter recommends:</p> <ol style="list-style-type: none"> 1) replacing the form with an electronic version of the adopted form and 2) adding directions on how a provider submitting an electronic IBR request shall comply with the statutory and regulatory requirements in Labor Code section 4603.6(b) and CCR section 9792.5.7(f) to concurrently serve a copy of the request upon the claims administrator with a copy of the supporting documents | <p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute (CWCI) December 26, 2013 Written Comment</p> | <p>The Division will ensure that the form and instructions on the DWC web site are materially the same as the DWC Form IBR-1.</p> <p>Regarding comments to the DWC Form IBR-1, the comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> | No action necessary. |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | <p>3) Correcting the mailing address: the required Folsom mailing address on the form differs from the Sacramento address on the web; the address that is incorrect must be corrected because the instructions on both the form and the web site warn that applications not sent to that address will not be considered filed.</p> <p>Commenter attached a sample Request for Independent Bill Review form with recommended changes identified by underscore and strikeout. The reasons for the recommended changes are summarized as follows:</p> <ul style="list-style-type: none"> • The Consolidation section and references has been deleted because the Institute believes that consolidations are not supported in SB 863 and see comments on section 9792.5.12 • Instruction to concurrently send a copy of the form and supporting documents to the claims administrator is necessary here so that it is clear that the instruction applies to both a paper and electronic | | | |
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| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | submission | | | |
| 9792.5.8 | <p>Commenter is in support of the change to cap the number or potential IBR requests that can be consolidated. Large consolidations can be difficult to review and respond in a timely fashion.</p> | <p>Lisa Anne Forsythe, Senior Compliance Consultant Coventry Workers’ Compensation Services December 26, 2013 Written and Oral Comment</p> | <p>The Division appreciates the comment.</p> | <p>No action necessary.</p> |
| 9792.5.8 | <p>Commenter recommends the following revised language:</p> <p>“When to Apply: A request for second bill review must be made within 90 days of service of the explanation of review <u>that reduced or denied the payment unless an extension is mutually agreed to in writing between the provider and the claims administrator.</u> that explained why the payment you sought in the initial bill was reduced or denied.”</p> <p>Commenter opines that the change would be consistent with proposed section 9792.5.5 (b)(1)(B)(3) which provides, “The 90-day time limit for requesting a second review may be extended by mutual written agreement between the provider and the claims</p> | <p>Steven Suchil Assistant Vice President American Insurance Association December 26, 2013 Written Comment</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
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| | administrator.” | | | |
| 9792.5.8 | <p>Commenter recommends that in the form, both the Consolidation area on the face of the form and in the instructions be deleted.</p> <p>Commenter also points out differing addresses in the area below the provider signature and in the instructions. Commenter recommends making this consistent.</p> | <p>Steven Suchil Assistant Vice President American Insurance Association December 26, 2013 Written Comment</p> | <p>Regarding consolidation of IBR requests, the comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. As to addresses, see above response to comment by CWCI regarding this section.</p> | <p>No action necessary.</p> |
| 9792.5.12 | <p>Commenter believes that there does not appear to be statutory authority to allow consolidation of IBR requests. Commenter does not believe that IBRO would be equipped to determine this threshold issue and recommends that it be deleted. In the alternative, commenter recommends the following language:</p> <p>“(c)(1) Requests for independent bill review by a single provider involving multiple dates of medical treatment, <u>goods, or medical-legal services...</u>”</p> | <p>Steven Suchil Assistant Vice President American Insurance Association December 26, 2013 Written Comment</p> | <p>Regarding consolidation of IBR requests, the comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period.</p> | <p>No action necessary.</p> |
| 9792.5.9 | <p>Commenter recommends the following revised language:</p> <p>“(b)(3) A statement that the claims administrator may dispute both</p> | <p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation</p> | <p>The comment does not address the substantive changes made to the proposed regulations during the 2nd 15-day comment period. That said,</p> | <p>No action necessary.</p> |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|-------------------------|--|---|--|--------|
| | <p>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 <u>the Administrative Director received the request, as</u> 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.”</p> <p>Commenter points out that Labor Code section 4603.6(d) requires the request to be assigned to an independent bill reviewer, and the provider and employer to be notified, within 30 days of receipt of the request and fee. To ensure this timeframe is met, it is necessary to count the fifteen days from the date the Administrative Director designated on the notification that the Request and fee was received.</p> | <p>Institute (CWCI) December 26, 2013 Written Comment</p> | <p>upon receipt of a request for IBR, the Administrative Director has 30 days to assign the request to the IBRO. A 15 day period is reasonable for notifying the parties after a decision is made that a request is eligible for review.</p> | |

| INDEPENDENT BILL REVIEW | RULEMAKING COMMENTS 2 nd 15 DAY COMMENT PERIOD | NAME OF PERSON/ AFFILIATION | RESPONSE | ACTION |
|----------------------------|---|--|---|-----------------------------|
| 9792.5.9 | <p>Commenter recommends the following revised language:</p> <p>“(c) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(3) must be concurrently served on the <u>other party provider</u>. Any document that was previously provided to the <u>other party provider</u> or originated from the <u>other party provider</u> need not be served if a written description of the document and its date is served.”</p> <p>Commenter objects to one-way communication. The same rule should apply to documents sent to the AD.</p> | <p>Steven Suchil Assistant Vice President American Insurance Association December 26, 2013 Written Comment</p> | <p>The notification provide under subdivision (b) neither requires nor requests the provider to submit documents to the Administrative Director. Only the claims administrator is asked to submit evidence showing the IBR request is either ineligible or without merit.</p> | <p>No action necessary.</p> |