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STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

Tuesday, April 9, 2013
Elihu Harris State Office Building
1515 Clay Street
Oakland, California

George Parisotto
Moderator
Acting Chief Counsel

Destie Overpeck
Acting Administrative Director

Rupali Das
Medical Director

Reported by: Barbara A. Cleland
Katherine L. Latini

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1 PUBLIC HEARING

2 OAKLAND, CALIFORNIA

3 TUESDAY, APRIL 9, 2013 - 10:06 A.M.

4 --000--

5 MR. PARISOTTO: I think we'll begin now. Good
6 morning and welcome back to many of you. Today is our
7 public hearing on the Division of Workers'
8 Compensation Independent Bill Review, Standardized
9 Paper Billing and Payment, and Electronic Billing and
10 Payment Proposed Regulations. My name is George
11 Parisotto. I'm the Acting Chief Counsel for the
12 Division, and joining me today is our Regulations
13 Coordinator on my right, Maureen Gray, and on my left
14 Acting Administrative Director, Destie Overpeck, and
15 Rupali Das, who is the Division's Medical Director.

16 As you know, emergency regulations are currently
17 in effect and have been in effect since January 1st,
18 2013. The regulations will remain in effect for six
19 months until July 1st, unless we ask for an extension
20 or unless -- until we complete this current
21 rule-making process. This public hearing is part of
22 the process to complete rule-making action and develop
23 permanent regulations. Copies of our proposed
24 regulations are over here on the table to my right,
25 and everything we have is also posted on the DWC

1 ruling-making web page.

2 Please be sure you've signed in. By signing in
3 you can let us know if you want to offer comments
4 today, and we can also keep you informed of any
5 additional developments we have in this rule-making
6 process. One thing to note, it appears that we are
7 having problems with our rule making, our mail box.
8 Thank you. dwcrules@dir.ca.gov. So, if you would
9 like to submit written comments via e-mail, I would
10 suggest you try that address and also send them to our
11 Regulations Coordinator, Maureen Gray, and her e-mail
12 address is m --

13 MS. GRAY: Gray.

14 MR. PARISOTTO: Gray. gray@dir.ca.gov.

15 Our hearing today will continue as long as there
16 are people present who wish to comment on our
17 regulations, but we'll close at 5 o'clock. If the
18 hearing continues into the lunch hour, we will take at
19 least an hour break. Written comments will be
20 accepted until 5 o'clock at the Division's office on
21 the 17th floor of this building.

22 The purpose of our hearing is to receive comments
23 on the proposed amendments to the IBR, Independent
24 Bill Review, and our billing regulations, and we
25 welcome any comments that you may have. All your

1 comments, both given here today and written, will be
2 considered by the Acting Administrative Director in
3 determining whether to adopt the regulations as
4 written or to change them. Please restrict the
5 comments, the subject of your comments, to the
6 regulations and any suggestions you may have for
7 changing them.

8 We will not be entering into any discussions this
9 morning, although we may ask you for clarification or
10 ask you to elaborate further on any points you are
11 presenting.

12 When you come up to give your testimony, please
13 give Maureen your business card and if you have one so
14 we can get the correct spelling of your name in the
15 transcript. If you do have any written comments, you
16 may give them to her also. When you testify, please
17 speak into the microphone, identify yourself for the
18 record, and talk in a reasonable measured manner so
19 our court reporters can take them down accurately, and
20 I wish to add that our court reporters today are
21 Barbara Cleland and Kathy Latini.

22 So, let me go to our list to see who signed in.
23 We'll start from there, and I apologize in advance if
24 I somehow mangle your name. I do have a tendency to
25 do that. Our first speaker today will be Patricia

1 Brown.

2 PATRICIA BROWN

3 MS. BROWN: Thank you. My name is Patricia
4 Brown, and I am a Deputy Chief Counsel at State
5 Compensation Insurance Fund. Thank you for your
6 tireless efforts in drafting these thoughtful and
7 thorough regulations. Your successful efforts will
8 play a key role in streamlining the system and
9 building a solid framework to ensure prompt and fair
10 payment of medical bills.

11 State Fund, as the largest insurer in California,
12 adjusted over 130,000 claims last year. Our
13 not-for-profit status allows us to focus our efforts
14 on delivering superior claims outcomes to the injured
15 workers and the employers that we serve. The IBR
16 process will enhance our ability to reduce litigation,
17 reduce costs, and increase the accuracy, consistency,
18 and speed of bill payment to the benefit of the entire
19 workers' compensation system.

20 Today we offer three recommendations on the
21 proposed regulations.

22 The first is proposed section 9792.5.9(b)(3)
23 which provides that, if a request for IBR is
24 determined to be eligible for IBR review, the
25 Administrative Director shall notify the provider and

1 claims administrator, and the claims administrator may
2 dispute eligibility by submitting a statement with
3 supporting documents to the Administrative Director or
4 her designee within the prescribed time frame.

5 State Fund recommends clarification of the
6 language to specify whether the submission of
7 documents by the claims administrator is limited to
8 the issue of eligibility for IBR review, or whether
9 the claims administrator may submit documents on other
10 payment or billing issues.

11 Second, proposed section 9792.12(c)(3) provides
12 the IBRO with the discretion to consolidate multiple
13 requests for Independent Bill Review if it appears
14 that the requests involve common issues of law and
15 fact or the delivery of similar or related services.

16 State Fund recommends that the IBRO not be
17 permitted to make such determinations. We believe it
18 is beyond the scope and expertise of the IBRO. As
19 much as State Fund is in favor of streamlining the
20 process to every extent possible, there are stringent
21 limits governing the submission of documents in the
22 IBR process. In fact, it appears that the proposed
23 regulations allow the claims administrator to submit
24 documents in only two narrow circumstances. The first
25 is the one I just mentioned under section

1 9792.5.9(b)(3). It appears that the claims
2 administrator is only permitted to submit documents on
3 the issue of eligibility of IBR review. The second is
4 under section 9792.5.10 in which the claims
5 administrator may only submit additional information
6 upon request of the IBRO. That means that the claims
7 administrator would have no meaningful opportunity to
8 be heard or submit evidence on the issue of
9 consolidation. Consolidation attempts can be
10 contentious and fact specific, but more importantly,
11 consolidation may substantially affect the rights of
12 the parties. Decisions regarding whether to
13 consolidate should allow a broad view of the evidence
14 under the domain of judges to give parties a full and
15 fair opportunity to be heard. We agree that
16 consolidation could be a beneficial option if there
17 was a mechanism by which a judge could refer a
18 consolidated case to IBR. If the IBRO may consolidate
19 with multiple requests for IBR, then the party should
20 be permitted to submit additional evidence.

21 Item 3, proposed section 9792.5.15 allows the
22 provider or carrier to appeal the decision of the IBRO
23 Administrator Director, but the language that required
24 service of the appeal on all parties is stricken.
25 State Fund recommends that the stricken language be

1 re-inserted to require service of any appeal upon all
2 parties in order to place them on notice that the
3 decision is being appealed.

4 That concludes my comments on behalf of State
5 Fund. Thank you for your kind attention.

6 MR. PARISOTTO: Thank you very much. David
7 Robin.

8 DAVID ROBIN

9 MR. ROBIN: Good morning, and thank you for
10 allowing me this opportunity to speak. My name is
11 David Robin. I'm an attorney. I work for a company
12 called The 4600 Group. It's one of a few companies
13 who represent the group health plan industry, those
14 insurance companies and HMOs who pay claims on
15 non-industrial conditions, and thereafter, when that
16 person, that employee, files a workers' compensation
17 case, has the opportunity to file a lien through
18 4903.1, or at least that's what it was up until
19 January of 2013.

20 Our question is really limited to the definition,
21 and specifically on 9792.54(i), which is defining
22 provider. No one in our industry believes that we're
23 a provider and thinks of this as a no brainer, but we
24 know from experience we are payers. We don't provide.
25 And there's a huge difference in that. We in this

1 industry have no ability to -- to comply with
2 standardized documentation that IBR requires that
3 second billings require. We can't change the forms
4 that come in. We have -- we've always had a different
5 type of proof for proving up a lien, whether it's
6 related, and how it interplays with the OMFS. I've
7 covered this in our documentation that we've given to
8 Ms. Gray, but we really want if, and we believe this
9 to be the truth, if -- what you mean by it, but we
10 know that, if we don't get something, an express
11 clarification that the group health industry who pays
12 claims are not providers for IBR, two things will
13 happen. We're always going to have an argument at the
14 Appeals Board whether we are subject to second review
15 and IBR. If we go into IBR, we can't comply. We'll
16 get bounced out, and we'll be subject to the whims of
17 the workers' compensation claims administrators,
18 whether they choose to pay or not, and, if they don't
19 pay with the time constraints for going up the ladder
20 on IBR, we'll effectively have that right that the
21 health industry has to file a lien on claims that
22 become work related without a remedy because there
23 won't be a -- there won't be any payment on the liens.
24 The other factor will be that those -- those lawyers
25 who represent the health plans, such as I do and my

1 partner Nancy, will be at the Board all the time
2 arguing this issue when the purpose of this litigation
3 is to streamline and get some of the issues out of the
4 Board. We just can't get away from the Board on this
5 one because we can't comply with those issues. So, we
6 really hope that you can find a way to expressly
7 clarify who a provider is, and that we as a payer in
8 the health industry on non-industrial claims that
9 become workers' compensation liens, are not part of
10 that provider. Thank you.

11 MR. PARISOTTO: Thank you. Howard Stiskin.

12 HOWARD STISKIN

13 MR. STISKIN: Good Morning. I'm Howard Stiskin,
14 S-t-i-s-k-i-n. I'm with the Workers' Compensation
15 Department for the City and County of San Francisco.
16 Thank you for the opportunity to testify. We offer
17 the following recommendation regarding section
18 9792.5.11 subsection (a), and this is regarding the
19 process for withdrawing disputes for IBR.

20 Per this section, withdrawal requires a joint
21 written request submitted to IBR from the medical
22 provider and the claims administrator. For the sake
23 of efficiency, considering that the medical provider
24 requests IBR, we propose that the medical provider
25 should be able to withdraw from IBR independently with

1 simply a copy to the claims administrator. Otherwise
2 there would be an increased burden on the claims
3 administrator regarding coordination of this joint
4 letter which is not required by statute.

5 Thank you for this opportunity.

6 MR. PARISOTTO: Thank you. Brian Allen.

7 BRIAN ALLEN

8 MR. ALLEN: Good morning. It's a pleasure to be
9 here. Thank you for the opportunity to share our
10 comments. My name is Brian Allen. B-r-i-a-n.
11 A-l-l-e-n. I'm here with StoneRiver Pharmacy
12 Solutions. We provide billing and claim processing
13 services for pharmacies here in California and across
14 the country. We have -- we generally are supportive
15 of the rule. We have a few comments we think will
16 make it a little bit better and more clear. First of
17 all, in the definition section 9792.5.4 we note there
18 is not a definition that outlines billing agents or
19 assignees. We would recommend actually referencing,
20 either mirroring or referencing, the definitions that
21 are in 9792.5.0. There's some good adequate
22 definition there that we think would fit well in this
23 section and clarify that I think the intent of the
24 rule is to allow agents and assignees to have standing
25 to process these IBRs and the second bill review. So

1 we'd certainly like that clarification. That would be
2 of beneficial and help to us.

3 In section 9792.5.5(d) the rule requires that a
4 copy of the Explanation of Review be included in the
5 request for second review, but frequently we don't get
6 an Explanation of Review, and we would like to use a
7 second bill review process to give payers another
8 opportunity to pay the bill without invoking our
9 rights that are outlined in the Labor Code for bills
10 when an EOR isn't received. We want to give them
11 another chance. We would like some explanation of the
12 rules as to how that can be handled. We suggest in
13 the date field of that form, of the SBR-1 form, just
14 being able to put EOR not received, so that it's clear
15 that it wasn't received and that that's why it's not
16 copied and attached to the request.

17 Also, in that section in paragraph (f) the word
18 receipt is used but it's not defined. If you look in
19 9792.5.7 in the timing of the IBR process, there's a
20 pretty good indication of what receipt means. We
21 would recommend just referencing that or mirroring
22 that in this section as well so that it's clear what
23 receipt means in that section.

24 In section 9792.5.6 the -- where you outline what
25 the SBR-1 form looks like, there isn't anything that

1 talks about how that should be signed or could be
2 signed. It sounds almost like the way the rule is
3 written that you want a handwritten signature on each
4 of those forms. We recommend some allowance for being
5 able to digitally reproduce a name or a signature or
6 something on that form so that you can somewhat
7 automate a very manual process.

8 In the Independent Bill Review section 9792.5.7
9 you're asking for a \$335 fee for each request. In our
10 world the amounts in dispute are often fairly small, a
11 hundred -- a hundred dollars, two hundred dollars. To
12 pay a \$335 fee for a small amount seems a little bit
13 kind of counterproductive to what I think what you're
14 trying to accomplish. We'd recommend a step fees
15 based system based on the dollar amount of the amount
16 in dispute. We've outlined that in our written
17 comments. I'm happy to go through that here if you'd
18 like, but you might want to just look at the written
19 comments, would be a little bit quicker. And the
20 other -- we'd also make the same note on the IBR form,
21 the signature notation about how do we sign those
22 forms.

23 And then in section 9792.5.12 regarding the
24 consolidation or separation of requests, you
25 established a \$50 threshold per bill. Again we think

1 that's a little bit of a small number if you really
2 want to encourage consolidation to help expedite
3 things. And I note what the State Fund said, and I
4 suspect that there's something that can be done in
5 rule making to address their concerns and address
6 ours, but we think that the consolidation is an
7 effective tool and it could be used to help handle
8 some of these smaller disputes, but we'd certainly
9 like to see that threshold raised to maybe like \$200
10 to make it more realistic and more, I think, adequate
11 reflect some of the smaller amounts that are in
12 dispute. It's pretty rare we get bills that are under
13 \$50 or a payment amounts that are \$50 off that we're
14 disputing. So, that would be our one recommendation.
15 And I think just in general, as a final note, there's
16 -- you're making a lot of changes to the Electronic
17 Billing Companion Guide to conform to these rules and
18 requirements, and we just want to note that the more
19 that changes, the further adrift you're getting from
20 the national standards that are being established by
21 IAIABC and other standards organizations. We'd just
22 give you a note of warning about that. We'd hate to
23 see California become an anomaly in the world. And I
24 think two good examples are the requirement of a
25 prescription to be submitted with copies of this

1 documentation which we hope is going to get fixed with
2 SB 146. But additionally I think there's a
3 requirement on -- to send copies of request for
4 authorization, which should already be in files
5 somewhere because they were generated by the payers.
6 So it doesn't make sense for a provider to send
7 something that was generated by the other side. But
8 just those kinds of things I think as you go through
9 these rules and you look at how that relates to the
10 Electronic Billing Guides. If you could harmonize
11 those, that would be great.

12 That's the extent of my comments. I did submit
13 written comments yesterday. I'll resubmit those to
14 you, Maureen, to make sure you have those, and I'm
15 open to any questions. Thank you very much.

16 MR. PARISOTTO: Thank you. Michelle Rubalcava.

17 MICHELLE RUBALCAVA

18 MS. RUBALCAVA: Good morning. My name is
19 Michelle Rubalcava. I am here on behalf of the
20 California Medical Association, and we represent
21 approximately three-seven thousand physicians in the
22 State of California. I want to thank you for allowing
23 me some time to share some of our suggestions with
24 you.

25 In the area of consolidation of claims and fees

1 schedules, the CMA would like some clarification on
2 when the Administrative Director or the Independent
3 Bill Review Organization will determine that a request
4 involves a common issue of law in fact or the delivery
5 of similarly related cases. We assume that these
6 claims will be subject to one filing fee of three
7 hundred and twenty-five, but we're not sure, and so we
8 would ask for some clarification on that issue.

9 In addition, CMA receives thousands of complaints
10 related to arbitrary and capricious down coding of
11 evaluation in management services by bill review
12 companies. Many of these billing issues we see
13 routinely deal with very small billing amounts.
14 Therefore, we would urge you to consider a more
15 reasonable filing fee, perhaps something along the
16 lines used by the DMHC in their IDR process.

17 In addition, the proposed regulations state the
18 IBR only may allow for the consolidation of requests
19 for Independent Bill Review by a single provider
20 showing a possible pattern and practice of
21 underpayment by the claims administrator for specific
22 billing codes. In the regulations it's not evident
23 how you are going to be defining possible pattern and
24 practice of underpayment. CMA would ask for a better
25 definition or perhaps more specificity on this point.

1 Also, we would like to see additional clarity on how
2 payment and interest will eventually be distributed to
3 the provider if and when the IBRO finds in favor of
4 the provider.

5 In the area of creating more transparency in the
6 IBR process, the CMA would like to encourage the
7 public disclosure of all IBR decisions. In order to
8 protect the anonymity of the reviewers and the
9 confidentiality of patients and providers we would
10 also suggest that would be identified.

11 Lastly, the CMA would like to urge you to
12 consider including a preference for contracting with
13 California owned and operated companies to provide IBR
14 services. We feel that California providers and
15 California based companies are in the best position to
16 provide the most relevant experience and analysis in
17 the adjudication of payment disputes.

18 That's it. Thank you for your time.

19 MR. PARISOTTO: Thank you. Steve Cattolica.

20 STEVE CATTOLICA

21 MR. CATTOLICA: Good morning. My name is Steve
22 Cattolica. I represent the California Society of
23 Industrial Medicine and Surgery, the California
24 Society of Physical Medicine and Rehabilitation, and
25 the California Neurology Society. We will provide

1 actually a number of written comments, but I wanted to
2 draw your attention to three issues that we think are
3 among many but nonetheless are very important. First
4 of all, we understand the legislative intent was that
5 Independent Bill Review essentially check and decide
6 issues where the dollar amount is at issue. Now
7 there's certainly lots and lots of different ways that
8 that can happen, but our interpretation of the intent
9 and having been in discussions about this concept for
10 a number of years prior to this, is that it's a fee
11 checker. If the MAT said one thing and the bill said
12 another and the reimburser a third, somebody does that
13 checking and the decision is made. To broaden the
14 scope of what IBR is actually going to end up
15 deciding, is to put the IBRO in a position where they
16 have no authority nor expertise. One of the issues,
17 which may sound a little off track, but I want to go
18 down the road simply because it's going to be
19 extremely critical, is the decision of whether or not
20 a contract applies. Contracted -- excuse me. Due to
21 the proliferation -- is that the right word,
22 proliferation of leased PPO networks combined with
23 arm-length relationships between bill review software
24 vendors and claims administrators and the actual
25 payer, sometimes the existence of a contract may be in

1 dispute, the existence of the contract. IBR does not
2 have the legal jurisdiction or the infrastructure to
3 decide these issues. With respect to PPO or MPN
4 provider contracts, new Labor Code 4616(a)(3) provides
5 that all MPN physicians must by January 1st of 14
6 affirmatively elect to be a member of the MPN. This
7 would seem to provide a positive documentation of a
8 contract relationship and help with the aforementioned
9 contract problem, but it won't. The manner and
10 process that networks will use to collect these
11 affirmative elections is critical. While we support
12 this initiative, compliance with this statute may
13 become a classic example of be careful of what you ask
14 for. There are roughly seventeen hundred MPNs
15 certified by the DWC. Most have hundreds, if not
16 thousands, of physicians, thousands of physicians, and
17 except for networks custom built by primary -- by --
18 primarily by self-insured providers, these MPNs are
19 based on PPO contracts for a relatively small number
20 of large networks that have been in business for a
21 long time much prior before -- prior to when MPNs were
22 in existence. We have firsthand knowledge that one of
23 the largest network plans to send its providers one
24 single blanket acknowledgment letter meant to meet the
25 Labor Code 4616(a)(3) requirement. A provider signing

1 this letter as an affirmative decision will not know
2 what individual MPNs are actually covered by the
3 letter because apparently the parent network, that is
4 the basic PPO, will not list the actual MPNs to which
5 the physician belongs. You can imagine what that
6 letter might look like if a physician were to belong
7 to hundreds of MPNs, maybe all seventeen hundred of
8 them. That's a long list, but, nonetheless, a
9 blanket. They won't know. And subsequently they will
10 not be given the opportunity to opt out of some, while
11 staying in others. It may have the unintended
12 consequence in fact of establishing a continuing
13 contract with an MPN that they didn't expect to or
14 want to continue. While expeditious, this method will
15 cause the very contract disputes that Labor Code
16 4616(a)(3) was meant to stop, and IBR will have no
17 effect in the inevitable reimbursement disputes that
18 will follow as a result.

19 We respectfully request that the Division
20 immediately take an active role in guiding MPNs and
21 their parent PPOs through this huge administrative
22 project that must be accomplished by the end of this
23 year. The intent of SB 863 in this regard was to
24 provide physicians with a means to acknowledge
25 participation in MPNs to which they are admitted.

1 Blanket, non-specific letters from large PPOs do not
2 meet that intent, and, as mentioned above, will likely
3 compound reimbursement issues based on contracts or
4 the lack of.

5 The second issue I'd like to raise has to do with
6 section 9792.5.11 where there's a process for the
7 provider and the payer to withdraw from the process.
8 And our basic question is, under what circumstances
9 does the Division actually expect this to take place?
10 We understand that the IBR -- IBRO may be due a
11 processing fee if a request is withdrawn. They've
12 done a little bit of work; they should get paid for
13 that. We suggest the same \$65 that's retained when a
14 request is found to be ineligible under 9792.5.7(e).
15 Why does this particular subdivision, point 11,
16 require more than that? At the point when a request
17 is found ineligible, the same documentation has been
18 submitted and reviewed by the IBRO. No more work is
19 performed when that request is withdrawn. This
20 appears to be unnecessarily punitive, especially when
21 the provider and the payer has settled the dispute.
22 Where is the incentive for a provider to settle if
23 they lose the entire \$335 simply because they've
24 settled the dispute with the payer? Of course, the
25 payer doesn't pay anything.

1 Lastly, but not in our written comments, but
2 here, under 9792.5.12(b)(3) subdivision points out one
3 of the most critical benefits of IBR from our
4 perspective, and one we urge the Division to take
5 seriously. Up to now the ability for providers to
6 muster the resources to prove that a claims
7 administrator is behaving badly in the course of the
8 billing and reimbursement process as a pattern and
9 practice have been extremely limited. We know of a
10 few and they've been effective, and we applaud the
11 process when it works. But far fewer than have likely
12 occurred so far. This is particularly true when
13 med-legal evaluations are reviewed improperly. We
14 trust that there will be no immunity for misconduct,
15 audit, or other penalties by simply participating in
16 the IBR process. If as a result of IBR, a claims
17 administrator is found to have systematically under
18 reimbursed providers, we would expect a swift target
19 audit would result, and the additional penalties and
20 fees would be assessed. As mentioned before, there's
21 little incentive in the IBR process for claims
22 administrators to stop the kind of mischief that
23 they've practiced in the reimbursement process. The
24 financial burden falls totally on the provider who,
25 when the process is over, under section point 15 has

1 very little practical resource and no effective
2 alternative. The Department of Industrial Relations
3 has rightfully prided itself on coordination of effort
4 among its operating departments with the goal of
5 slowing the underground economy. Providing data from
6 one department to another is the cornerstone of that
7 effort. We see IBR as a similar opportunity. We
8 again urge the Division to implement steps to take
9 advantage of the finding that IBR may provide, and
10 that goes, of course, both ways, to the provider
11 community as well.

12 Thank you. We'll submit these timely later on
13 this afternoon. Thank you.

14 MR. PARISOTTO: Thank you very much. Jonathan
15 Ng.

16 JONATHAN NG, M.D.

17 MR. NG: Good morning. Thank you. My name is
18 Jonathan Ng. Spelled N, as in Nancy, G, as in George.
19 I'm a practitioner. I'm a cardiologist, internist.
20 I'm here to testify for the section 9795 for simple
21 point, and that is on ML-106. Code ML-106 is for the
22 purpose of billing for med-legal supplementary
23 reports. In that section, section (b), the results of
24 laboratory or diagnostic tests which are ordered by
25 the physician as part of the initial evaluation is

1 prohibitive from billing, and that just doesn't make
2 any sense at all. Especially in the field of internal
3 medicine and cardiology quite often one has to order
4 very elaborate, even invasive testing, from sleep
5 studies to angiogram to MRI of the heart and on and
6 on. It's impossible to have those testing be
7 available at the time of the initial evaluation. I've
8 been told that several things one could do from
9 holding off the report for a month to other steps, but
10 it's all gaming the process. We have only 30 days to
11 submit our report, and quite often this invasive
12 expensive test will take more than a month to get
13 approved, not to mention get it done. And so it
14 doesn't really make sense to have that section in
15 there because it takes time and effort to get those
16 tests done. Some people would do the tests
17 immediately at the time of the evaluation or even
18 before the evaluation, and that's not fair for the
19 patient, for the applicant, because you haven't even
20 seen the patient. How can you do testing on them?
21 So, anyway, I urge you to abolish that section. It
22 doesn't make any sense because the amount of time that
23 the physician spend in doing the supplementary report
24 is reflected in the effort to control that cost by
25 swearing under perjury that the actual time you spend

1 in preparing those reports. So, anyway, I urge you to
2 abolish that section. Thank you.

3 MR. PARISOTTO: Thank you. Lisa Anne Forsythe.

4 LISA ANNE FORSYTHE

5 MS. FORSYTHE: Hi, good morning. We're going to
6 submit written comments that are much more extensive,
7 but I'm just going to hit the cliff notes here for
8 everyone's edification.

9 First I'd like to dovetail off of what Ms. Brown
10 from the State Fund mentioned before, that's certainly
11 one of our biggest concerns, that there's a lack of a
12 formalized response process for the defendants. I
13 would also add to that that we have some concerns,
14 excuse me, that substantive evidence may be submitted
15 to the IBRO that we as defendants have never seen
16 before and have no opportunity to respond to. So I
17 think there should be some sort of mechanism for a
18 close of discovery or some sort of response mechanism
19 or something. Otherwise, we can have a decision
20 fostered upon us that we've never seen the evidence to
21 support, and we have -- we have an issue with that.

22 She had mentioned use, perhaps, of the 15-day
23 objection period for assignment to the IBRO as the
24 possibility for us to be able to supply a substantive
25 comment or substantive response. We'd even suggest

1 that perhaps a standardized response form might make
2 sense to keep in the idea of it being mechanized and
3 consistent.

4 Our second major point I discussed a bit with
5 Destie in the past, our concern over a lack of parity
6 between billing time frames, standardized billing
7 claim time frame, lien claim time frames and lien time
8 frames. We're concerned that now that we have the IBR
9 process, that we understand that liens are now
10 restricted to the 18-month time frames starting in
11 July, but we're concerned that that will not prohibit
12 providers from sending billing statements to us many
13 years after the fact to which we have a statutory
14 obligation to respond with an EOR that would
15 theoretically then create jurisdiction for IBR at any
16 point in the future. So we would like parity with
17 those. So whether someone is going through the
18 billing statement track, medical treatment track, IBR
19 track, or the lien track, the time frames for filing
20 -- for initial filings should be -- there should be
21 parity between those two, 18 months on both sides.

22 Thirdly, we've had a lot of internal discussions
23 about what we as a payer should do if a second bill
24 review request comes to us that's incomplete,
25 inadequate, doesn't have enough documentation, etc.

1 We're wondering what we as a payer are supposed to do
2 with that. Is there some sort of a duty for us to
3 say, hey, you gave us something that doesn't cut it or
4 -- and then what happens if we do that, and then they
5 respond back, is that a third request for second bill
6 review or what is that? You know, if there are
7 multiple requests that occurred during that 90-day
8 time frame, what is that? Do we say it comes in once,
9 you get one bite at the apple, that's it, your remedy
10 is IBR, or what is that? We would love the regs to be
11 a little bit tighter with that, so we have clear
12 direction on how to respond to that. Because a lot of
13 times we get reduce, reuse, recycle, over and over and
14 over during that time period.

15 Thirdly -- or I guess fourthly, the handwritten
16 exception on the second bill review for on the -- on
17 the alternate CMS-1500 and the UB-04, really, that's
18 not a good one. Our feeling is that the whole -- one
19 of the major points behind the medical billing and
20 payment guide was to establish typewritten,
21 consistent, clear forms being sent to us as a payer so
22 allowing those fields to be populated in a handwritten
23 manner flies in the face of, I believe, what was
24 trying to be accomplished in that guide, Version 1.0,
25 and furthermore, for us as a payer, since we're trying

1 to expedite payments in an automated fashion, that
2 would require us to stop the bill, look at it
3 manually, blah blah blah, and it would really
4 undermine, I think, part of what we were trying to do
5 with this entire process. So we have much more
6 extensive comments that I'll provide in a written
7 basis, but those are our highlights. Thank you.

8 MR. PARISOTTO: Thank you. Carl Brakensiek.

9 CARL BRAKENSIEK

10 MR. BRAKENSIEK: Good morning. Carl Brakensiek
11 on behalf of the California Society of Industrial
12 Medicine and Surgery, California Society of Physical
13 Medicine and Rehabilitation and the California
14 Neurology Society.

15 Steve already presented some extensive testimony,
16 and I would just like to fill in a few little gaps.

17 First of all, in my opinion, the legislature did
18 a terrible job when they put this IBR language into SB
19 863. It was not well thought out. And I want to
20 commend you for your yeoman efforts in putting
21 together these regulations and trying to -- to fill in
22 the gaps that the legislature left. The objective, as
23 we understand IBR, was to reduce litigation, was to
24 see that providers are paid in a more timely manner
25 without taking up the time of judges and causing

1 unnecessary delays. Unfortunately, I think there's
2 more that needs to be done, and we would urge that, as
3 you take another look at these regulations, that
4 perhaps you could expand on them further to provide
5 more guidance to the payer and provider community as
6 to what happens under particular circumstances. For
7 example, in your instructions for requesting
8 Independent Bill Review, you indicate that IBR will
9 not determine a reasonable fee for services that --
10 for that category of services that are not covered by
11 a fee schedule. The question becomes what about the
12 many procedure codes that we have that are coded by a
13 report. Those services are under the fee schedule,
14 but they're by report. So the question is will the
15 Independent Bill Review Organization determine whether
16 the charge for an IBR by report code was appropriate
17 or is that open. And if it's not covered by IBR, how
18 is that billing to be resolved? What -- What if the
19 dispute, for example, is the amount of time a
20 physician, a treating physician, spent in reviewing
21 medical records? The doctor bills for 45 minutes of
22 bill review, of records review, and the payor says,
23 well, we think you could have reviewed those records
24 in 30 minutes, not 45 minutes. How do you resolve
25 that dispute? Is that covered by Independent Bill

1 Review or is there some other dispute resolution
2 process for that issue? And if so, I would urge your
3 regulations to clarify which track needs to be taken.
4 What about a situation in which the payer paid the
5 doctor's bill in full, but it was late? So you've got
6 a situation in which there may be penalties and
7 interest to be resolved. If the only issue is the
8 payment of penalties and interest, does that come
9 under Independent Bill Review or does that resolve in
10 some other situation -- some other process? What do
11 you do in a situation in which the payer completely
12 ignores the provider's bill? The provider sends in
13 the bill and nothing happens. There's no EOB or no
14 EOR. They just don't pay the bill. How does that
15 situation get resolved? You also indicate in your
16 instructions that IBR will not determine the
17 appropriate reimbursement -- or just resolve issues of
18 the use of analogous codes. If they don't cover
19 analogous codes, how do you get that issue resolved?
20 What is the process in that case? There's a number of
21 questions that we urge that -- that you address. One
22 of the big areas of concern we have is that your
23 regulations appear to permit the Independent Bill
24 Review Organization to interpret contracts between
25 doctors, and Steve touched on this with the MPN

1 contracts, but I have some very grave due process
2 concerns with Independent Bill Review companies
3 interpreting contracts. As Steve pointed out, what if
4 there's a dispute as to whether or not there's a
5 contract at all? How does that get resolved? But
6 assuming there is a contract, the term says that the
7 Independent Bill Review company will, "Apply the terms
8 of the contract." But what if you disagree as to the
9 meaning of those terms? What if the payer says, well,
10 this is what we meant in this contract, and the payer
11 said, no, when I signed it, I thought this is what you
12 meant. How does that issue get resolved? What if a
13 particular issue, a billing dispute, which is
14 supposedly -- there is a contract in place, but the
15 contract itself is silent, how do you resolve that
16 issue when the contract is silent? We don't know.

17 Over on page -- on Regulation 9792.5.15, I would
18 like to just suggest for purposes of clarification,
19 that in subdivision (a), which indicates when there
20 has been a ruling of the AD, that additional amounts
21 are payable, that regulation directs the payer to make
22 those payments. I would urge that you add a clause to
23 that to say that "and the payer shall reimburse the
24 provider for any IBR fees paid pursuant to section
25 9792.5.14(b)." I know you cover that in that

1 regulation but for clarity purposes, if you could make
2 it clear that the provider is entitled to a
3 reimbursement for the fee, that would be appropriate.
4 On that same page, in 9792.5.15, in subdivision -- it
5 would be (c), sub (1), this is the information which
6 is to be submitted over which -- the process after
7 there's been an overturning of the AD's initial
8 Independent Bill Review decision. It says, they shall
9 submit the dispute to Independent Medical Review by a
10 different IBRO, if available. I would suggest that
11 the word "Medical" in there should be "Bill". It may
12 be a typographical error that you'd like to address.
13 And the question is when -- when you do submit the
14 bill to a second round of IBR, does the payer have to
15 pay the filing fee again or is that all included in
16 the first filing fee that they paid?

17 In Dr. Ng's testimony a few minutes ago, he
18 requested an amendment to the Medical-Legal Fee
19 Schedule regarding supplemental evaluations. I would
20 also like to request, since you are making changes to
21 the Medical-Legal Fee Schedule, that you also make a
22 very tiny change in the definition of ML-103
23 complexity code number 5. Right now, you get three
24 complexity credits for having six or more hours spent
25 on any combination of the three complexity factors of

1 face-to-face time, records review, and research.
2 There is -- has been an interpretation by the Medical
3 Unit that in order to get those three credits, you
4 must spend some time on all three of those -- those
5 elements. And having been involved in the creation of
6 the Medical-Legal Fee Schedule, that certainly was not
7 the intent that the Industrial Medical Council made in
8 its recommendation to the Administrative Director. It
9 basically, in order to get the three credits, you can
10 have six hours total time in any of those -- those
11 three categories, but you don't have to do all three.
12 Because, for example, you could have a situation where
13 you have one hour of face-to-face time with the
14 patient and five and a half hours of records review.
15 If that's all you have, you would only get two
16 credits, and not three credits, even though the
17 physician spent more than six hours in this case. So
18 what that, in effect, does is to require them to do
19 research. Five minutes of medical research would then
20 give them the third point, and that doesn't make any
21 sense. So we're suggesting that you just delete the
22 word "three" in that particular definition so that any
23 combination of one through three in ML-103 would give
24 them the three credits. That makes it much easier,
25 and it would prevent unnecessary gaming of the system.

1 with many of us in the audience here today. It's been
2 a rather extraordinary series of meetings. One of the
3 things that has stood out the most to me is the number
4 of providers, be they medical providers, interpreters,
5 copy services, who have come before you and said they
6 just don't get paid. They submit their bills, they
7 submit a bill for \$150, they may get \$50, they may get
8 \$25, or it may get ignored. The question that I have,
9 a rhetorical question at this point since you're not
10 responding, when did it become acceptable for
11 insurance companies not to pay providers? Look at it
12 on the other way. Those providers probably have a
13 workers' compensation insurance policy. Can they tell
14 the insurance company, oh, you gave me a bill for
15 \$700, maybe in three or four years, I'll pay you 50
16 percent of that. That's the problem right now. We
17 have a system in which the insurance companies
18 essentially cannot pay the bill. They'll wait three
19 or four years and then outside some judge's chamber
20 three or four years from now, they'll decide --
21 they'll get an agreement with the provider to take 50
22 percent because that's better than nothing for the
23 provider. That's the system we're operating under
24 right now. And that's just wrong. It shouldn't be
25 that way. And I believe that you have a fundamental

1 responsibility to help change that. I'd like to raise
2 the same issue that's been raised by a couple other
3 people, which is 9792.5.12(c)(3). I'll read it.
4 "Upon a showing of good cause and after consultation
5 with the Administrative Director, the IBRO may allow
6 the consolidation of requests or independent bill
7 review by a single provider showing a possible pattern
8 and practice of underpayment by a claims administrator
9 for specific billing codes." If that is the remedy
10 for a pattern and practice of underpayment by a claims
11 administrator, this system is not going to work. We
12 need to get serious. If there is a pattern and
13 practice of underpayment of bills, you need to do
14 something about it. In the hearings last week, I
15 provided you with copies of what the Department of
16 Managed Health Care does. One of those letters that I
17 provided you, again, I get these off the Department of
18 Managed Health Care web site, they're public letters,
19 one of the letters I provided to you last week was
20 indeed a \$350,000 fine against a provider for late
21 payment of provider bills. Incidentally, I had
22 someone from the audience come up to me afterwards
23 almost apoplectic about a \$350,000 fine. Well, guess
24 what? That was low. We have here a copy of a letter
25 of agreement in which the focus of the department's

1 investigation with the plan's failure to provide the
2 Knox-Keene Act covering claims payment, provider
3 disputes, and unfair payment patterns. The amount of
4 the penalty against the plan was \$900,000. The
5 department suspended \$400,000 of the penalty
6 contingent upon the financial examination
7 demonstrating that the payer fully complies with
8 claims payment and provisions of Knox-Keene Act. But
9 there was still an agreement to pay \$500,000. The
10 second one I'd like to submit to you, DMHC announces
11 nearly five million dollars in health plan fines for
12 improper payment of rider claims. This incidentally
13 was under the last administration, the Schwarzenegger
14 administration, a Republican governor. Our clear and
15 consistent message is that California's hospitals and
16 physicians must be paid fairly and on time. You have
17 a responsibility to make sure that this system works.
18 If it has become standard operating practice, and I
19 contend that the testimony that you've received shows
20 that it has in far too many cases, to simply not pay
21 the bill, that has to be stopped. If there are
22 circumstances in which providers are billing for
23 services that have not been provided, fine, go after
24 the provider. But if the payer is doing something
25 very similar, simply not paying the bill, they need to

1 be hammered. Thank you.

2 MR. PARISOTTO: Thank you. Jonathan Roven.

3 JONATHAN ROVEN

4 MR. ROVEN: Hi, my name is Jonathan Roven. I'm a
5 California licensed attorney, and I represent medical
6 providers in billing disputes.

7 The new IBR regulations are effectively
8 eliminating the doctor's ability to collect from the
9 judicial system. When a party provides services for
10 another party without having to pay for it, that's
11 typically called unjust enrichment. In this type of
12 breach of contract action, the plaintiff is usually
13 able to take a defendant to court to try and get
14 reimbursed for the reasonable value of their services.
15 The lien and Declaration of Readiness to Proceed
16 system helps doctors and medical providers use this
17 quasi judicial system to get paid that reasonable
18 value. The normal statute of limitations for a breach
19 of written contract action in California is four years
20 from the date of the breach. The new IBR regulations
21 are reducing that amount of time to 90 days.
22 Insurance companies are currently recommending zero
23 allowance for thousands of dollars worth of services
24 provided by medical providers. If these providers
25 don't file the requisite documents within the 90-day

1 period, then to my understanding, the Explanation of
2 Benefits is deemed satisfied. This necessarily gives
3 insurance companies thousands of dollars of services
4 for free. Complying with these extremely limited time
5 statutes is onerous, costly, and goes against the
6 public policy of allowing a plaintiff to go after the
7 reasonable value of their services within a reasonable
8 time frame. The lien system is more beneficial than
9 the proposed IBR system because it allows parties a
10 larger time frame to get the proper documentation
11 together and proof of the reasonable value of their
12 services. This is more consistent with public policy
13 of allowing aggrieved parties to assert claims within
14 a reasonable period of time. I believe that the new
15 IBR system is compromising that public policy. Thank
16 you.

17 MR. PARISOTTO: Thank you. Amber Ott.

18 AMBER OTT

19 MS. OTT: Hi, Amber Ott, O-t-t, California
20 Hospital Association.

21 So I did submit written comments, so I'll try to
22 keep this brief, but I wanted to raise a few points
23 that are especially important to hospitals. So the
24 definition of a provider as it stands in the
25 regulations currently excludes essential parties from

1 participating in the claims administration process.

2 As you all know, hospitals use vendors and other
3 resources to help bill and appeal and adjudicate
4 claims, and this really limits the ability of a
5 hospital to use any outside sources to assist in that
6 process. We would ask that you expand the definition
7 of a provider to also mean any agent, contractor, or
8 subcontractor that is utilized by that hospital.

9 The next issue I'd like to touch on has also been
10 addressed by some others in the room, and that's the
11 time frame for the second review on the IBR. So for
12 the second review, hospitals have 90 days, which is
13 just woefully inadequate. Under current law, AB 1455
14 allows a Knox-Keene license health plan. Hospitals
15 have a minimum of one year to apply to those types of
16 plans, and many hospitals struggle with meeting that
17 deadline. So to reduce that to 90 days really will
18 force hospitals to forfeit most of these payments.
19 Also the two listed options that will trigger the
20 deadline for the second review are not mutually
21 exclusive, so we would ask that you define it as the
22 later of the two. Similarly, for requesting an IBR,
23 the 30 days is really just unreasonable. And there
24 are five trigger deadlines for that which we would
25 also request that you define the latter of the five as

1 the ultimate trigger deadline. So IBRs are meant to
2 resolve disputes between -- or regarding one date of
3 service and one billing code. I can only assume this
4 was meant for physicians and not for hospitals because
5 as we know, many hospital stays are longer than one
6 day, especially if we're talking about an in-patient
7 stay. So it would be problematic for a hospital to
8 only be able to appeal for the one day of stay. And
9 also for one -- one service code, one billing code,
10 outpatient claims have multiple CPT codes on there,
11 and they're -- they're all required in order to
12 accurately price the claim. So to only be able to
13 appeal one of those codes really wouldn't be
14 appropriate. In addition, in-patient claims will have
15 one DRG assigned to the claim, but in the case of the
16 complex final procedures, you'll also need the code
17 for the Revenue Code 278 to appropriately adjudicate
18 that claim. Similarly, the consolidation request also
19 is limited to one date of service and one billing
20 code. In addition, the dispute must not exceed
21 \$4,000. That also is unreasonable in a hospital
22 environment. Most in-patient claims exceed \$4,000.
23 So to consolidate any in-patient claims and stay
24 within that limit really is not going to happen. And
25 on the outpatient side, that would also be

1 put in through this lengthy process. Specifically,
2 I'd like to commend Director Christine Baker and
3 Acting Director Destie Overpeck for the leadership
4 during this process implementing SB 863, which was a
5 bipartisan labor/employer work comp reform. It was
6 data driven, and it was well vetted, so we appreciate
7 the efforts of getting that into place.

8 Our coalition is generally supportive of the IBR
9 comments. We have a couple of highlights that I'm
10 going to give today, though, I've provided a little
11 bit more extensive written commentary.

12 The first point is something that wasn't
13 addressed in the regulations, and we think should have
14 been. It's the start of the IBR process, which is the
15 initial payment by the provider to -- or to the
16 provider by the employer. Under Labor Code 4603.2,
17 there's a 45-day deadline to provide this payment.
18 What SB 863 did was not alter this deadline, but it
19 also requires that the EOR be provided with the
20 payment. We would ask the Division to define "with"
21 as meaning as long as both of those are provided
22 within 45 days, that the employers meet the deadline.
23 Right now it's problematic because EORs and payments
24 are generally sent from two separate locations. So if
25 -- in order to comply, they had to be sent together or

1 arrive contemporaneously. It just becomes a complex
2 burden and would risk both payment penalties and audit
3 penalties. It seems illogical because you could have
4 a situation where an employer provides payment on day
5 eight and an EOR on day eleven and would not be in
6 compliance with this if they were supposed to be
7 provided together, as we think it states in the Labor
8 Code presently. However, if you provided both of
9 these documents on day 44, which would be providing to
10 the provider a month later, you would be in
11 compliance, so we just think that this should be
12 squared up where as long as both are provided, then
13 the employer is in compliance.

14 The second point I'll just echo, it's been made a
15 couple of times, is the consolidation. We stated in
16 our emergency regulations, we think this should be
17 stricken. We think this is a judicial function. It
18 is -- It does occur in the work comp system, but it's
19 rare, it's extraordinary, and it's done in front of
20 the Board after multiple hearings and vetting of
21 issues. We don't think that the IBRO is equipped to
22 handle these types of issues and as a result, we think
23 that numerous claims, which have -- which do not have
24 common issues will in fact be decided together. So
25 those are my highlights today, though, again, we are

1 providing some extensive commentary. I thank you for
2 the opportunity to speak. I thank you for your
3 efforts, and I look forward to working with the
4 Division as this process continues.

5 MR. PARISOTTO: Thank you very much. Well, I
6 have gone through the list of everyone who indicated
7 they wished to speak, so does anybody have any
8 additional comments they would like to present?

9 ADAM FOWLER

10 MR. FOWLER: Yes. My name is Adam Fowler, I'm
11 with PMSI. I apologize. I thought I checked the
12 "yes" box on the -- on the sheet. I may have not, so
13 it's my --

14 MR. PARISOTTO: You know what? You actually did,
15 and I did miss that, I passed it over, and I
16 apologize.

17 MR. FOWLER: Oh, okay, as long as it wasn't on
18 purpose. Okay.

19 My name is Adam Fowler. Last name is
20 F-o-w-l-e-r. I'm with PMSI. We're a provider of
21 pharmacy and other ancillary medical services for
22 injured workers. We are also active participants and
23 leaders in NCPDP and the IAIABC.

24 I appreciate this opportunity to just briefly
25 note our general support for the intent of the

1 permanent regulations. We believe the amendments
2 contained therein represent DWC's earnest intent to
3 meet the requirements imposed by SB 863, which
4 included a host of rule-making activities that we know
5 were associated with certain time frames that I'm sure
6 were potentially a pain for the Division to get
7 through, and we appreciate your earnest ability to get
8 to it, and we really appreciate it.

9 We also in addition would like to thank DWC for
10 its continued dialog with standards setting
11 organizations, such as the IAIABC and the NCPDP. As
12 leaders in NCPDP's Workers' Comp and property casualty
13 billing and state reporting task group, we're
14 especially appreciative with DWC's outreach recently
15 to NCPDP in order to come up with a -- or to formalize
16 a more standard solution to identify a request for
17 second bill review on a pharmacy, paper, or electronic
18 form. NCPDP internally has already begun discussions
19 to work on a more standard solution, and we look
20 forward to working with them on that in the future.

21 Also our submitted written comments, which are
22 more detailed, have several requests for
23 clarifications and suggestions that I won't go into
24 here today to avoid spending too much time. We
25 believe that answers to those questions may assist

1 PMSI and other stakeholders in properly complying with
2 the permanent regulations once they are adopted. A
3 lot of those questions are based upon our personal
4 experience since January complying with the emergency
5 rules.

6 Just thank you again for allowing us the
7 opportunity to provide our comments. We really
8 appreciate it.

9 MR. PARISOTTO: Thank you very much. So I guess
10 I have to ask two questions now. Is there anybody
11 else who had checked "yes" that I either intentionally
12 or unintentionally passed over? Is there anyone else
13 who wishes to testify?

14 STEVE CATTOLICA

15 MR. CATTOLICA: Yes. My name is Steve Cattolica.
16 You know who we represent.

17 I'm presenting these comments separate from our
18 others because it specifically has to do with
19 electronic billing and because it's so integrated into
20 the IBR process, and I know the desire of the Division
21 is for provider participation in electronic billing, I
22 think this is important to understand. As we've
23 commented elsewhere and already, the IBR process is in
24 need of refinement, if it's to be ready to handle the
25 volume and types of disputes contemplated by the

1 Division. But in the meantime, providers do not need
2 a new, and in many ways, dysfunctional billing and
3 reimbursement system preventing them from getting
4 properly paid in the first place. Based on input from
5 our members, it's apparent to us that as eBilling
6 operates today, the system is a deterrent to
7 participation. As odd as it may seem, providers who
8 contemplate submitting bills electronically must
9 decide to trade the well-known and well-worn problems
10 of the paper billing with the new frontier of
11 electronic billing that is itself replete with its own
12 set of collection problems not contemplated by the
13 Division when it set up this potentially efficient
14 program. The current nature of this new frontier
15 denies reimbursement to providers by methods that
16 cannot be resolved through IBR. In ways we enumerate
17 later in our written comments, which we'll provide,
18 providers are not being reimbursed for services
19 properly submitted, regardless of the amount. For
20 providers submitting electronic bills, it appears
21 impossible to arrive at a point where IBR is even
22 available. We urge the Division to explore the issues
23 that we're going to raise in our written comments and
24 do what may be necessary to bring electronic billing
25 to a level of efficiency that the community

1 anticipated and deserves. Electronic billing must not
2 be allowed to become the new way of delaying
3 reimbursement or a way of shifting reimbursement
4 disputes from the bill review system to the bill
5 submission system and away from the IBR process. It
6 cannot become a source for systematic -- excuse me,
7 systemic delays and new disputes for which there is no
8 ready avenue for resolution and IBR is not designed to
9 address. Despite the promise of electronic billing
10 technology, physicians or their billing services are
11 being compelled to make hundreds of telephone calls to
12 carriers only to be told that the providers should
13 submit their bills via fax or mail, if they want to
14 get paid. And we have a record of a number of
15 carriers who are not even accepting electronic bills
16 despite the requirement to do so, and we'll provide
17 more of that documentation a little bit later.

18 I want to double back to a couple of things that
19 have been said with respect to the fee, the \$335 fee.
20 I used to be in managed care. Some of the folks in
21 the audience used to be my customers. When we would
22 get a prospect, we'd want to decide or estimate what
23 our revenue was going to be if we landed that
24 prospect. And if it was a bill review customer, we
25 would decide how many bills they were going to provide

1 to us and what our revenue might be. And granted,
2 this was a decade or so ago, but the revenue was
3 pretty much the number of bills times about eight
4 bucks, eight bucks to do bill review. That was it. I
5 don't know where the Division came up with the number
6 335, but I believe that there's a requirement that it
7 resemble and somehow reflect either the cost or the
8 benefit, the value of the service being provided to
9 the participants. I don't see the correlation between
10 those two numbers, especially if the provider who
11 settles the dispute prior to having to go through IBR,
12 has to give up the whole of that amount for having
13 done the right thing and settling it away from IBR.
14 The second is consolidation. Consolidation has been
15 amply provided -- or spoken about is an advantage to
16 everybody, and yet the Division -- and, and it's a
17 complicated issue. We applaud your folks even trying
18 to begin to decipher all of this. But consolidation
19 needs to be encouraged, not prescriptively restricted.
20 And we would just urge the Division to do everything
21 it can to allow for consolidation to happen. And I
22 agree with the comment that was made earlier with
23 respect to who gets to decide consolidation. I think
24 that decision needs to lie with the Administrative
25 Director because that's the only place that all the

1 information is going to reside at one spot at one
2 time. If it's allowed to be a decision by the IBRO,
3 then not knowing how many might be necessary, where
4 the different requests have gone, if it's multiple
5 codes, that's almost going to be a decision that's
6 impossible to make. So we would hope that the
7 Division looks closer at consolidation as an avenue to
8 make IBR work better and not become more protracted.
9 Thank you.

10 MR. PARISOTTO: Thank you. Is there anyone else
11 who wishes to testify? Well, if no one else will
12 testify, this hearing will be closed.

13 I'd like to thank everyone today who offered
14 comments for some very valuable information. I
15 thought this was incredibly productive. The
16 opportunity to file written comments will stay open
17 until 5 o'clock this afternoon. Those comments should
18 be delivered to the DWC office up on the 17th floor of
19 this building. As I mentioned earlier, we might be
20 having problems with our mail box, so if you'd like to
21 submit comments electronically, you can submit them to
22 dwcrules@dir.ca.gov. And I would suggest you also
23 send them to our Regulations Coordinator Maureen Gray
24 at mgray@dir.ca.gov. I assume that we will go through
25 all of the sign-up sheets probably later on today, and

1 if you did manage to attend all four of our public
2 hearings in the course of the last month, you probably
3 will be entitled to some award.

4 On behalf of the Acting Administrative Director,
5 I'd like to extend our thanks for attending and your
6 input.

7 The hearing is now closed.

8 (Proceedings adjourned at 11:30 a.m.)

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R E P O R T E R S ' C E R T I F I C A T E

We, Barbara A. Cleland and Katherine L. Latini,
Official Hearing Reporters for the State of
California, Department of Industrial Relations,
Division of Workers' Compensation, do hereby certify
that the foregoing is a full, true and correct
transcript of the proceedings taken by us in shorthand
on the date and in the matter described on the first
page hereof.

Barbara A. Cleland
Barbara A. Cleland
Official Hearing Reporter
Workers' Compensation Appeals Board

Katherine L. Latini
Katherine L. Latini
Official Hearing Reporter
Workers' Compensation Appeals Board

Dated: April 15, 2013