

Independent Bill Review Public Meeting - October 2, 2012
Division of Workers' Compensation

Excerpts of Senate Bill 863

The Legislature finds and declares all of the following:

(h) That the performance of independent bill review is a service of such a special and unique nature that it must be contracted pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code, and that independent bill review is a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code. Existing law provides no method of medical billing dispute resolution short of litigation. Existing law does not provide for medical billing and payment experts to resolve billing disputes, and billing issues are frequently submitted to workers' compensation judges without the benefit of independent and unbiased findings on these issues. Medical billing and payment systems are a field of technical and specialized expertise, requiring services that are not available through the civil service system. The need for independent and unbiased findings and determinations requires that this new function be contracted pursuant to subdivision (b) of Section 19130 of the Government Code.

Labor Code section 139.5:

(a) (1) The administrative director shall contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The independent review organizations shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state. The administrative director may establish additional requirements, including conflict-of-interest standards, consistent with the purposes of Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4, that an organization shall be required to meet in order to qualify as an independent review organization and to assist the division in carrying out its responsibilities.

(2) To enable the independent review program to go into effect for injuries occurring on or after January 1, 2013, and until the administrative director establishes contracts as otherwise specified by this section, independent review organizations under contract with the Department of Managed Health Care pursuant to Section 1374.32 of the Health and Safety Code may be designated by the administrative director to conduct reviews pursuant to Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 of Division 4. The administrative director may use an interagency agreement to implement the independent review process beginning January 1, 2013. The administrative director may initially contract directly with the same organizations that are under contract with the Department of Managed Health Care on substantially the same terms without competitive bidding until January 1, 2015.

(b) (1) The independent medical review organizations and the medical professionals retained to conduct reviews shall be deemed to be consultants for purposes of this section.

(2) There shall be no monetary liability on the part of, and no cause of action shall arise against, any consultant on account of any communication by that consultant to the administrative director or any other officer, employee, agent, contractor, or consultant of the Division of Workers' Compensation, or on account of any communication by that consultant to any person when that communication is required by the terms of a contract with the administrative director pursuant to this section and the consultant does all of the following:

(A) Acts without malice.

(B) Makes a reasonable effort to determine the facts of the matter communicated.

(C) Acts with a reasonable belief that the communication is warranted by the facts actually known to the consultant after a reasonable effort to determine the facts.

(3) The immunities afforded by this section shall not affect the availability of any other privilege or immunity which may be afforded by law. Nothing in this section shall be construed to alter the laws regarding the confidentiality of medical records.

(c) (1) An organization contracted to perform independent medical review or independent bill review shall be required to employ a medical director who shall be responsible for advising the contractor on clinical issues. The medical director shall be a physician and surgeon licensed by the Medical Board of California or the California Osteopathic Medical Board.

(2) The independent review organization, any experts it designates to conduct a review, or any officer, director, or employee of the independent review organization shall not have any material professional, familial, or financial affiliation, as determined by the administrative director, with any of the following:

(A) The employer, insurer or claims administrator, or utilization review organization.

(B) Any officer, director, employee of the employer, or insurer or claims administrator.

(C) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.

(D) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.

(F) The employee or the employee's immediate family, or the employee's attorney.

(d) The independent review organizations shall meet all of the following requirements:

(1) The organization shall not be an affiliate or a subsidiary of, nor in any way be owned or controlled by, a workers' compensation insurer, claims administrator, or a trade association of workers' compensation insurers or claims administrators. A board member, director, officer, or employee of the independent review organization shall not serve as a board member, director, or employee of a workers' compensation insurer or claims administrator. A board member, director, or officer of a workers' compensation insurer or claims administrator or a trade association of workers' compensation insurers or claims administrators shall not serve as a board member, director, officer, or employee of an independent review organization.

(2) The organization shall submit to the division the following information upon initial application to contract under this section and, except as otherwise provided, annually thereafter upon any change to any of the following information:

(A) The names of all stockholders and owners of more than 5 percent of any stock or options, if a publicly held organization.

(B) The names of all holders of bonds or notes in excess of one hundred thousand dollars (\$100,000), if any.

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business.

(D) The names and biographical sketches of all directors, officers, and executives of the independent review organization, as well as a statement regarding any past or present relationships the directors, officers, and executives may have with any employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, provider group, or board or committee of an employer, workers' compensation insurer, claims administrator, medical provider network, managed care organization, or provider group.

(E) (i) The percentage of revenue the independent review organization receives from expert reviews, including, but not limited to, external medical reviews, quality assurance reviews, utilization reviews, and bill reviews.

(ii) The names of any workers' compensation insurer, claims administrator, or provider group for which the independent review organization provides review services, including, but not limited to, utilization review, bill review, quality assurance review, and external medical review. Any change in this information shall be reported to the department within five business days of the change.

(F) A description of the review process, including, but not limited to, the method of selecting expert reviewers and matching the expert reviewers to specific cases.

(G) A description of the system the independent medical review organization uses to identify and recruit medical professionals to review treatment and treatment recommendation decisions, the number of medical professionals credentialed, and the types of cases and areas of expertise that the medical professionals are credentialed to review.

(H) A description of how the independent review organization ensures compliance with the conflict-of-interest requirements of this section.

(3) The organization shall demonstrate that it has a quality assurance mechanism in place that does all of the following:

(A) Ensures that any medical professionals retained are appropriately credentialed and privileged.

(B) Ensures that the reviews provided by the medical professionals or bill reviewers are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting medical professionals for individual cases achieves a fair and impartial panel of medical professionals who are qualified to render recommendations regarding the clinical conditions and the medical necessity of treatments or therapies in question.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the medical professionals or bill reviewers retained to perform the reviews through conflict-of-interest policies and prohibitions, and ensures adequate screening for conflicts of interest, pursuant to paragraph (5).

(4) Medical professionals selected by independent medical review organizations to review medical treatment decisions shall be licensed physicians, as defined by Section 3209.3, in good standing, who meet the following minimum requirements:

(A) The physician shall be a clinician knowledgeable in the treatment of the employee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review.

(B) Notwithstanding any other provision of law, the physician shall hold a nonrestricted license in any state of the United States, and for physicians and surgeons holding an M.D. or D.O. degree, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. The independent medical review organization shall give preference to the use of a physician licensed in California as the reviewer.

(C) The physician shall have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restrictions, taken or pending by any hospital, government, or regulatory body.

(D) Commencing January 1, 2014, the physician shall not hold an appointment as a qualified medical evaluator pursuant to Section 139.32.

(5) Neither the expert reviewer, nor the independent review organization, shall have any material professional, material familial, or material financial affiliation with any of the following:

(A) The employer, workers' compensation insurer or claims administrator, or a medical provider network of the insurer or claims administrator, except that an academic medical center under contract to the insurer or claims administrator to provide services to employees may qualify as an independent medical review organization provided it will not provide the service and provided the center is not the developer or manufacturer of the proposed treatment.

(B) Any officer, director, or management employee of the employer or workers' compensation insurer or claims administrator.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the treatment.

(D) The institution at which the treatment would be provided.

(E) The development or manufacture of the treatment proposed for the employee whose condition is under review.

(F) The employee or the employee's immediate family.

(6) For purposes of this subdivision, the following terms shall have the following meanings:

(A) "Material familial affiliation" means any relationship as a spouse, child, parent, sibling, spouse's parent, or child's spouse.

(B) "Material financial affiliation" means any financial interest of more than 5 percent of total annual revenue or total annual income of an independent review organization or individual to which this subdivision applies. "Material financial affiliation" does not include payment by the employer to the independent review organization for the services required by the administrative director's contract with the independent review organization, nor does "material financial affiliation" include an expert's participation as a contracting medical provider where the expert is affiliated with an academic medical center or a National Cancer Institute-designated clinical cancer research center.

(C) "Material professional affiliation" means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the independent review organization. "Material professional affiliation" does not include affiliations that are limited to staff privileges at a health facility.

(e) The division shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the administrative director, filed with it by an independent review organization under contract pursuant to this section. The division may charge a fee to the interested person for copying the requested information.

(f) The Legislature finds and declares that the services described in this section are of such a special and unique nature that they must be contracted out pursuant to paragraph (3) of subdivision (b) of Section 19130 of the Government Code. The Legislature further finds and declares that the services described in this section are a new state function pursuant to paragraph (2) of subdivision (b) of Section 19130 of the Government Code.

Labor Code section 4603.2:

(a) (1) Upon selecting a physician pursuant to Section 4600, the employee or physician shall notify the employer of the name and address, including the name of the medical group, if applicable, of the physician. The physician shall submit a report to the employer within five working days from the date of the initial examination, as required by Section 6409, and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.

(2) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was entitled to select the physician pursuant to Section 4600, the employee shall be entitled to continue treatment with that physician at the employer's expense in accordance with this division, notwithstanding Section 4616.2. The employer shall be required to pay from the date of the initial examination if the physician's report was submitted within five working days of the initial examination. If the physician's report was submitted more than five working days after the initial examination, the employer and the employee shall not be required to pay for any services prior to the date the physician's report was submitted.

(3) If the employer objects to the employee's selection of the physician on the grounds that the physician is not within the medical provider network used by the employer, and there is a final determination that the employee was not entitled to select a physician outside of the medical provider network, the employer shall have no liability for treatment provided by or at the direction of that physician or for any consequences of the treatment obtained outside the network.

(b) (1) Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received. Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

(2) Except as provided in subdivision (d) of Section 4603.4, or under contracts authorized under Section 5307.11, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1, in effect on the date of service. Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each separate, itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician. If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer. An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. Any properly documented list of services provided and not paid at the rates then in effect under Section 5307.1 within the 45-day period shall be paid at the rates then in effect and increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization, unless the employer does both of the following:

(A) Pays the provider at the rates in effect within the 45-day period.

(B) Advises, in an explanation of review pursuant to Section 4603.3, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of an itemization that includes services provided by a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the itemization shall satisfy the requirements of this paragraph.

An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(3) Notwithstanding paragraph (1), if the employer is a governmental entity, payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made within 60 days after receipt of each separate itemization, together with any required reports and any written authorization for services that may have been received by the physician.

(4) Duplicate submissions of medical services itemizations, for which an explanation of review was previously provided, shall require no further or additional notification or objection by the employer to the medical provider and shall not subject the employer to any additional penalties or interest pursuant to this section for failing to respond to the duplicate submission. This paragraph shall apply only to duplicate submissions and does not apply to any other penalties or interest that may be applicable to the original submission.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates, and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of an itemization submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that itemization by the physician or medical provider. When an individual or entity conducting a itemization review determines that additional information or documentation is necessary to review the itemization, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing an itemization of service submitted by a physician or medical provider shall not alter the procedure codes listed or recommend reduction of the amount of the payment unless the documentation submitted by the physician or medical provider with the itemization of service has been reviewed by that individual or entity. If the reviewer does not recommend payment for services as itemized by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or changed other parts of the itemization and the specific deficiency in the itemization or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(e) (1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

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

(B) The item and amount in dispute.

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

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

(2) If the only dispute is the amount of payment and the provider does not request a second review within 90 days, the bill shall be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. This time limit may be extended by mutual written agreement.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(f) Except as provided in paragraph (4) of subdivision (e), the appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

Labor Code section 4603.3:

(a) Upon payment, adjustment, or denial of a complete or incomplete itemization of medical services, an employer shall provide an explanation of review in the manner prescribed by the administrative director that shall include all of the following:

- (1) A statement of the items or procedures billed and the amounts requested by the provider to be paid.
- (2) The amount paid.
- (3) The basis for any adjustment, change, or denial of the item or procedure billed.
- (4) The additional information required to make a decision for an incomplete itemization.
- (5) If a denial of payment is for some reason other than a fee dispute, the reason for the denial.
- (6) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.

(b) The administrative director may adopt regulations requiring the use of electronic explanations of review.

Labor Code section 4603.4:

(a) The administrative director shall adopt rules and regulations to do all of the following:

- (1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.
- (2) Require acceptance by employers of electronic claims for payment of medical services.
- (3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

(c) The rules and regulations requiring employers to accept electronic claims for payment of medical services shall be adopted on or before January 1, 2005, and shall require all employers to accept electronic claims for payment of medical services on or before July 1, 2006.

(d) Payment for medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be made with an explanation of review by the employer within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made with an explanation of review of any uncontested amounts within 15 working days after electronic receipt of the billing, and payment of the balance shall be made in accordance with Section 4603.2.

Labor Code section 4603.6:

(a) If the only dispute is the amount of payment and the provider has received a second review that did not resolve the dispute, the provider may request an independent bill review within 30 calendar days of service of the second review pursuant to Section 4603.2 or 4622. If the provider fails to request an independent bill review within 30 days, the bill shall be deemed satisfied, and neither the employer nor the employee shall be liable for any further payment. If the employer has contested liability for any issue other than the reasonable amount payable for services, that issue shall be resolved prior to filing a request for independent bill review, and the time limit for requesting independent

bill review shall not begin to run until the resolution of that issue becomes final, except as provided for in Section 4622.

(b) A request for independent review shall be made on a form prescribed by the administrative director, and shall include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final explanation of the second review. The administrative director may require that requests for independent bill review be submitted electronically. A copy of the request, together with all required documents, shall be served on the employer. Only the request form and the proof of payment of the fee required by subdivision (c) shall be filed with the administrative director. Upon notice of assignment of the independent bill reviewer, the requesting party shall submit the documents listed in this subdivision to the independent bill reviewer within 10 days.

(c) The provider shall pay to the administrative director a fee determined by the administrative director to cover no more than the reasonable estimated cost of independent bill review and administration of the independent bill review program. The administrative director may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation adopted by the administrative director. If any additional payment is found owing from the employer to the medical provider, the employer shall reimburse the provider for the fee in addition to the amount found owing.

(d) Upon receipt of a request for independent bill review and the required fee, the administrative director or the administrative director's designee shall assign the request to an independent bill reviewer within 30 days and notify the medical provider and employer of the independent reviewer assigned.

(e) The independent bill reviewer shall review the materials submitted by the parties and make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination. If the independent bill reviewer deems necessary, the independent bill reviewer may request additional documents from the medical provider or employer. The employer shall have no obligation to serve medical reports on the provider unless the reports are requested by the independent bill reviewer. If additional documents are requested, the parties shall respond with the documents requested within 30 days and shall provide the other party with copies of any documents submitted to the independent reviewer, and the independent reviewer shall make a written determination of any additional amounts to be paid to the medical provider and state the reasons for the determination within 60 days of the receipt of the administrative director's assignment. The written determination of the independent bill reviewer shall be sent to the administrative director and provided to both the medical provider and the employer.

(f) The determination of the independent bill reviewer shall be deemed a determination and order of the administrative director. The determination is final and binding on all parties unless an aggrieved party files with the appeals board a verified appeal from the medical bill review determination of the administrative director within 20 days of the service of the determination. The medical bill review determination of the administrative director shall be presumed to be correct and shall be set aside only upon clear and convincing evidence of one or more of the following grounds for appeal:

- (1) The administrative director acted without or in excess of his or her powers.
- (2) The determination of the administrative director was procured by fraud.
- (3) The independent bill reviewer was subject to a material conflict of interest that is in violation of Section 139.5.
- (4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.
- (5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review and not a matter that is subject to expert opinion.

(g) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent bill review by a different independent review organization. In the event that a different independent bill review organization is not available after remand, the administrative director shall submit the dispute to the original bill review organization for review by a different reviewer within the organization. In no event shall the appeals board or any higher court make a determination of ultimate fact contrary to the determination of the bill review organization.

(h) Once the independent bill reviewer has made a determination regarding additional amounts to be paid to the medical provider, the employer shall pay the additional amounts per the timely payment requirements set forth in Sections 4603.2 and 4603.4.

Labor Code section 4622:

All medical-legal expenses for which the employer is liable shall, upon receipt by the employer of all reports and documents required by the administrative director incident to the services, be paid to whom the funds and expenses are due, as follows:

(a) (1) Except as provided in subdivision (b), within 60 days after receipt by the employer of each separate, written billing and report, and if payment is not made within this period, that portion of the billed sum then unreasonably unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of receipt of the bill and report by the employer. If the employer, within the 60-day period, contests the reasonableness and necessity for incurring the fees, services, and expenses using the explanation of review required by Section 4603.3, payment shall be made within 20 days of the service of an order of the appeals board or the administrative director pursuant to Section 4603.6 directing payment.

(2) The penalty provided for in paragraph (1) shall not apply if both of the following occur:

(A) The employer pays the provider that portion of his or her charges that do not exceed the amount deemed reasonable pursuant to subdivision (e) within 60 days of receipt of the report and itemized billing.

(B) The employer prevails.

(b) (1) If the provider contests the amount paid, the provider may request a second review within 90 days of the service of the explanation of review. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and shall include all of the following:

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

(B) The party or parties requesting the service.

(C) Any item and amount in dispute.

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

(E) Any additional information requested in the original explanation of review and any other information provided in support of the additional payment requested.

(2) If the provider does not request a second review within 90 days, the bill will be deemed satisfied and neither the employer nor the employee shall be liable for any further payment.

(3) Within 14 days of the request for second review, the employer shall respond with a final written determination on each of the items or amounts in dispute, including whether additional payment will be made.

(4) If the provider contests the amount paid, after receipt of the second review, the provider shall request an independent bill review as provided for in Section 4603.6.

(c) If the employer denies all or a portion of the amount billed for any reason other than the amount to be paid pursuant to the fee schedules in effect on the date of service, the provider may object to the denial within 90 days of the service of the explanation of review. If the provider does not object to the denial within 90 days, neither the employer nor the employee shall be liable for the amount that was denied. If the provider objects to the denial within 90 days of the service of the explanation of review, the employer shall file a petition and a declaration of readiness to proceed with the appeals board within 60 days of service of the objection. If the employer prevails before the appeals board, the appeals board shall order the physician to reimburse the employer for the amount of the paid charges found to be unreasonable.

(d) If requested by the employee, or the dependents of a deceased employee, within 20 days from the filing of an order of the appeals board directing payment, and where payment is not made within that period, that portion of the billed sum then unpaid shall be increased by 10 percent, together with interest thereon at the rate of 7 percent per annum retroactive to the date of the filing of the order of the board directing payment.

(e) (1) Using the explanation of review as described in Section 4603.3, the employer shall notify the provider of the services, the employee, or if represented, his or her attorney, if the employer contests the reasonableness or necessity of incurring these expenses, and shall indicate the reasons therefor.

(2) The appeals board shall promulgate all necessary and reasonable rules and regulations to insure compliance with this section, and shall take such further steps as may be necessary to guarantee that the rules and regulations are enforced.

(3) The provisions of Sections 5800 and 5814 shall not apply to this section.

(f) Nothing contained in this section shall be construed to create a rebuttable presumption of entitlement to payment of an expense upon receipt by the employer of the required reports and documents. This section is not applicable unless there has been compliance with Sections 4620 and 4621.

Issues for Discussion

- What is the current volume of electronic billing in the workers' compensation system? (4603.3(b).)
- Are there differences between the electronic billing rules and the paper billing rules that should be taken into account in the Independent Billing Review (IBR) regulations.
 - The Division is considering deferring an electronic IBR until 7/2013 (or beyond).
- The Division is considering regulations for consolidating or aggregating bill review requests. (4603.6 (c).)
 - If consolidation is instituted, what factors should be considered in the consolidation?
 - Should there be a graduated schedule for consolidating small bills if bills are consolidated?
- How does the second bill review process fit with the reconsideration processes already in place?
 - What alterations are necessary for the existing system? What additional issues need to be considered?
 - What information should the second review form contain? (4622(b) (1).)
- Changes necessary, if any, to the required explanation of benefit?
 - Should more information be required? (4622(a) (1) *"If the employee, within the 60 day period, contests the reasonableness and necessity for incurring the fees, service, and expenses using the explanation of review required by Section 4603.3.)*
 - If so, what additional information should be included EOB?
- Liability issues can stop IBR. (4603.6 (a).)
 - When in the process are liability objections raised now? Is this the earliest that the issue of liability could be raised?
 - On the M/L side, does 4622(c) apply where there is an objection to the exam on other grounds and other procedures have been instituted, for example and appeal under section 5300 or an objection to the M/L exam? (139.3, for example.)
- Acquisition of additional information by IBRO. (4603.6 (e).)
 - Should all contact be in writing?

- If not, under what circumstances is oral communication with a party allowed, if at all?
- What information should be in the determination issued by the IBRO? (4603.6 (e).)