DWC 21st Annual Educational Conference:
Independent Medical Review (IMR) and Independent Bill Review (IBR)

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February 10-11, 2014, Oakland

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UR and IMR Regulations
UR Process Overview

- Physicians submit Request for Authorization
- Claims administrators approve treatments
- Cases that are not approved must be reviewed by a physician who uses medical evidence to
  - Approve treatment or
  - Deny treatment
- Response in five working days

SB 863 Utilization Review Changes

- UR may be deferred if there is a liability dispute for either the injury or the recommended treatment.
- A UR decision to deny or modify a treatment request is effective for 12 months.
  - No action needed on a request for the same treatment unless there is a documented change in material facts.
- An explanation of benefits can serve as notification of a retrospective UR approval.
Utilization Review/ RFA Form

• Mandatory use of the Request for Authorization Form (DWC Form RFA-1) or accepted alternate.
• RFA must (1) identify the employee and the provider, (2) specify the recommended treatment, and (3) include documentation showing the medical necessity of the treatment.
• The claims administrator may accept an alternate RFA:
  • “Request for Authorization” must be clearly written at the top of the first page.
  • All requested treatment must be on the first page.
  • The request is accompanied by supporting documentation.

Utilization Review

• A request for expedited review that is not reasonably supported by evidence may be reviewed under the standard timeframes.
• If an additional test or specialized consultation is requested, a denial can issue if the results are not provided within 30 days of the RFA.
State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

About the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician’s Progress Report Form PR-2, an equivalent narrative report substantiating the requested treatment.

New Request
Resubmission – Change in Material Facts
Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
Check box if request is a written confirmation of a prior oral request.

Employee Information
Name (Last, First, Middle):
Date of Injury (MM/DD/YYYY):
Date of Birth (MM/DD/YYYY):
Claim Number:
Employer:

Requesting Physician Information
Name:
Practice Name:
Contact Name:
Address: City: State:
Zip Code:
Phone:
Fax Number:
Specialty:
NPI Number:
E-mail Address:

Claims Administrator Information
Company Name:
Contact Name:
Address: City: State:
Zip Code:
Phone:
Fax Number:
E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis
ICD-Code
Service/Good Requested
CPT/HCPCS Code (If known)
Other Information (Frequency, Duration, Quantity, etc.)

Provider fills out RFA form
Treatment Approved
UR Denial, Delay, Modification
Liability dispute
Defer UR until resolved

UR denial letter to IW along with completed IMR form
Independent Medical Review

Utilization Review
Utilization Review and Independent Medical Review

- Appeals of UR decisions for medical necessity must be made by independent medical review (IMR).
- UR decision final unless IW requests IMR.
  - Includes denial of spinal surgery.
  - Disputes not involving medical necessity of a treatment must be resolved prior to IMR.

Utilization Review and Independent Medical Review

- The written UR denial, or modification of a treatment request must be sent to IW with an “Application for Independent Medical Review,” DWC Form IMR-1.
  - All fields, except for the signature of the employee, completed by the claims administrator.
  - Must include envelope to the Injured Worker.
APPLICATION FOR INDEPENDENT MEDICAL REVIEW
DWC Form IMR

Section I. To be completed by the Employee:

To effect an appeal regarding medical treatment and allow the independent medical review organization designated by the Administrative Director to review those records and information relevant for review of the disputed treatment identified on this form. These records may include medical, diagnostic imaging reports, and other records related to my case.

I authorize the Division of Workers' Compensation and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

I understand that I may designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization.

I wish to designate:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee’s behalf.

Authorized Representative Designation for Independent Medical Review

I accept the above designation to act on the Employee's behalf regarding my application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be the authorized representative.

I certify that I have reviewed and consent to obtain medical records.
Independent Medical Review (IMR)

- Replaces QME procedure
- Medical expertise to resolve treatment disputes to provide timely, appropriate care for injured workers
- Determinations are binding
  - Limited grounds for appeal to WCAB

Independent Medical Review (IMR)

- Costs paid by the employer/claims administrator
  - $550 for one reviewer
- Provided by MAXIMUS Federal Services (MFS) until 12/31/14
  - Reviewers specialty matched to request
  - IMR reviewers anonymous outside IMRO
IMR Process

• Requested by injured worker/designee
  • 30 days from issuance of UR determination
  • Physician may join with or assist in IMR process
• Complete IMR application requires:
  • Signed, completed IMR Form
  • Copy of UR determination letter
  • Copy of application to be sent to the claims administrator

IMR Process

• Expedited review: unless UR decision was expedited, need documentation confirming employee’s condition
• Internal appeal by claims administrator/URO
  • Runs concurrently with IMR process
  • Must be requested 10 days after UR decision
  • Must be completed 30 days after the request received
  • IMR Application only if decision is modified
Eligibility for IMR

- Initial review of application for eligibility
  - Incomplete application despite attempts to obtain missing documentation
    - Liability dispute
    - Issue at dispute is not medical treatment
  - Denied claim
  - Timelines not met
  - UR denied due to absent medical records
- Separate IMR requests may be consolidated for review

IMR Assignment and Records

- Notice of Assignment and Request for Information (NOARFI)
- Records submission by claims administrator and employee within 15 days following NOARFI, e.g.:
  - Six months of medical records relevant to the condition
  - Copy of the IMR Application
  - Reasonable information supporting medical necessity of the treatment
  - Newly developed or discovered records
Withdrawal of IMR

- IMR may be terminated at any time if employer approves treatment
- Reduced cost if withdrawn before assignment to reviewer ($215)

IMR Review

- 30 days from receipt of documentation
- No records submitted by claims administrator?
  - No IMR determination based solely in information in UR determination
How Long Does IMR Take?

- 30 days to submit missing information:
  - No statutory timeline, DWC & MFS attempt to obtain
- 50 days to make determination:
  - 15 days to get documents to MFS
    - 8 C.C.R. § 9792.10.5
  - 30 days “of the receipt of the request for review and supporting documentation to issue ... determination”
    - Labor Code § 4610.6; 8 C.C.R. § 9792.9.6(g)(i)
  - 5 days for mailing

Timeline: Complete IMR Request

- UR delay/denial/modification
- IMR request submitted to MFS
- MFS assigns to reviewer & requests medical records
- MFS issues determination
- Up to 30 days*
- Up to 50 days*

*Up to 80 days to issue determination
Incomplete IMR Request: Emergency Regulations

- Potentially ineligible or Incomplete/missing records
  - MFS and/or DWC staff request missing documents from parties
    - ~30 days
      - Documents not received
        - DWC issues final ineligibility determination
      - Documents received, case ineligible for IMR
        - To “Complete IMR Request”
      - Documents received, case eligible for IMR

Incomplete IMR Request: Proposed Final Regulations

- Potentially ineligible or incomplete application
  - Incomplete applications will be declared ineligible by DWC
    - ~30 days
      - DWC makes eligibility determination
        - Ineligible
        - Eligible to “Complete IMR Request”
IMR Appeal and Penalties

- 20 days to appeal IMR Determination to WCAB
  - Limited grounds
  - 8 C.C.R. § 10957.1 (WCAB Rules)
- Administrative Penalties
  - Order to Show Cause by Administrative Director
- IMR Penalties - 8 C.C.R. § 9792.12(c)
  - Failure to include IMR Application in UR decision
  - Failure to advise injured worker of IMR process
  - Failure to provide medical records

IMR Workflow at MFS
IMR Process

Applications are received today via fax or by mail

Applications Received

• Applications are received today via fax or by mail

Cases Created

• All the data on the Application is entered into the system
• The case is created in entellitrak*

* entellitrak is the Case Management Systems used by MFS
IMR Process

- MFS conducts Preliminary Review to determine if there are any eligibility issues. A few examples:
  - Has the UR been submitted with the application?
  - Is the application signed?
  - Was the application received in time (30 days from the UR)?
  - Was there a liability dispute?
  - Was the UR denial based on missing medical records?

IMR Process

- NOARFI is sent to the Claims Administrator (CA) requesting medical records
- The same NOARFI is also sent as a “cc” to the Injured Worker (IW) / Applicant Attorney (AA)
- CA have 15 days to submit all requested documents
- CA are encouraged to submit a list of all the documents submitted for the review
- The 45 day clock begins per regulations to produce a Final Decision
Once all the medical records have been received the case is sent to a reviewer on the medical panel for review

- Once the MPR is returned the Final Decision Letter is created
- The Letter is reviewed for Quality Assurance and Quality Control

Final Decision Letter is sent to both the IW/AA and the Claims Administrator

- The duration from a NOARFI through to a FDL is 45 days if everything is competed as scheduled
  - Medical records are received from the Claims Administrators (15 days)
  - MPR's are sent, returned and Quality reviewed by MAXIMUS (30 days)
• For applications that are received without a UR, a notice is sent to both the IW/AA and the CA
  • This first notice requests the UR within 15 days
  • It is the responsibility of the CA to submit a copy of the UR to the IW/AA. It is the responsibility of the IW/AA to submit the UR to MFS with the application.

• If the UR is not received within the first 15 days, a second notice is sent. If not received within 15 days of the second notice (30 days in total) the case will be referred to the DWC for an eligibility determination
• Cases will also be declared ineligible by the DWC if the application is missing a signature
• DWC makes eligibility determination based on issues raised by MFS at Preliminary Review. A few examples:
  • Was the application received in time (30 days from the UR)?
  • Was there a liability dispute?
  • Was the UR denial based on missing medical records?

• The CA, IW/AA, or the treating physician have 15 days to submit records
If the medical records are not received within 15 days, MFS sends a Second Request for Information. If after 2 days the records are not received:
- The case will be dismissed
- The Claims Administrators could be assessed a penalty by the DWC

A case can be terminated for:
- IW/AA withdraws review
- Treatment in dispute is authorized by the Claims Administrator
- A termination letter is sent to all parties
IMR online application update

- Application awaiting final approval
- MFS completes development
- MFS completes System Testing
- User Acceptance Testing
- Training video available online
- Online application goes live – Q2 2014

IMR Experience to Date
INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/19/2013 disputing the Utilization Review Denial dated 5/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. A decision has been made for each of the treatment and/or services that were in dispute:

1) MAXIMUS Federal Services, Inc. has determined the retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13 is not medically necessary and appropriate.

Medical Qualifications of the Expert Reviewer:
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopaedic Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Case Summary:
Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 17, 2013.
Rationale for Decision

1) Regarding the request for 2nd set of epidural steroid injection Left L5-S1 lumbar transforaminal:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make Decision:

The Claims Administrator based its decision on the Low Back Complaints in O’DELM Practice Guidelines, 2nd Edition (2004), Chapter 12 pg. 303, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the guidelines used by the Claims Administrator were not appropriate for the issue at dispute. The Expert Reviewer used the Chronic Pain Medical Treatment Guidelines (May, 2009), Epidural Injection. Pg. 46, which is part of the (MTUS).

Rationale for the Decision:
The employee sustained a work-related injury on August 23, 2012 to the lower back. Medical records provided for review indicate treatments have included pain medication and epidural steroid injection. The request is for 2nd set of epidural steroid injection left L5-S1 lumbar transforaminal.

The MTUS Chronic Pain Medical Treatment guidelines indicates the criteria for repeat epidural steroid injections are documented pain and functional improvement, including at least 50% pain relief associated with a reduction of medication use for six to eight weeks. The medical records provided for review indicate some pain relief for 1-2 weeks with the use of less pain medications with symptoms increasing after six or eight week which would not meet guideline criteria for a repeat injection. The request for 2nd set of epidural steroid injection left L5-S1 lumbar transforaminal is not medically necessary and appropriate.

In 2013, Most IMR Applications Were Submitted After July

Data as of January 22, 2014
Current Status of IMR

<table>
<thead>
<tr>
<th>Applications Submitted</th>
<th>83,691</th>
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<tr>
<td>Final Determinations</td>
<td>7,885</td>
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<tr>
<td>Cases closed due to other reasons (duplicate, ineligible, terminated)</td>
<td>14,059</td>
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<tr>
<td>Cases completed</td>
<td>21,944 (26% of applications submitted)</td>
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<tr>
<td>Cases awaiting missing information, records, or eligibility determinations</td>
<td>34,032</td>
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<tr>
<td>Cases in pipeline with complete information to proceed</td>
<td>27,715</td>
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As of 1/29/14

Top Ten IMR Reviewer Specialties

<table>
<thead>
<tr>
<th>Reviewer Specialty</th>
<th>Percentage of Total Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM &amp; R</td>
<td>42%</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>21%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>13%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>6%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>5%</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>3%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>2%</td>
</tr>
<tr>
<td>Psychology</td>
<td>2%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1%</td>
</tr>
</tbody>
</table>

Determinations dated through 11/12/13
Average Two Treatments Requests per IMR Determination

- IMR Determinations
- IMR Treatment Decisions

Timeliness of IMR Decisions Issued

- Most of the untimely IMR decisions were issued in September and October 2013
- Reasons for late decisions
  - Unanticipated high volume
  - Incomplete applications
  - Paper process
- Planned process refinements will help avoid future delays

Average Number of Days to Issue IMR Determination*

- Standard: 48.2 days
- Expedited: 5.3 days

*From date of assignment to reviewer

January-October 2013
N=1,133 decisions
Most UR Decisions Upheld by IMR

3,009 Treatment decisions (2,436 upheld, 573 overturned)

Pharmaceuticals Most Common IMR Decision

Determinations dated through 11/12/13
Pharmaceuticals: Injections Most Frequent

- Narcotic Analgesics: 157
- Muscle Relaxants: 114
- Compound Meds: 102
- NSAID: 101
- Proton Pump Inhibitor: 82
- Other Analgesics: 86
- Benzodiazepines: 49

Determinations dated through 11/12/13

Surgery: Spine vs. Non-Spine
IMR Upholds UR at Similar Rates

- Spine: UR Upheld 39, UR Overturned 8
- Non-Spine: UR Upheld 57, UR Overturned 11

Determinations dated through 11/12/13
Surgery Requests: Spine Most Common

![Bar graph showing UR Overturned and UR Upheld for different body parts]

Determinations dated through 11/12/13

IMR Decision Hierarchy

- Medical Treatment Utilization Schedule, Labor Code Section 5307.27
- Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service
- Nationally recognized professional standards
- Expert opinion
- Generally accepted standards of medical practice
- Treatments likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious

Labor Code Section 4610.5(c)(2)
Doctors in California's workers' comp system are required to provide evidence-based medical treatment

Guidelines are laid out in the MTUS

Set in regulation based on recommendations from a committee of experts under the guidance of the DWC Executive Medical Director

"Rebuttable presumption of correctness"

Currently being updated

Clinical Topics
- Neck and upper back
- Shoulder
- Elbow disorders
- Forearm, wrists, hand
- Low back
- Knee
- Ankle and foot
- Stress-related
- Eye

Special topics
- Acupuncture
- Chronic Pain
- Post-surgical treatment

*In Progress*

- Strength of Evidence
- Opioid Treatment
- Updates of all sections
Evidence-Based Medicine

http://www.cochrane.org/about-us/evidence-based-health-care

Not All Requested Treatments are Medically Necessary

In fact, some may be harmful.

--Choosing Wisely, American Board of Internal Medicine Foundation*

*An initiative of the ABIM Foundation, Choosing Wisely is focused on encouraging physicians, patients and other health care stakeholders to use evidence-based recommendations and to think and talk about medical tests and procedures that may be unnecessary, and in some instances can cause harm.
IMR Case Studies

Questions on IMR?
Best Practice Tips for Providers to Obtain Medically Necessary Care

- **Document**
  - Medical & treatment history
  - Functional improvement
  - Evidence-basis of treatment recommendations

- **Communicate**
  - Pursue peer to peer discussions with UR

- **Advocate**
  - Describe treatment options and consequences
  - Explain IMR process (may act as designee)
  - Submit medical records for IMR if requested

Use Evidence-based Medicine to Obtain Medically Necessary Care

- Follow evidence-based practices (MTUS)
  - Or
- Provide scientifically-based evidence in other guidelines or peer-reviewed publications
  - For a requested treatment that is
    - Inconsistent with MTUS or
    - For a condition or injury not addressed in the MTUS
- MTUS “strength of evidence” proposed regulations soon to be released for public comment
IBR Regulations

Independent Bill Review (IBR)

- Process to resolve disputes regarding the amounts paid for medical services in workers’ comp system
- Will not apply to cases:
  - Where the injury itself is in dispute
  - Where there is a dispute about whether or not the provider is authorized to treat the worker
  - Service or good not covered by a fee schedule
- Provided by an independent organization
  - Maximus Federal Services under contract until 12/31/14
Prerequisites to requesting IBR

- **Note changes to DWC Billing Guides**
  - **Initial bill review** by the Claims Administrator Explanation of Review (EOR)
    - Reasons for rejection or reduction of bill
    - Timeframes in Labor Code § 4603.2
  - **Mandatory second review** requested by the provider with additional information
    - Request within 90 days of first EOR
    - DWC Form SBR-1 or modified standard bill
    - Must include required elements. 8 C.C.R. § 9792.5.5 (d)

Prerequisites to requesting IBR

- Second Explanation of Review within 14 days
- Payment of undisputed or additional amounts owed within 21 days
- Timeframes can be extended by agreement
Explanation of Review

- Under Labor Code section 4603.3, an EOR must include:

  (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.
Explanation of Review

(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.

IBR: Who and What?

• Providers File for IBR
  • Includes hospitals and billing agents
  • Must use the AD form (DWC Form IBR-1)
    • Can be completed online or mailed
    • Provider must pay a fee ($335)
      • Reimbursed by claims administrator if provider prevails
    • May request consolidation of separate requests
  • There must be a fee schedule for service billed
IBR Procedure

- Provider must submit with IBR request:
  - DWC Form IBR-1 and filing fee.
  - Original billing itemization, supporting documents, and EOR;
  - Second review request, supporting documents, and EOR;
  - Relevant provisions of Labor Code section 5307.11 contract, if applicable;
  - Documents must be indexed and arranged.
- Consolidation and Disaggregation of IBR requests (section 9792.5.12).
IBR – Eligibility

- Eligible? Consider timeliness, completion of second review, authorization of treatment, payment of fee, dispute under existing fee schedule.
- If request ineligible, provider reimbursed $270
- Claims administrator given opportunity to contest eligibility and IBR request.
  - 15 days to respond

IBR – Procedure

- Provider may withdraw IBR request at any time prior to determination.
  - $270 is reimbursed if withdrawal is prior to assignment of the request to IBRO.
- IBR reviewer may request additional documents.
  - Must be received 35 days after request.
IBR – Consolidation

- Up to 20 individual requests may be consolidated.
- Grounds for consolidation:
  - Multiple dates of services, one employee, one claims administrator, one billing code, one fee schedule, $4,000 limit;
  - Multiple billing codes, one employee, one claims administrator, one date of service;
  - Pattern and practice of underpayment: multiple employees, one claims administrator, one billing code, one or multiple dates of service, (aggregate amounts up to $4,000 or individual amounts less than $50 each).
- IBRO may disaggregate an IBR request.

Independent Bill Review

- Review
  - IBR Reviewer will apply OMFS, Medical-Legal fee schedule, or contract rates to determine if additional amounts owed.
  - Will apply as necessary all billing, payment, and coding rules.

- Decision within 60 days of assignment.
- Limited appeal to WCAB.
IBR Workflow

- Applications are received via fax, mail or electronically
IBR Workflow

- All the data on the Application is entered into the system
- The case is created in entellitrak

IBR Workflow

- Preliminary review is conducted to determine if the request is eligible for review
  - Is the application signed and dated by the Provider?
  - Has payment been made?
  - Was the billed service authorized?
  - Was the Date of Service prior to January 1, 2013?
  - Was the application received within 30 days of the Claims Administrator’s final determination?
  - Did provider submit the Second Bill Review final determination?
  - Is request for IBR applicable?
• If case is deemed eligible for IBR:
  • Notice of Opportunity to Dispute Liability sent to Claims Administrator
  • Notice of eligibility sent to the Provider
  • 15 day clock begins for Claims Administrator dispute response
  • If no response, case assigned
  • Case reviewed for possible request for additional information
  • Letter of Assignment sent and if needed, request for additional information
  • 60 day clock begins, from date of Assignment, to complete the Final Decision
• If case appears ineligible, it will then be referred to the DWC for further review. Some examples are:
  • Liability disputes
  • Service not covered under the adopted fee schedule
  • Incomplete second review

• Case does not move to Eligible status until DWC completes review
Ineligible claims will receive notification directly from the DWC.
If eligible, MAXIMUS notified through entellitrak.

Once eligibility is determined, Eligibility noticing occurs.
After 15 days, case moves to Assignment.
Assignment notices are sent.
IBR Experience to Date

IBR Applications: Slow, Steady Rise
### Current Status of IBR

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications Submitted</td>
<td>1,104</td>
</tr>
<tr>
<td>Final Determinations</td>
<td>263</td>
</tr>
<tr>
<td>Cases ineligible</td>
<td>41</td>
</tr>
<tr>
<td>Cases completed</td>
<td>304 (27% of applications submitted)</td>
</tr>
<tr>
<td>Cases awaiting eligibility determinations</td>
<td>474</td>
</tr>
<tr>
<td>Cases in pipeline with complete information to proceed</td>
<td>326</td>
</tr>
</tbody>
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As of 1/29/14

### Most IBR Determinations Decided in Favor of Provider

- 42% Payment Denied
- 58% Payment Approved

195 IBR Decisions (81 Upheld and 114 Reversed) January 1, 2013 to January 24, 2014

IBR decisions are posted on DWC webpage: [http://www.dwc.ca.gov/ivr/IBR.htm](http://www.dwc.ca.gov/ivr/IBR.htm)
Decision in favor of provider:
Only IBR fee owed

Decision in favor of provider:
IBR fee and cost of service owed
Tips for IBR

- Submit IBR for billing disputes involving fee schedule
- Read instructions carefully
  - Submit all documents
  - Follow all timelines
- Posted IBR determinations are a great learning tool
- More detailed analysis of IBRs to come

We would like to acknowledge:
- John Gordon, Research Unit
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- DWC Medical Unit Staff
- DWC Legal Unit Staff
- MFS Staff