

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

February 3-4, 2014, Los Angeles
February 10-11, 2014, Oakland

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UR and IMR Regulations

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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

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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.

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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.

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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.

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State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
 DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or 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 Birth (MM/DD/YYYY): _____
 Date of Injury (MM/DD/YYYY): _____ Claim Number: _____ Employer: _____

Requesting Physician Information

Name: _____ Contact Name: _____
 Practice 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 (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (if known)	Other Information: (Frequency, Duration Quantity, etc.)

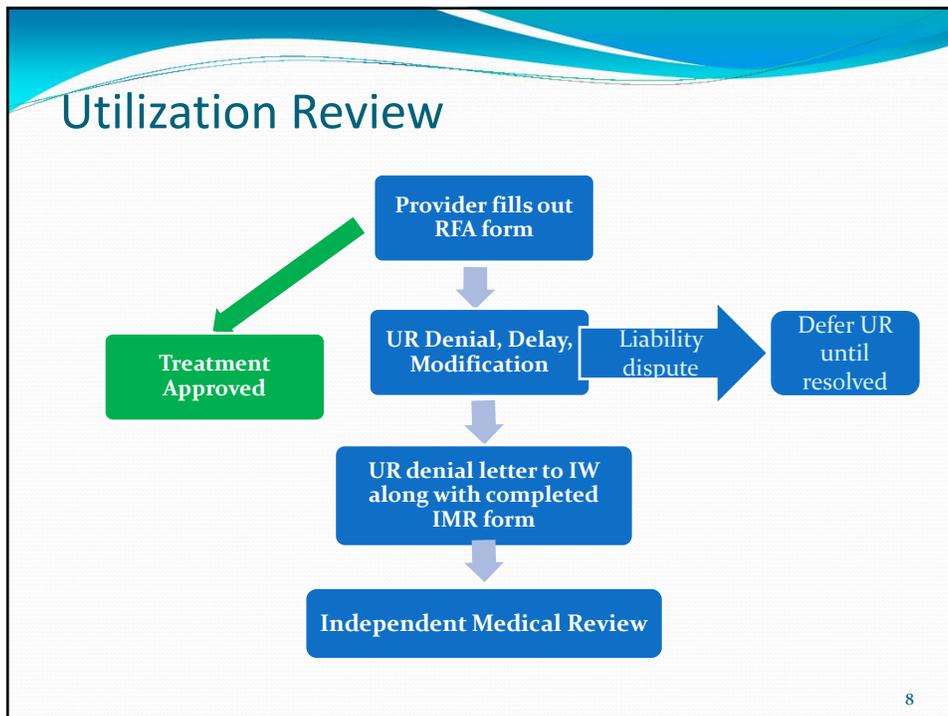
Requesting Physician Signature: _____ Date: _____

Claims Administrator/Utilization Review Organization (URO) Response

Approved Denied or Modified (See separate decision letter) Delay (See separate notification of delay)
 Requested treatment has been previously denied Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned): _____ Date: _____
 Authorized Agent Name: _____ Signature: _____
 Phone: _____ Fax Number: _____ E-mail Address: _____
 Comments: _____

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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.

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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.

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State of California, Division of Workers' Compensation
APPLICATION FOR INDEPENDENT MEDICAL REVIEW
 DWC Form IMR

- TO REQUEST INDEPENDENT MEDICAL REVIEW:**
1. Sign and date this application and consent to obtain medical records.
 2. Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:
DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138000, Sacramento, CA 95813-8000
FAX Number: (916) 605-4270
 3. Mail or fax a copy of the signed application to your Claims Administrator.

Type of Utilization Review: <input type="checkbox"/> Regular <input type="checkbox"/> Expedited	Modification after Appeal <input type="checkbox"/>
Employee Name (First, MI, Last):	
Address:	
Phone Number:	Employer Name:
Claim Number:	Date of Injury (MM/DD/YYYY):
WCIS Jurisdictional Claim Number (if assigned):	EMIS Case Number (if applicable):
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last):	
Practice Name:	
Address:	
Phone Number:	Fax Number:
Claims Administrator Name:	
Adjuster/Contact Name:	
Address:	
Phone Number:	Fax Number:
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical):	
Date of Utilization Review Determination Letter:	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1.	
2.	
3.	
4.	
Request for Review and Consent to Obtain Medical Records	
I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.	
Employee Signature:	Date:

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Authorized Representative Designation for Independent Medical Review
 (To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print): _____

I wish to designate

Name of Individual (Print): _____

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to 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 designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature: _____ Date: _____

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.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name: _____
 I am a/an: _____
 (Professional status or relationship to the Employee, e.g., attorney, relative, etc.)
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ Fax Number: _____
 State Bar Number (if applicable): _____
 Representative Signature: _____ Date: _____

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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

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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

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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

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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

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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

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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

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Withdrawal of IMR

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

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IMR Review

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

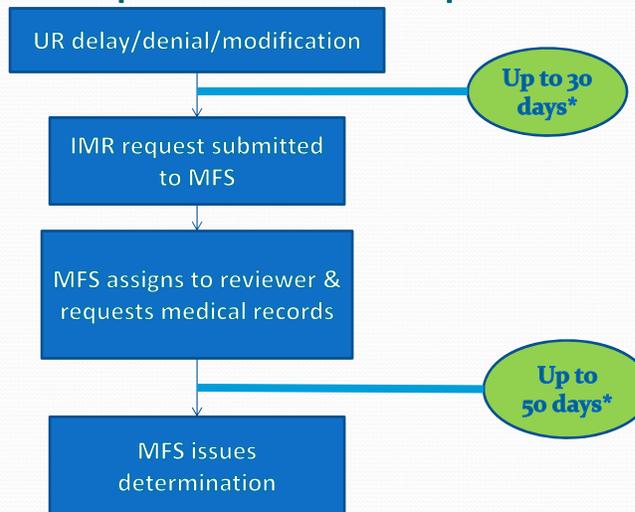
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How Long Does IMR Take?

- 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)(1)
 - 5 days for mailing

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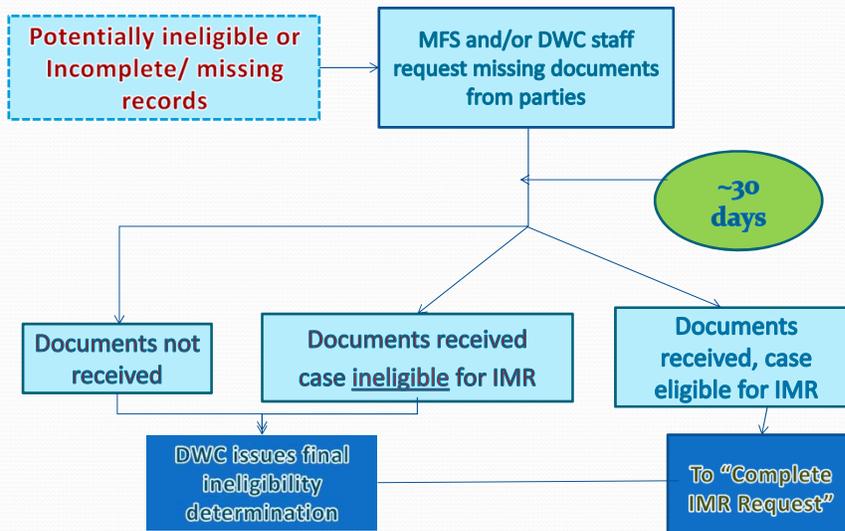
Timeline: Complete IMR Request



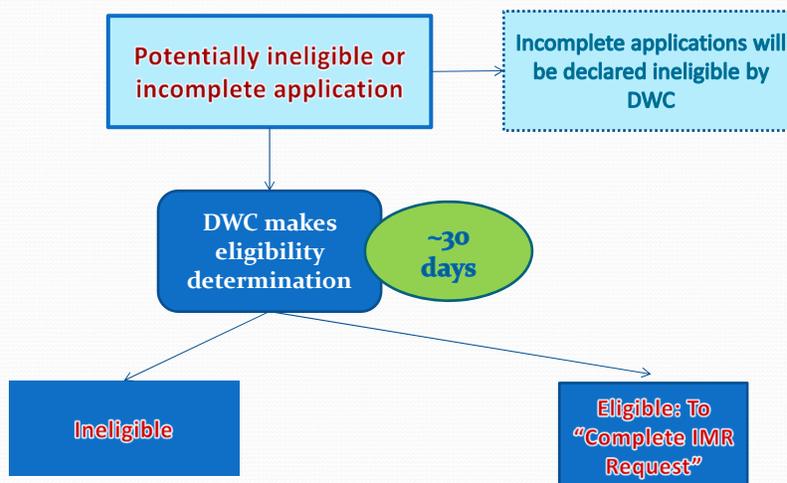
*Up to 80 days to issue determination

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Incomplete IMR Request: Emergency Regulations



Incomplete IMR Request: Proposed Final Regulations



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

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IMR Workflow at MFS

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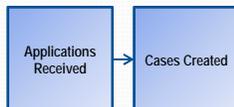
IMR Process



- Applications are received today via fax or by mail

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IMR Process



- 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

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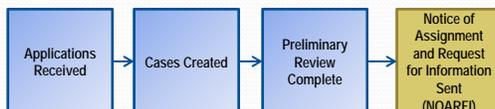
IMR Process



- 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?

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IMR Process

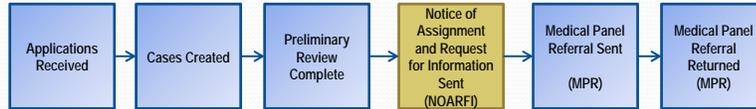


- NOARFI is sent to the Claims Administrator (CA) requesting medical records
- The same NOARFI is also sent as a “cc” to the Injured Worker (IW) / Applicant Attorney (AA)
- CA have 15 days to submit all requested documents
- CA are encouraged to submit a list of all the documents submitted for the review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

Denotes that a letter has been sent

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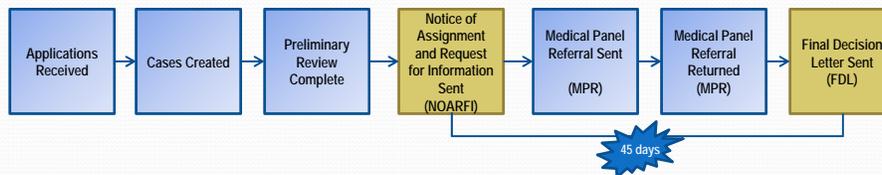
IMR Process



- 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

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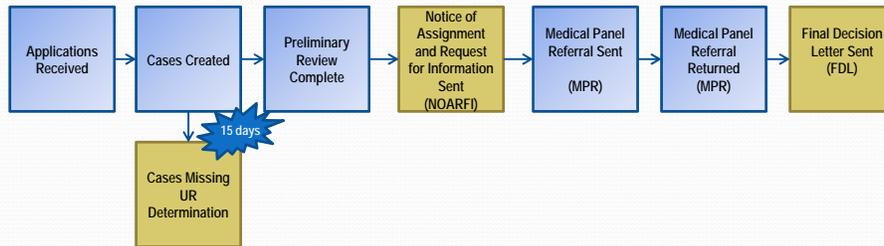
IMR Process



- 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 completed as scheduled
 - Medical records are received from the Claims Administrators (15 days)
 - MPR's are sent, returned and Quality reviewed by MAXIMUS (30 days)

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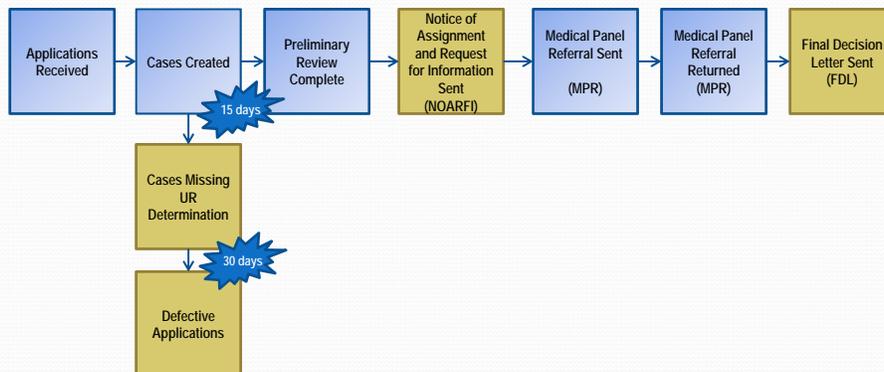
IMR Process



- 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.

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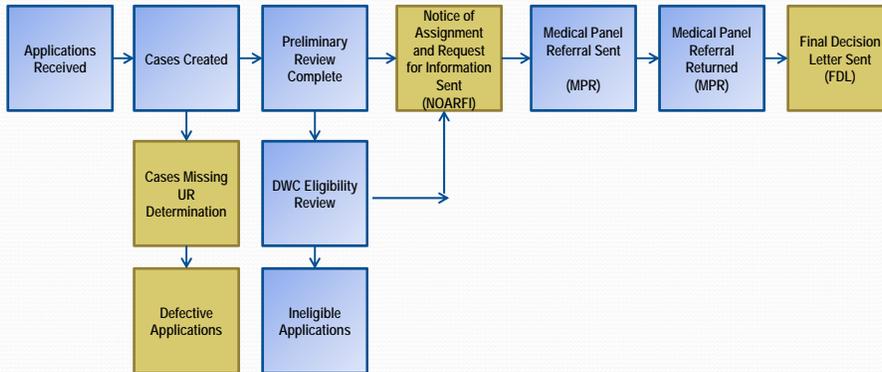
IMR Process



- 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

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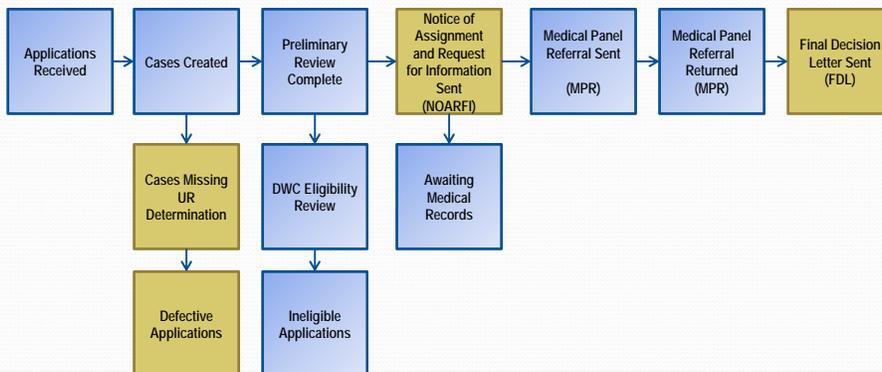
IMR Process



- 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?

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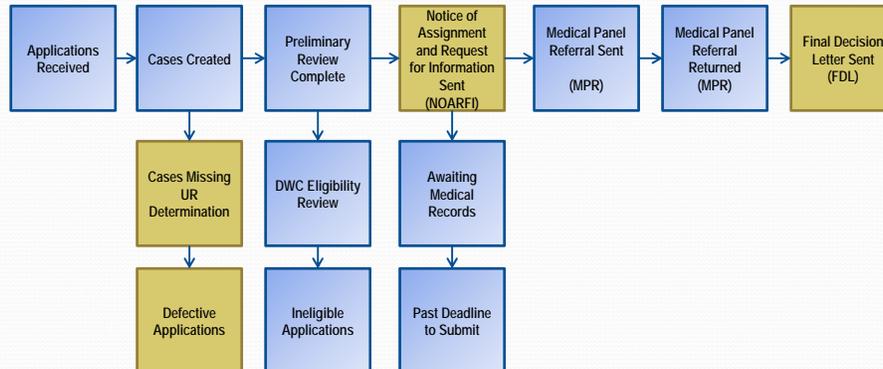
IMR Process



- The CA, IW/AA, or the treating physician have 15 days to submit records

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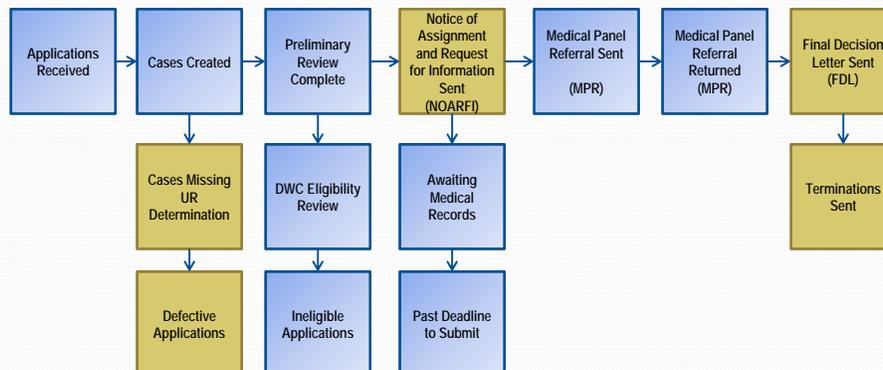
IMR Process



- 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

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IMR Process



- 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

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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

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IMR Experience to Date

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MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 9/20/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 5/17/2013
Date of Injury: 1/8/2013
IMR Application Received: 6/19/2013
MAXIMUS Case Number: CM13-0000565

- 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.**

http://www.dir.ca.gov/dwc/IMR/IMR_Decisions.htm

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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.

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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 His/Her Decision:

The Claims Administrator based its decision on the Low Back Complaints (ACQEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 300, 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).

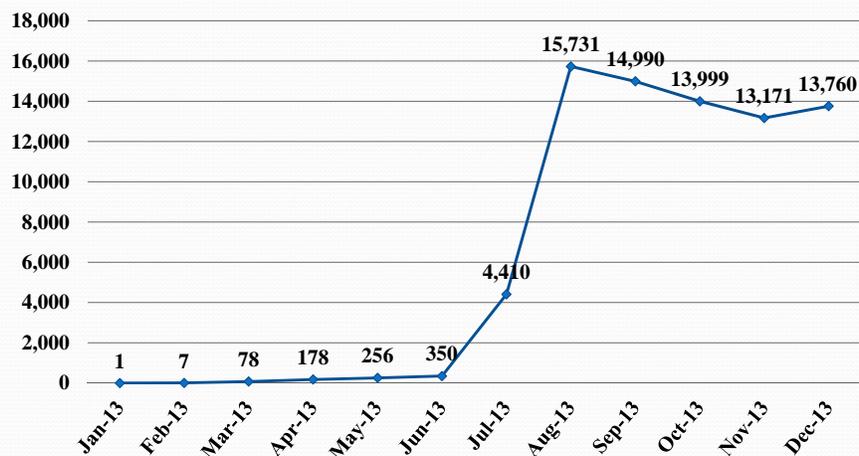
Rationale for the Decision:

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.

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In 2013, Most IMR Applications Were Submitted After July



Data as of January 22, 2014

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Current Status of IMR

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

As of 1/29/14

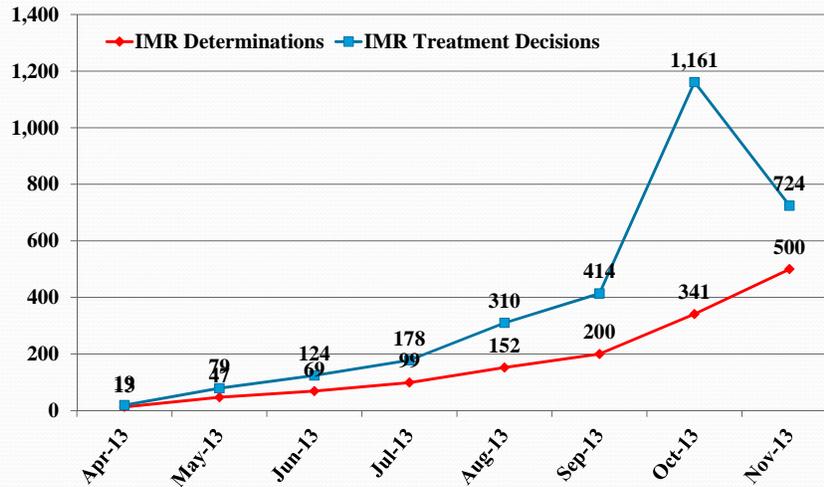
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Top Ten IMR Reviewer Specialties

Reviewer Specialty	Percentage of Total Reviews
PM & R	42%
Occupational Medicine	21%
Orthopedic Surgery	13%
Family Medicine	6%
Internal Medicine	5%
Chiropractic	3%
Anesthesiology	2%
Neurology	2%
Psychology	2%
Psychiatry	1%

Determinations dated through 11/12/13

Average Two Treatments Requests per IMR Determination

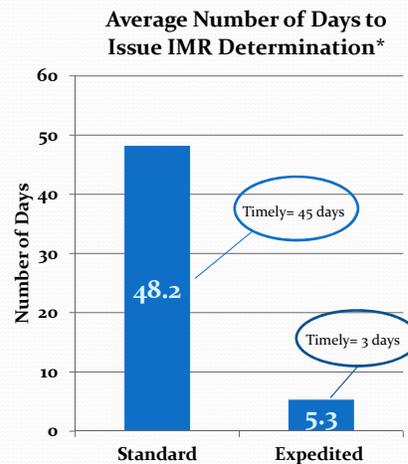


Determinations dated through 11/12/13

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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

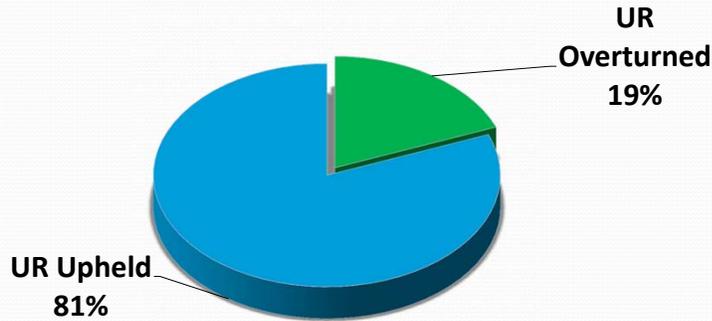


*From date of assignment to reviewer

January-October 2013
N= 1,133 decisions

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Most UR Decisions Upheld by IMR

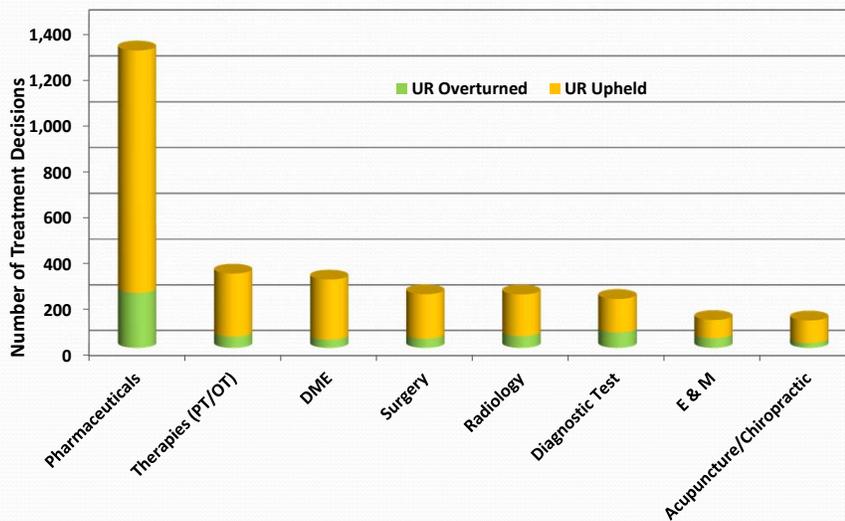


3,009 Treatment decisions (2,436 upheld, 573 overturned)

Determinations dated through 11/12/13

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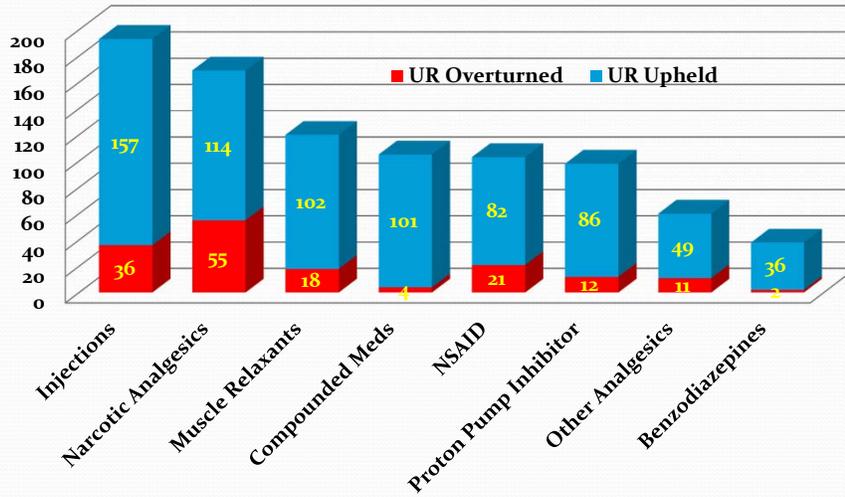
Pharmaceuticals Most Common IMR Decision



Determinations dated through 11/12/13

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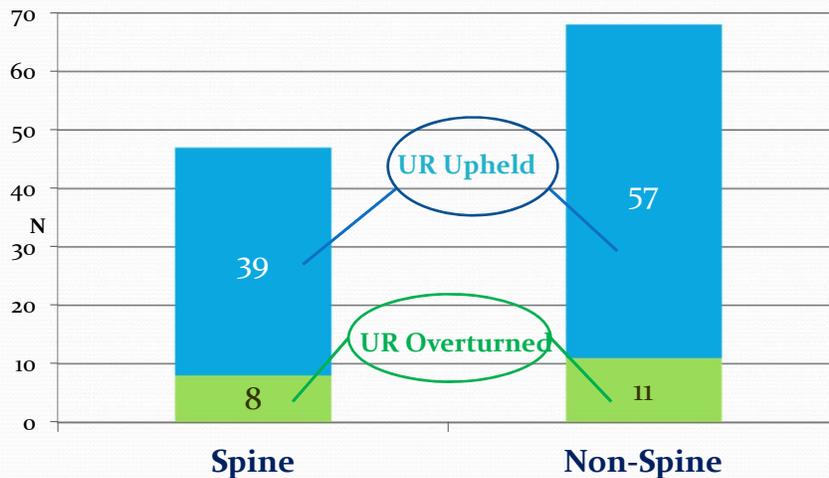
Pharmaceuticals: Injections Most Frequent



Determinations dated through 11/12/13

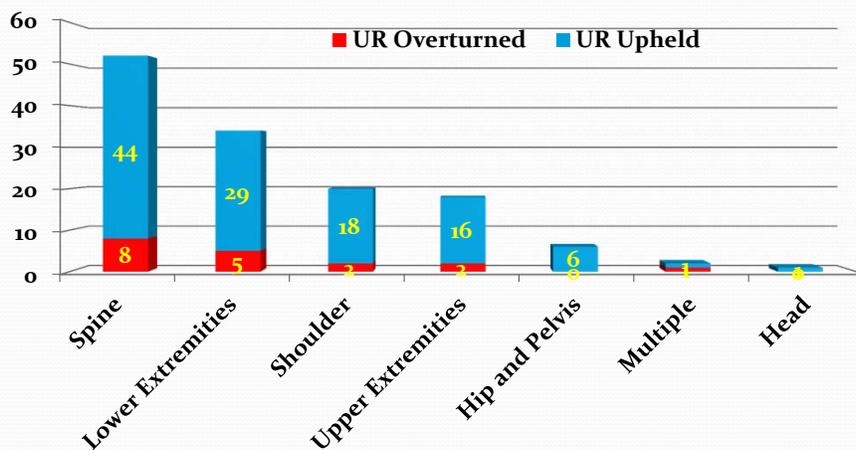
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Surgery: Spine vs. Non-Spine IMR Upholds UR at Similar Rates



Determinations dated through 11/12/13

Surgery Requests: Spine Most Common



Determinations dated through 11/12/13

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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)

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Medical Treatment Utilization Schedule

- 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

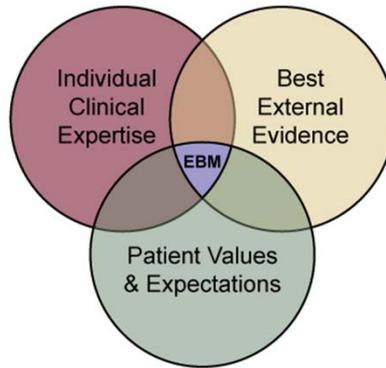
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MTUS Regulations

- 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

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Evidence-Based Medicine

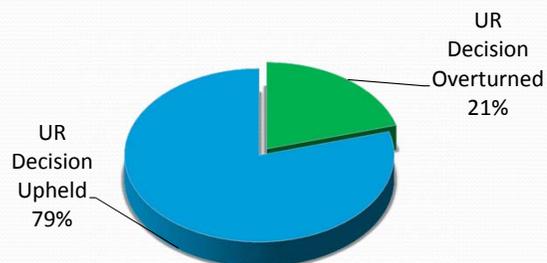


<http://www.cochrane.org/about-us/evidence-based-health-care>

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.

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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

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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

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IBR Regulations

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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

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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)

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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

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 State of California
 Division of Workers' Compensation
Provider's Request for Second Bill Review
Claims Case of Injuries, Ills & Death 923.12

The Medical Provider signing below seeks reconsideration of the denial and/or adjustment of the billed charges for the medical services or goods, or medical legal services, provided to the injured employee.

Employee Information						
Employee Name (Last, First, Middle):						
Date of Birth (MM/DD/YYYY):				Claim Number:		
Date of Injury (MM/DD/YYYY):				Employer Name:		
Provider Information						
Provider Name:			Contact Name:			
Address:						
Phone:			Fac Number:			
E-mail Address:			NPI Number:			
Claims Administrator Information						
Claims Administrator Name:			Contact Name:			
Address:						
Phone:			Fac Number:			
Bill Information						
Provider's or Claims Administrator's Bill Identification Number (if any):						
Date Explanation of Review Received by Provider:						
List of disputed services or goods (attach additional pages if necessary):						
Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider Signature:			Date:			

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


 State of California
 Division of Workers' Compensation
Request for Independent Bill Review
 California Code of Regulations, Title 8, Section 9792.11

Employee Information	
Employee Name (Last, First, Middle):	Claim Number:
Date of Injury (MM/DD/YYYY):	Employer Name:
Date of Birth (MM/DD/YYYY):	Provider Information:
Provider Information	
Provider Name:	Contact Name:
Address:	Phone:
City:	Fax Number:
State:	NPI Number:
Email Address:	Provider Type:
	<input type="checkbox"/> Ambulance <input type="checkbox"/> Clinical Laboratory <input type="checkbox"/> DMEPOS Supplier <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Hospital Outpatient
	<input type="checkbox"/> Interpreter <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Qualified Medical Evaluator <input type="checkbox"/> Agreed Medical Evaluator
	<input type="checkbox"/> Treating Physician <input type="checkbox"/> Other Practitioner – specify: _____
Provider Specialty	
Claims Administrator Information	
Claims Administrator Name:	Contact Name:
Address:	Phone:
City:	Fax Number:
State:	Email Address:
Bill Information	
Applicable Fee Schedule(s)	
<input type="checkbox"/> Physician Services <input type="checkbox"/> Inpatient Hospital Services <input type="checkbox"/> Hospital Outpatient Departments and Ambulatory Surgical Centers	
<input type="checkbox"/> Pharmaceutical <input type="checkbox"/> Pathology and Laboratory Services <input type="checkbox"/> DMEPOS	
<input type="checkbox"/> Ambulance Services <input type="checkbox"/> Medical-Legal Fee Schedule <input type="checkbox"/> Interpreter <input type="checkbox"/> Other – specify: _____	
Or <input type="checkbox"/> Contract for Reimbursement Rates	
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service (MM/DD/YYYY):	
Service/Code in Dispute (include modifier, if any):	
Amount Billed:	Amount Paid:
	Amount in Dispute:
Reason for Disputing Reduction or Denial of Full Payment:	
Consolidation	
Should this Request be Consolidated with Other Disputed Billed Services or Goods? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for Consolidation:	
Disputed Service/Goods to be Consolidated (list all, use attachment if necessary)	
Date of Service (MM/DD/YYYY):	
Service/Code in Dispute (include modifier, if any):	
Amount Billed:	Amount Paid:
	Amount in Dispute:
Reason for Disputing Reduction or Denial of Full Payment:	
Documents to Accompany Request (Must be Indexed and Separated)	
The original billing itemization and original supporting documentation.	
The explanation of review provided in response to the original billing.	
The request for second bill review and original documentation supporting second review.	
The explanation of review provided in response to the second bill review request.	
If applicable, the relevant contract provisions for reimbursement rates.	
Provider Signature:	Date:
If mailed, send to: DWC-IBR c/o Maximus Federal Services, Inc., 825 Coolidge Drive, Suite 100, Folsom, CA 95690.	
Concomitantly send a copy of this request to the Claims Administrator.	

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 at MFS

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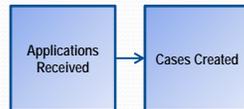
IBR Workflow

Applications
Received

- Applications are received via fax, mail or electronically

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IBR Workflow



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

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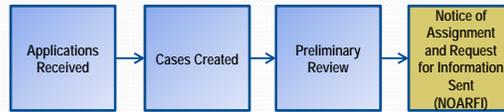
IBR Workflow



- 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?

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IBR Workflow



- 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

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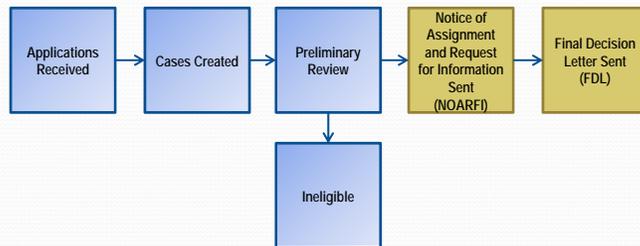
IBR Workflow



- Coding review completed
- Final case audit by Chief Coder
- Final Decision Letter written
- Final Decision Letters sent to Provider and Claims Administrator

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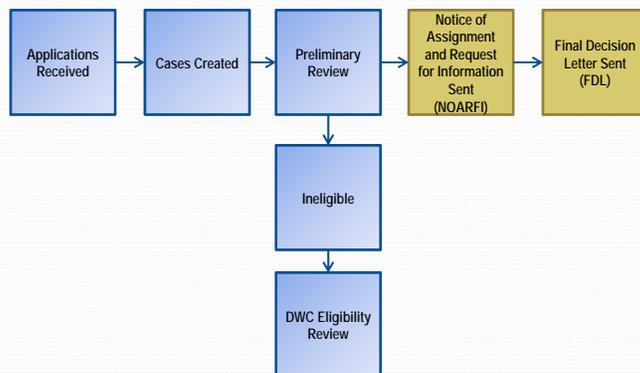
IBR Workflow



- 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

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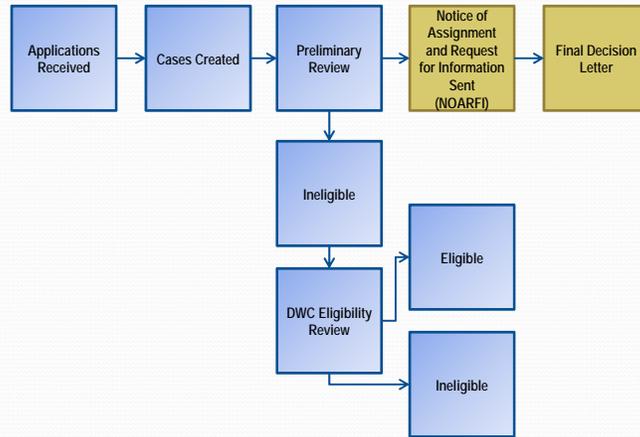
IBR Workflow



- Case does not move to Eligible status until DWC completes review

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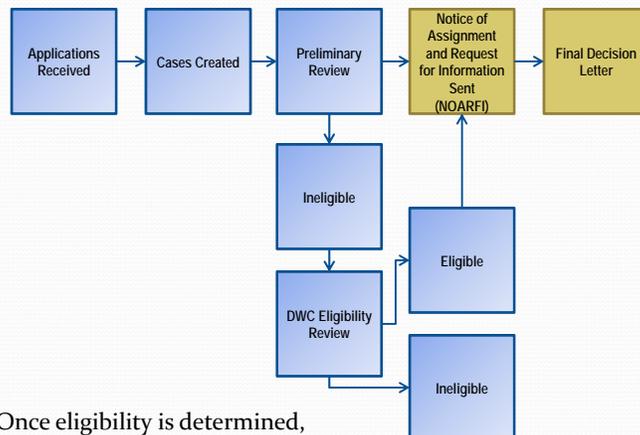
IBR Workflow



- Ineligible claims will receive notification directly from the DWC
- If eligible, MAXIMUS notified through entellitrak

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IBR Workflow

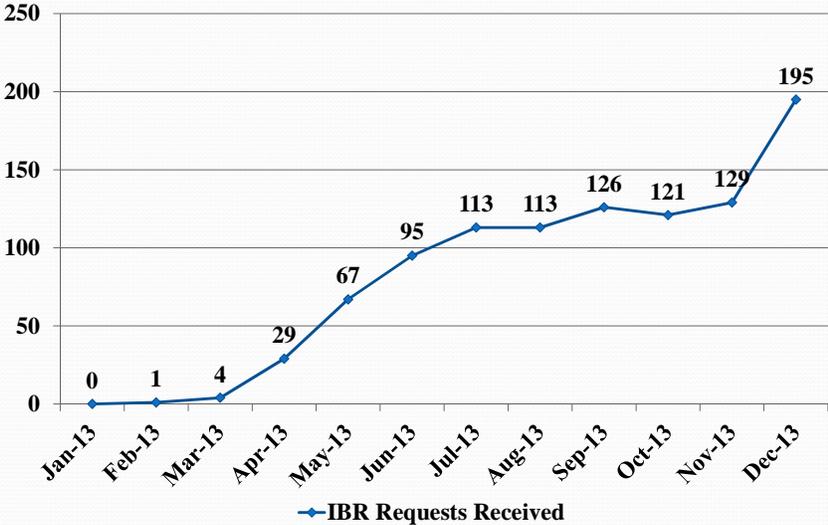


- Once eligibility is determined, Eligibility noticing occurs
- After 15 days, case moves to Assignment
- Assignment notices are sent

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IBR Experience to Date

IBR Applications: Slow, Steady Rise



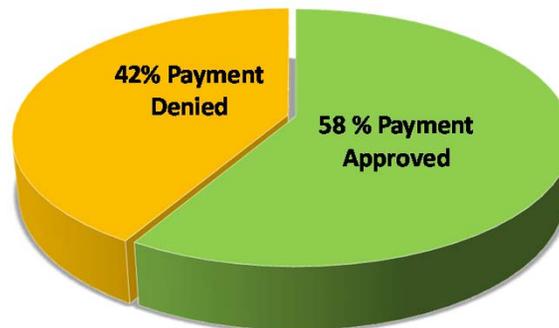
Current Status of IBR

Applications Submitted	1,104
Final Determinations	263
Cases ineligible	41
Cases completed	304 (27% of applications submitted)
Cases awaiting eligibility determinations	474
Cases in pipeline with complete information to proceed	326

As of 1/29/14

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Most IBR Determinations Decided in Favor of Provider



195 IBR Decisions (81 Upheld and 114 Reversed) January 1, 2013 to January 24, 2014
IBR decisions are posted on DWC webpage: <http://www.dir.ca.gov/dwc/IBR.htm>

MAXIMUS
Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

12/3/2013

Independent Bill Review Final Determination Reversed

██████████
██████████
██████████

Re: Claim Number: ██████████
Claims Administrator name: ██████████
Date of Disputed Services: 2/21/2013 – 2/21/2013
MAXIMUS IBR Case: CB13-0000363

Dear ██████████:

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/17/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$0.00, for a total of \$335.00.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:
The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule or negotiated contract: OMFS

Decision in favor of provider:
Only IBR fee owed



MAXIMUS
Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

11/5/2013

Independent Bill Review Final Determination Reversed

██████████
██████████
██████████

Re: Claim Number: ██████████
Claims Administrator Name: ██████████
Date of Disputed Services: 4/15/2013 – 4/19/2013
MAXIMUS IBR Case: CB13-0000367

Dear ██████████:

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/5/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$1,977.02, for a total of \$2,312.02.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:
The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule or negotiated contract: PPO Contract
- Other: Official Medical Fee Schedule guidelines

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



THANK YOU

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

