

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
1.0 - Definitions Medical Billing & Payment Guide	<p>Commenter recommends the following revised language:</p> <p>(a) “Assignee” means a person or entity that has purchased the right to payments for medical goods or services from the health care provider or health care facility and is authorized by law to collect payment from the responsible payer <u>after the person who was entitled to payment has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all rights, title, and interests in the remaining accounts receivable to the assignee.</u></p> <p><i>Commenter states that the Legislature, in Senate Bill 863, adopted Labor Code section 4903.8 to clarify under what circumstances a lien payment can be made to persons or parties other than those entitled to payment at the time the expenses were incurred. The Legislature clarified that an assignee is entitled to payment only if the person who was entitled to</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. The Labor Code section referenced by the commenter restricts payment to an assignee pursuant to a lien filed under Labor Code section 4903 subdivision (b). The statute does not prohibit an assignee from pursuing payment remedies prior to the lien process. Therefore the billing rules do not restrict “assignee” in the same manner that would apply to a lien claimant.</p>	<p>No action necessary.</p>

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	<p><i>payment has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all rights, title, and interests in the remaining accounts receivable to the assignee.</i></p>			
<p>1.0 - Definitions Medical Billing &amp; Payment Guide</p>	<p>Commenter suggests including the following definition as letter (k):</p> <p><b>(k) A contested bill or a contested portion of a bill is one that is reduced or not paid for a reason other than adjustment made pursuant to an applicable fee schedule or contract.</b></p> <p><i>Commenter opines that adding a definition for “contested bill” will identify which bills are “contested.” Commenter states that providers do not bill at or below the maximum reasonable Official Medical Fee Schedule allowances or contracted fees; they routinely submit bills to California workers’ compensation claims administrators and to other types of payers at high standard rates and rely on payers to adjust them to “rates then in effect,” under the prevailing fee schedule or contract.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. When a claims administrator objects to a bill because of the applicability of a fee schedule or a contract the bill is “contested”. There is no legal support for commenter’s assertion that a bill is not “contested” if the reason for objecting to the billed amount is based upon the fee schedule provisions or contractual provisions.</p>	<p>No action necessary.</p>

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	<p><i>Commenter opines that one reason providers bill significantly above scheduled and contracted fees is to avoid violating Medicare rules that forbid billing other payers at rates lower than Medicare's; another reason is that it is more efficient to rely on the payer to calculate the allowable fees and apply the payment rules than having to program and calculate those rates and rules themselves. The claims administrator is providing a service in this respect. Commenter states that such a billing is not "contested" unless the provider claims that the amount paid was not accurately reviewed according to the fee schedule or to the contract rate. Bills that are reduced or denied for reasons other than adjustment to an applicable fee schedule or contract are "contested bills."</i></p>			
1.0 - Definitions Medical Billing & Payment Guide	<p>Commenter recommends the following revised language:</p> <p>(m) "Explanation of Review" (EOR) means the explanation of payment or the denial of the payment <b>as defined issued in the manner described</b> in Appendix B. Paper EORs conform to Appendix B - 3.0. Electronic EORs</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. The subdivision (m) refers to EOR "as defined in Appendix B" because Appendix B sets forth the parameters of what constitutes the paper and electronic EORs.</p>	<p>No action necessary.</p>

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	<p>are issued using the ASC X12N/005010X221 Health Care Claim Payment/Advice (835). <b>No explanation of review is required when a bill is paid in full.</b> EORs use the following standard codes:</p> <p><i>Commenter opines that this characterization may be preferable as Appendix B describes the content requirements of the explanation of review and the manner in which it must be conveyed.</i></p> <p><i>Commenter states that explanations of review have historically been issued to explain why a service or item was paid at less than the amount billed. They have not historically been required or issued when the billed fee was paid in full. Commenter sees no CARC/RARC in Appendix B that can be used when making a payment in full. Since no explanation of review is necessary when a bill is paid in full, commenter recommends that the Administrative Director clarify that an explanation of review is not required when a bill paid in full.</i></p>		<p>Disagree that an EOR is not required when a bill is paid in full. The “explanation of review” is issued even when a bill is paid in full. In that case, the EOR serves as a “remittance advice.” Labor Code section 4603.2 states that “Payments shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days of receipt...” Labor Code section 4603.3 states: “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....” It appears that it would be useful to clarify that the EOR is a “remittance advice” when the bill is paid in full or in part.</p>	<p>Revise language in Appendix B Standard Explanation of Review/Remittance Advice to improve clarity.</p>
1.0 - Definitions Medical Billing &	Commenter recommends the following revised language:	Brenda Ramirez Claims & Medical	Disagree. Although historically in workers’ compensation the	No action necessary.

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Payment Guide	<p>(p) “Itemization of services” means the list of medical treatment, goods or services provided using the codes required by Section One – 3.0 to be included on the uniform billing form or electronic <b>claim</b> format.</p> <p><i>Commenter states that since the meaning of the term “claim” in workers’ compensation is not the meaning intended here, she suggests deleting the term here.</i></p>	<p>Director CWCI April 9, 2013 Written Comment</p>	<p>word “claim” often denoted the injured worker’s entire claim for workers’ compensation benefits, the word “claim” is expanding to include a claim for payment of medical services. This is in large part due to the fact that the HIPAA compliant electronic medical billing formats are called “Health Care Claim”. See Appendix B, Section Two (“Health Care Claim: Dental ASCX12N/005010X224A2”; “Health Care Claim: Professional ASCX12N/005010X224A1”; “Health Care Claim: Institutional ASCX12N/005010X224A2 ”.)</p>	
1.0 - Definitions Medical Billing & Payment Guide	<p>Commenter recommends the following revised language:</p> <p>(q) “Medical Treatment” means the treatment, goods and services as defined by Labor Code Sections 4600 <b>and</b> <b>4603.2(b).</b></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. Labor Code section 4600 defines the scope of workers’ compensation medical treatment. Labor Code section 4603.2(b) regarding billing does not define the scope of “medical treatment”. It does cross reference to Labor Code 4600 by listing “providers of services provided</p>	No action necessary.

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	<p><i>Commenter states that Labor Code Section 4603.2(b) adds clarity as it includes a more comprehensive listing of services provided pursuant to Labor Code Section 4600.</i></p>		<p>pursuant to Section 4600” that shall conform to billing rules. Labor Code section 4603.2 is effective as a statutory provision and it is unnecessary to add it to the definition of “medical treatment”.</p>	
<p>1.0 - Definitions Medical Billing &amp; Payment Guide</p>	<p>Commenter recommends the following revised language:</p> <p>(t) Official Medical Fee Schedule (OMFS) means all of the fee schedules <b>for services described in Labor Code sections 4600 and 4603.2, including, but not limited to those</b> found in Article 5.3 of Subchapter 1 of Chapter 4.5 of Title 8, California Code of Regulations (Sections 9789.10 - <b>9789.111 9792.1</b>); adopted pursuant to Section 5307.1 of the Labor Code for all medical services, goods, and treatment provided pursuant to Labor Code Section 4600.</p> <p><i>Commenter opines that these recommended modifications are more inclusive of current and anticipated fee schedules.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. The OMFS subject to the billing rules is encompassed by sections 9789.10 – 9789.111. The Article 5.5 (sections 9790 – 9792.1) applies to services rendered prior to 2004. Labor Code section 5307.1 gives the administrative director authority to adopt medical fee schedules for treatment, care, services and goods described in Labor Codes section 4600. It does not specify section 4603.2.</p>	<p>No action necessary.</p>

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1.0 Standardized Billing/Electronic Billing Definitions Medical Billing & Payment Guide	<p>Commenter recommends the following revised language:</p> <p>(a) "Assignee" means a person or entity that has purchased the right to payments for medical goods or services from the health care provider or health care facility and is authorized by law to collect payment from the responsible payer <u>after the person who was entitled to payment has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interests in the remaining accounts receivable to the assignee.</u></p> <p>Commenter opines that SB 863 enacted Labor Code Section 4903.8 to clarify that an assignee is entitled to payment only if the person who was entitled to payment has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interests in the remaining accounts receivable to the assignee.</p>	Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment	Disagree. The Labor Code section referenced by the commenter restricts payment to an assignee pursuant to a lien filed under Labor Code section 4903 subdivision (b). The statute does not prohibit an assignee from pursuing payment remedies prior to the lien process. Therefore the billing rules do not restrict "assignee" in the same manner that would apply to a lien claimant.	No action necessary.
1.1 Field Table CMS 1500 Medical Billing &	Commenter recommends there be clarification on the appropriate use of CMS-1500 Field 24D which can be	Sandy Shtab Senior Government Affairs Manager	Disagree. Commenter notes that the NUCC guidance is very specific on formatting the	No action necessary.

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Payment Guide	<p>added to the <i>Medical Billing and Payment Guide, 1.1 Field Table CMS 1500</i>. Per NUCC guidance, CMS-1500 Field 24D accepts NDC codes in the shaded area for each of the six available lines on the bill. The guidance is very specific on the format of the NDC data, however there is great variance in how providers are currently populating the CMS-1500 when submitting medications. Commenter recommends the Field Table notes be appended to further clarify:</p> <p><b><i>“Medications with the same NDC, dispensed on the same day shall be consolidated into a single line which clearly identifies the NDC, the total number of units dispensed and days supply in the shaded area of field 24D.”</i></b></p> <p>Commenter opines that this clarification, along with an example of the correct billing format, will cut down on the number of bills which are flagged as duplicates and rejected for payment. Bill review systems are programmed to identify duplicate billings on the same date. When</p>	<p>Healthsystems April 8, 2013 Written Comment</p>	<p>NDC data and states that there is great variance in how providers are populating the CMS 1500. This is an education and compliance issue; it does not necessitate a revision of the regulation. The 1.1 Field Table (and 1.2 Field Table for the new CMS 1500 form) provide additional information that is needed specifically for California workers’ compensation needs. It is not intended to duplicate the information that is in the 1500 Claim Form Instruction Manual.</p>	

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	<p>providers bill multiples of the same medication on several lines in the same bill, those lines may be rejected for payment and ultimately the provider will request a second review for those outstanding lines on the original bill. This rulemaking process is an opportune time to provide clarity on this issue. Additional guidance in this area is expected to reduce the number of second reviews that physicians, PBMs and bill review entities must address.</p>			
<p>2.0 Medical Billing &amp; Payment Guide</p>	<p>Commenter notes that the proposed changes would permit providers to <i>handwrite</i> on Form CMS-1500 and the UB-04 to indicate that Second Bill Review is being requested. Commenter opines that such an addition is directly contrary to the stated objectives of standardized, “clean bills”, and will hamper payers in their efforts to process billings quickly and efficiently, as handwritten notations cannot be processed in an automated fashion.</p> <p>Commenter recommends removal of the language in Section 2.0 that allows for handwritten notations on the CMS-1500 and UB-04, and requires that the</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Disagree. For many providers submitting paper bills, there may be no readily available method to insert the second bill review request code without handwriting the code on the copy of the original bill.</p>	<p>No action necessary.</p>

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	fields needed for Second Bill Review be populated in a typewritten manner, consistent with all other fields on the forms.			
3.0 Medical Billing & Payment Guide General Comment	<p>Commenter states that proposed changes to the Electronic Billing guide are concerning as California continues to drift further from the national standards established by the IAIABC and other standards organizations. For example, California is the only state requiring the attachment of the prescription or referral from the treating physician. Commenter opines that the standards do not anticipate such a requirement. Commenter opines that in California, since most of the treatment is in-network and most of the procedures are pre-approved, there really isn't a need for this requirement except on a limited basis. Commenter recommends that this rule be amended to require that a copy of the referral be submitted only when pre-approval for the procedure had not been obtained. In the case of pharmacy, commenter states that there really isn't a need to ever submit a copy of the prescription, especially since it is extremely difficult to do.</p>	<p>Brian Allen Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment</p> <p>Gregory M. Gilbert SVP Reimbursement &amp; Government Relations Concentra April 8, 2013 Written Comment</p>	<p>Disagree with commenter's suggestion that the prescription should not be required because most of the treatment is in network. The SB 863 added the requirement to Labor Code section 4603.2(b)(1) that a bill be accompanied by "the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician..." This provision is apparently intended to reinforce the role of the primary treating physician. The legislature did not distinguish between physicians in or out of the medical provider network. In addition the Labor Code section 4603.2(b)(1) requires submission of a copy of prior authorization in any case where it was received.</p> <p>Agree in part with comment</p>	<p>No action necessary.</p> <p>Amend 3.0 Complete</p>

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			regarding prescriptions to support pharmacy bills. Statutory changes made by Senate Bill 146 (Statutes of 2013, Chapter 129) necessitate changes to the documentation requirements as a copy of the prescription must be submitted only in limited circumstances prescribed in SB 146.	Bills to add language to (b)(12) to provide an exception to the requirement to submit a prescription if the treatment or services were performed by other than the primary treating physician. The exceptions are: if there is a written agreement to provide the prescription; an employer et al may request a copy of the prescription during a review of records. A pharmacy bill may be resubmitted by 3/31/2014 if denied after 1/1/2013 due to lack of submitting a prescription.
3.0 Complete Bills, (b)(11) and (12) Medical Billing & Payment Guide	Commenter states that if the referral documentation has already been submitted to the adjuster as part of the request for authorization process, why must it be submitted again? <b>Recommendation:</b> Requests for	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013	Disagree. The statute requires submission of the authorization and referral documentation with the request for payment. Labor Code section 4603.2(b)(1).	No action necessary.

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	authorization and receipt of authorization should not be required to be submitted with a bill but allow for an authorization number to be provided in box locator 23 of the HCFA as needed. Update the RFA form to require the payor provide to the provider an authorization number.	Written Comment		
3.1 Field Table NCPDP Medical Billing & Payment Guide	<p>Commenter recommends the following revised instructions under Paper Form Item Number 17:</p> <p>Enter the claim number assigned by the workers' compensation Payer, if known. If claim number is not <b>known assigned</b>, then enter the value of 'Unknown'</p> <p><i>Commenter opines that the pharmacy must enter the claim number if assigned. Commenter opines that it is not sufficient for the individual completing the form to routinely enter "unknown" because he or she does not "know" the claim number.</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	Disagree. The requirement cannot be based on whether the claim number is "assigned" because it may be assigned by the claims administrator but not communicated to the pharmacy. There is no evidence that the pharmacy would "routinely" enter "unknown" if the claim number was in fact known to the pharmacy. Providers have an interest in submitting the claim number if known as this will expedite processing of the claim.	No action necessary.
Appendix A, 1.0 CMS-1500 Medical Billing & Payment Guide	Commenter notes that the guidelines indicate usage of the CMS-1500 version 02/12 by July 1, 2013. However, the NUCC has <i>proposed</i> the CMS-1500 version 02/12 with	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra	Disagree with the assertion that the proposed regulations suggested adoption of the version 02/12 of the CMS 1500. The proposal merely	Revise Appendix A, 1.0 CMS 1500 to adopt the new 1500 form, and to specify mandatory usage date

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	<p>effective date October 1, 2013 but has also indicated the date may be revised after CMS approval and public comment period concludes. There is no apparent indication on CMS’s site that the proposed CMS-1500 v. 02/12 is under analysis. There are several fields where data may be contained but NUCC suggests removal. Payers need to analyze whether or not the removal of the data meets their requirements. Additionally, the CMS-1500 version 02/12 is modified to support ICD10, and the ICD10 requirements have been postponed to 10/1/2014</p> <p><b>Recommendation:</b> There should be no requirement to utilize the CMS-1500 version 02/12 until CMS has approved, the public comment period has concluded, and a reasonable timeframe for adoption has been set (this should be set such that providers and payers have time to become aware, have appropriate time to modify systems/workflows, and have appropriate time to test with vendors / payers, etc).</p>	<p>April 8, 2013 Written Comment</p>	<p>updated the 1500 Health Claim Form Instruction Manual, but retained the version 08/05 of the 1500 Form. Agree that adoption of the 1500 Form version 02/12 should not be adopted before it is approved for use by CMS. The 1500 version 02/12 has been approved by the NUCC and by CMS. The DWC proposes to adopt it in sync with Medicare usage dates, including a “dual use” period of January 6, 2014 through March 31, 2014.</p>	<p>of April 1, 2014 and a “dual usage” period of January 6, 2014 – March 31, 2014. Reorganize the 1.0 CMS 1500 form and Instruction Manual effective dates into table format for clarity.</p>
<p>Appendix A, 1.0 CMS-1500; Field</p>	<p>Commenter notes that verbiage reads “Box 19 is also to be used to</p>	<p>Gregory M. Gilbert SVP Reimbursement</p>	<p>Agree in part. Agree that if the supporting documents are in</p>	<p>Revise 1.1 Field Table CMS 1500,</p>

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<p>19 Medical Billing &amp; Payment Guide</p>	<p>communicate the Attachment Information, if applicable. Attachment information is required in Box 19 and on supporting document(s) associated on this bill, <b>when the document(s) is submitted separately from the bill</b>".</p> <p><b>Assumption / request for confirmation:</b> If the bill is submitted by paper and the attachments are contained in the bill package, then field 19 may be left NULL</p> <p><b>Assumption / request for confirmation:</b> If an attachment is being sent separately, and if the referencing bill is also submitted, then again, this field is NOT required</p> <p><b>QUESTION:</b> If the bill was submitted prior to attachments, how would one know what the unique attachment number would be if there are multiple attachments being sent at a later time (since there are different report type codes, etc. for different attachments)</p> <p><b>Recommendation:</b> Field 19 is optional on paper bill since there</p>	<p>&amp; Government Relations Concentra April 8, 2013 Written Comment</p>	<p>the same envelope with bill, need not enter attachment numbers in Box 19. Disagree that Field 19 should be optional since there needs to be standardized way to identify supporting documentation if it is sent separately from the bill. Disagree with commenter's assumption that where an attachment is "sent separately" and "if the referencing bill is also submitted" field 19 is not required. Where the attachment is sent separately the Field 19 must identify it. The provider will need to structure the bill and supporting documentation submission to be in the same envelope/package or to have the supporting documentation identified in Field 19.</p>	<p>Field 19 to provide that if the supporting documents are submitted in the same envelope/package with the bill Field 19 may be left blank.</p>

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Appendix A, 1.0 CMS-1500; Field 21 Medical Billing & Payment Guide	could be multiple attachments  Commenter notes there are no reference requirements for CMS-1500 v 02/12. If CMS-1500 v 02/12 is required on/after 07/01/2013, this should specify for both versions: 08/05 and 02/12.	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Disagree with comment to the extent that it implies there should have been reference to requirements for CMS 1500 version 02/12. Commenter notes there are no reference requirements for the CMS 1500 version 02/12 in the proposal. That is because the regulation did not contain a proposal to adopt the new 1500 02/12 form as it was still pending approval by the CMS. The proposed regulations updated the Instruction Manual for the CMS 1500 version 08/05. Agree in part, insofar as when the CMS 02/12 version is adopted there should be “requirements” instructions.	Revise the Appendix A to add 1.2 Field Table CMS 1500 (02/12)
Appendix B Jurisdiction Report Type Codes and DWC Descriptions Electronic Medical Billing and Payment Companion Guide	Commenter would like to know if he is correct in his assumption that since PR-2 is not listed as a Jurisdiction report, it will be attached using report type code ‘09’ for ‘Progress Report’ (instead of ‘OZ’ with specific jurisdiction report type code).	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Agree with commenter’s interpretation. A PR-2 (Primary Treating Physician’s Progress Report) would be report type code “09”. This was removed from the list of “jurisdiction report type codes” as it is a national standard report type code and not a specific California workers’	No action necessary.

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<p>Appendix B. Standard Explanation of Review Medical Billing &amp; Payment Guide</p>	<p>Commenter recommends the following revised language:</p> <p>The paper EOR must include all of the data elements indicated as “R” (required) in Appendix B - 3.0 Table for Paper Explanation of Review. For data elements listed as “S” (situational) the data element is required where the circumstances described are applicable. Data elements listed as “O” (optional) may be included in the EOR, but are not required. The payer may include additional <del>messages and data</del> <u>explanatory language</u> in order to provide further detail to the provider. The Division of Workers’ Compensation has not developed a standard paper form or format for the EOR. Payers providing paper EORs may use any format as long as all required and relevant situational data elements are present.</p> <p>The 3.0 Field Table for Paper Explanation of Review specifies use of the DWC Bill Adjustment Reason Codes and DWC Explanatory Messages as situational data elements</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>compensation report code.</p> <p>Disagree. It is important that the claims administrator send sufficient information and explanation to the provider regarding the review and payment of the claim. Commenter’s suggested language does not advance that objective.</p>	<p>No action necessary.</p>
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	<p>(Fields 41 and 52.) The Table 1.0 DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk includes the DWC Bill Adjustment Reason Codes, a description of the billing problem the code is describing, the Explanatory Message, and any special instructions or additional information required when using that code. The paper EOR does not utilize the Claims Adjustment Reason Codes or the Remittance Advice Remark Codes. These are included in the table in order to provide a crosswalk between the DWC Bill Adjustment Reason Codes and the corollary CARC and RARC codes used in electronic EORs. The claims administrator <del>shall</del> <u>may</u> utilize additional narrative explanatory language to supplement the DWC Bill Adjustment Reason Codes <u>Explanatory Message where necessary</u> to <u>more</u> fully explain why the bill is adjusted, denied, or considered incomplete.</p> <p><i>Commenter recommends maintaining the standard DWC reason codes and DWC Explanatory Messages, but permitting additional narrative</i></p>			

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<p>Preface Document Change Control Electronic Medical Billing &amp; Payment Companion Guide</p>	<p><i>explanatory language.</i></p> <p>Commenter recommends the following revised language:</p> <p>Documentation change control is maintained in this document through the use of the Change Control Table shown below. Each change made to this companion guide after the creation date is noted along with the date and reason for the change. <u>The changes noted and dated 01/01/2013 in the table are effective for bills received on and after January 1, 2013 (or the date these regulatory changes are adopted).</u></p> <p><i>Commenter recommends that the Division clarify here that the changes apply to all bills received on and after January 1, 2013 (or the date these regulations are adopted) so that there is no confusion in the regulated community over when they are effective.</i></p> <p><i>Commenter recommends copying and pasting into this table the changes and reasons from the rulemaking documents. Commenter provides an</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agree in part. The regulation's Documentation Change Control Table listed the emergency regulation version. The further changes made during the certificate of compliance rulemaking action should be added as a new row on the document control table. Disagree with the suggestion to add the substance of the changes to the guide itself as it would be cumbersome and not add sufficient additional utility.</p>	<p>Revise page iv to add a new row to the Documentation Change Control Table.</p>

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	<i>example of the table in her written comments [copy is available upon request].</i>			
Electronic Medical Billing & Payment Companion Guide – General Comment	<p>Commenter recommends replacing the term “clean bill” with “complete bill” or otherwise “complete bill” wherever it appears in the Guides, including in the table of contents, the section 9.0 introduction, and in the text, headings and diagrams of sections 9.1, 9.2.1, 9.3, and 9.3.1 of this Guide.</p> <p><i>Commenter state that the term “clean bill” is not defined and may cause confusion.</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	Agree.	Revise Companion Guide to substitute “complete bill” for “clean bill”.
2.11.3 Corrected Bill Transactions Electronic Medical Billing and Payment Companion Guide	<p>Notes that section references “Void must be submitted to cancel the incorrect bill, followed by the submission of a new original bill with the correct information”</p> <p>Commenter questions what is required in the “void” transaction? Does this require all elements of the original bill plus the appropriate cancellation code (8)?</p> <p><b>Recommendation:</b> The cancellation request should only require the original bill’s unique identification number (as provided by the submitter)</p>	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Disagree. The “Void” and “Resubmission” process is modelled on, and in conformity with, the International Association of Industrial Accident Boards and Commission’s (IAIABC) model Electronic Billing and Payment National Companion Guide (identified as a document relied upon.) The DWC has aligned the ebilling procedures with the national standard to the extent possible. The DWC does not perceive a	No action necessary.

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	along with the appropriate cancellation code.		need to diverge from IAIABC in the method to void a bill.	
2.4.7 Document/Attachment Information Electronic Medical Billing and Payment Companion Guide	<p>Commenter notes that documentation states “Documentation related to the electronic bill must be submitted within five working (5) days of submission of the electronic medical bill and must identify the following elements:</p> <ol style="list-style-type: none"> <li>1. Patient Name (Injured Employee);</li> <li>2. Claims Administrator Name;</li> <li>3. Date of Service;</li> <li>4. Date of Injury;</li> <li>5. Social Security Number ( if available);</li> <li>6. Claim Number;</li> <li>7. Unique Attachment Indicator Number”</li> </ol> <p><b>Commenter opines that this is inconsistent with the Medical Billing Payment Guide v1.1 section 7.3 where many of the above noted fields have been removed.</b></p> <p><b>Recommendation:</b> As previously noted, Remove requirement to include specified data elements on each individual attachment since they are already required to be included in the</p>	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Agree. The requirements should be consistent with the Medical Billing and Payment Guide section 7.3(b) which has eliminated all of the identifiers except for the unique attachment indicator number.	Revise Section 2.4.7 to eliminate the specific documentation identifiers except for the unique attachment indicator number and keep only the unique attachment number identifier in 7.3..

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3.3.1 ASC X12N/0050 10X222 Health Care Claim Professional (837) Electronic Medical Billing and Payment Companion Guide	header or on a coversheet. Commenter would like to know that his assumption that anything with strikethrough means the elements are no longer required and may be left as NULL is correct.	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Disagree to the extent commenter’s question implies a need for clarifying language. The introductory language in 3.3 makes it clear that the 3.3.1 table is only intended to provide the public with special instructions beyond the Type 3 Technical Report for the ASC X12N/005010X222. The 3.3 states: “When the application/instructions for California workers’ compensation need clarification beyond the HIPAA implementation, it is identified in the following table...” Therefore, the strikethrough on data elements in 3.3.1 only signifies that DWC has determined there is no need for a special workers’ compensation instruction. The Type 3 Technical Report for the ASC X12N/005010X222 (which is incorporated by reference in the regulation) has requirements embedded within it. So a data element with strikethrough in the DWC	No action necessary.
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			Companion Guide is not necessarily “null”; the status of the data element is determined by the Type 3 Technical Report.	
3.3.1 ASC X12N/0050 10X222 Health Care Claim Professional (837); 2010CA REF Property and Casualty Claim Number, Electronic Medical Billing and Payment Companion Guide	Commenter references the instructions for 2010CA REF Property and Casualty Claim Number which states that the segment is required and that a bill missing a claim number shall be placed in pending status for up to 5 working days to attach the claim number. Commenter asks what “missing” means: is it “no value provided” or if 2010CA REF02 contains a value of “unknown”? Commenter asks what “pending status means” and if the bill is resubmitted, is it a “duplicate” or a “corrected” bill.	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Disagree to the extent commenter’s questions imply a need for clarifying language. The table in 3.3.1 sets forth special instructions for workers’ compensation in regard to populating the loops and segments, but the table does not set forth all the processing instructions. Commenter appears to overlook Chapter 9, especially section 9.2 Complete Bill-Missing Claim Number Pre-Adjudication Hold (Pending) Status, section 9.2.1 Missing Claim Number – ASC X12N/005010X214 Health Care Claim Acknowledgment (277).	No action necessary.
3.3.1 ASC X12N/005010X222 Health Care Claim Professional (837); 2300 PWK01 (Report Type	Commenter’s assumption is that for multiple attachments, there will be multiple PWK Loops and each attachment will be followed by it’s own coversheet.	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013	Disagree. The Report Type Codes appear in the ASC X12N/005010X222 Health Care Claim Professional (837). The copyright to the Health Care Claim Professional (837)	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
Code), PWK06 (Attachment Control Number) Electronic Medical Billing and Payment Companion Guide	Commenter opines that the 005010 Report Type Codes should be included as an Appendix in this document to prevent confusion.	Written Comment	is held by the Accredited Standards Committee (ASC.) The ASC does not allow “duplication” of material in the 837. The Companion Guide must be constructed to avoid duplication of the ASC material; therefore the DWC cannot publish the Report Type Codes in the DWC Companion Guide.	
3.3.1 ASC X12N/005010X222 Health Care Claim Professional (837); 2300 K301 Fixed Format Information Electronic Medical Billing and Payment Companion Guide	Commenter has no idea when this applies. Commenter opines if this would be if the visit is in a CA center but the employer’s fee schedule state is <u>NOT</u> CA? Or if the visit is <u>NOT</u> in CA but the employer’s fee schedule state is CA? Commenter states that this section is very confusing and opines that it needs significant clarification.	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013 Written Comment	Disagree. The billing guide governs bills submitted under California workers’ compensation laws, therefore it follows that California is the “jurisdiction” and this segment would be required when the billing provider’s state is outside of California. The language in the regulation on 2300 K301 is the language recommended by the IAIABC model Companion Guide (a document relied upon.)	No action necessary.
3.3.1 ASC X12N/005010X222 Health Care Claim Professional (837); 2310B PRV (Rendering	Commenter notes that the regulation indicates: “The Rendering Provider Specialty Information is required for California workers’ compensation medical bills.”	Gregory M. Gilbert SVP Reimbursement & Government Relations Concentra April 8, 2013	Disagree. The table in 3.3.1 sets forth special instructions for workers’ compensation in regard to populating the loops and segments, but the table does not set forth all the	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
<p>Provider Specialty Information); 2420A PRV (Provider Specialty Code) Electronic Medical Billing and Payment Companion Guide</p>	<p>Commenter notes that there are no guidelines on what to populate here. Are there specific specialty codes? If so, where in the documentation are they found?</p> <p>What distinction is to be made for 2310B PRV and 2420A PRV since the description in the companion guide is the same?</p>	<p>Written Comment</p>	<p>processing instructions. Commenter appears to overlook the substance of ASC X12N/005010X222 Health Care Claim Professional (837) (a document incorporated by reference) that contains the specifications for 2310B and 2420A. The ASC X12N/005010X222 Health Care Claim Professional (837) requires that the specialty code be the Health Care Provider Taxonomy Code (external code source 682, adopted by the National Uniform Claim Committee.) The taxonomy codes cover all kinds of providers, including traditional medical providers such as doctors, nurses, chiropractors, but also other providers such as transportation providers, interpreters, chore providers, etc.</p> <p>The ASC X12N/005010X222 Health Care Claim Professional (837) specifies that the Loop 2000A applies to the Billing Provider, Loop</p>	

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	<p>What if there is no specialty? Is a NULL value accepted?</p> <p><b>Recommendation:</b> This field is optional. Currently his employer does not use this field for EDI billing</p>		<p>2310B applies to the Rendering Provider at the claim level, and Loop 2420A applies to the Rendering Provider at the line level. In each of these loops the 837 identifies the PRV segment as provider specialty information.</p> <p>See description above regarding taxonomy codes; they are comprehensive and it is anticipated that all providers will have a taxonomy code that describes the specialty of the provider when performing the service being billed. A “null” value would not be acceptable since the instructions say “required.”</p> <p>The provider specialty is important for properly paying the bill (for example in certain circumstances a nurse practitioner may be paid 85% of the physician fee, a physician may be entitled to the Health Professional Shortage Area (HPSA) Bonus Payment is he/she is a</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			<p>psychiatrist performing service in a HPSA, etc.) In addition, the provider specialty in billing is important as it allows accurate transmittal of specialty by the payer to the state as part of the workers' compensation information system reporting. This data is important to the DWC for policy analysis and administration of the workers' compensation system.</p> <p>This specialty data has been required in the DWC Companion Guide since it was adopted, becoming effective Oct. 18, 2012.</p>	
6.1 and 6.2(b) Medical Billing & Payment Guide	<p>Commenter notes that these sections state that claims administrators are required to issue an explanation of review (EOR) "concurrently" with the payment. Commenter seeks clarification of the following:</p> <ul style="list-style-type: none"> <li>Does this mean the EOR is required to be in the same envelope/ mailing as the payment check, or just that the</li> </ul>	<p>Kevin C. Tribout Executive Director of Government Affairs PMSI March 19, 2013 Written Comment</p> <p>Adam Fowler PMSI Oral Comment</p>	<p>Disagree. Labor Code section 4603.2(b)(2) expressly provides in pertinent part that "payment shall be made by the employer with an explanation of review pursuant to Section 4603.3 within 45 days after receipt of each [complete medical bill]." The plain meaning of the statute is clear and reflects the intention of the</p>	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>EOR must be sent at the same time as the payment check? Commenter recommends that an EOR in relation to payment be deemed compliant if sent within the 45-day payment timeframe, especially given that some payments may be made through EFT and not with a paper check –preventing the ability to include a paper EOR with that EFT.</p> <ul style="list-style-type: none"> <li>• Related to the above, how should this work when payment is made through electronic funds transfer (EFT) but the EOR is in a paper form? Commenter recommends the same as above.</li> <li>• Can an electronic EOR (an 835 file compliant with DWC's electronic EOR requirements) be submitted in response to a bill originally submitted on paper, or does the EOR in relation to a paper bill have to be in a paper form that is compliant with DWC's paper EOR requirements?</li> </ul>		<p>Legislature that the payment and the EOR be sent together.</p> <p>The Appendix B, Table 3.0 Table for Paper Explanation of Review, addresses the use of EFT and issuance of a paper EOR. Data Item No. 2 is “Method of Payment” and directs the payer to indicate a paper check or EFT, and Data Item No. 3 “Payment ID Number” directs the inclusion of the “Paper Check Number or EFT Tracer Number.”</p> <p>Pursuant to Labor Code section 4603.4, participation in electronic billing is optional for the medical provider. Therefore, where the provider submits a paper bill, it is anticipated the payer will issue a paper EOR. However, a provider and payer are not prohibited from entering a voluntary agreement that an electronic EOR may be issued in response to a paper bill.</p>	
6.2 - Timeframes	Commenter recommends the	Brenda Ramirez	Disagree. See Response above	No action necessary.

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Medical Billing & Payment Guide	<p>following revised language:</p> <p>(a) If the non-electronic bill or a portion of the bill is contested, denied, or considered incomplete, the claims administrator shall so notify the health care provider, health care facility or billing agent/assignee in the explanation of review. The explanation of review must be issued within 30 days of receipt of the bill and must provide notification of the items being contested, the reason for contesting those items and the remedies open to the health care provider, health care facility or billing agent/assignee. The explanation of review will be deemed timely if sent by first class mail and postmarked on or before the thirtieth day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth day after receipt. <b>A contested bill or a contested portion of the bill is one that is</b></p>	<p>Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>to Commenter's suggestion relating to 1.0 Definitions, advocating the addition of a subdivision (k) defining "contested bill".</p>	

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	<p><u>not paid in full and is reduced or not paid for a reason other than adjustment made pursuant to an applicable fee schedule or contract.</u></p> <p><i>Commenter states that providers do not bill at or below the maximum reasonable Official Medical Fee Schedule allowances or contracted fees; they routinely submit bills to California workers' compensation claims administrators and to other types of payers at high standard rates and rely on payers to adjust them to "rates then in effect," under the prevailing fee schedule or contract. Commenter opines that one reason providers bill significantly above scheduled and contracted fees is to avoid violating Medicare rules that forbid billing other payers at rates lower than Medicare's; another reason is that it is more efficient to rely on the payer to calculate the allowable fees and apply the payment rules than having to program and calculate those rates and rules themselves. The claims administrator is providing a service in this respect. Such a billing is not "contested"</i></p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>unless the provider claims that the amount paid was not accurately reviewed according to the fee schedule or to the contract rate. Bills that are reduced or denied for reasons other than adjustment to a fee schedule or contract are "contested bills."</i></p>			
6.4 - Penalty Medical Billing & Payment Guide	<p>Commenter recommends the following revised language:</p> <p>(a) Any non-electronically submitted bill determined to be complete, not paid within 45 days (60 days for a governmental entity) or objected to within 30 days <b>if contested</b>, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).</p> <p><i>Commenter references her comments made under the recommended definition of a contested bill.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. Labor Code section 4603.2 subdivision (b) requires the bill to be paid within 45 days (60 for governmental agency) or objected to within 30 days. Commenter's language is surplusage and does not add meaning to the provision. There is nothing in the statute to suggest that "objection" to a bill is not a "contest" of the bill. See also Response above to Commenter's suggestion relating to 1.0 Definitions, advocating the addition of a subdivision (k) defining "contested bill".</p>	No action necessary.
6.4(b) Medical Billing & Payment Guide	<p>Regarding the late/untimely payment interest provision noted in this section and elsewhere in the rules and guides, commenter inquires how is it expected that a provider should bill interest if untimely paid:</p>	<p>Kevin C. Tribout Executive Director of Government Affairs PMSI March 19, 2013 Written Comment</p>	<p>Disagree with the suggestion that interest on a late paid bill should be requested as a "Second Bill Review" or on a new bill/invoice. The interest and 15% increase owing due to</p>	No action necessary.

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	<ul style="list-style-type: none"> <li>• As a request for SBR?</li> <li>• On a separate bill/invoice?</li> </ul> <p>Commenter would like to know if DWC has any guidance on if there is any specific code (standard or otherwise) that should be used on a bill/invoice to indicate an interest charge to make it clear to claims administrators the purpose of the charge.</p>		<p>an untimely payment of a medical bill are to be paid by the claims administrator without the need for the provider to submit a bill for the interest or SBR. The Division is not aware of any standard billing forms or standard codes for billing interest. The provider owed interest and increase could seek payment be presenting a demand letter setting forth the applicable facts to support the demand.</p>	
7.3(a) Electronic Bill Attachments (a) Medical Billing & Payment Guide	<p>Commenter inquires if there any specific format required for the coversheet? Or is it at the discretion of the sender? <b>Recommendation:</b> Verbiage should be included in the guide that the coversheet design/order of fields, etc is at the discretion of the sender.</p>	<p>Gregory M. Gilbert SVP Reimbursement &amp; Government Relations Concentra April 8, 2013 Written Comment</p>	<p>Disagree. DWC does not believe the language needs clarification. Since the language does not specify format requirements for the coversheet, it is apparent that the sender may format it.</p>	<p>No action necessary.</p>
7.3(b) – Electronic Bill Attachments Medical Billing & Payment Guide	<p>Commenter recommends adding the following revised language:</p> <p>(4) Date of Service</p> <p>(5) Date of Injury</p> <p>(6) Social Security Number (if available)</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree with suggestion to reinstate 3 identifiers (date of service, date of injury, and social security number) and add one new identifier (the date of birth) to attachments that support electronic bills. The DWC believes that in order to increase the efficiency</p>	<p>Revise Section 2.4.7 to eliminate the specific documentation identifiers except for the unique attachment indicator number and keep only the unique attachment number</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><b>(7) Date of Birth</b></p> <p><i>Commenter opines that if a claim number is not provided, the employee's social security number or date of birth and date of injury are necessary to identify the injured employee and claim, and the date of service is sometimes needed to identify the correct billing.</i></p>		<p>of electronic billing, the identification of the attachments must be streamlined. The unique attachment indicator number should be adequate to match the electronic bill with the documentation, as it includes a unique number, and embeds the "report type code" that identifies the type of documentation. The "patient's name" and "claim number" will be eliminated from the required attachment identifiers.</p> <p>Also, see response above to Gregory M. Gilbert SVP Reimbursement &amp; Government Relations Concentra April 8, 2013 Written Comment, relating to Section 2.4.7.</p>	<p>identifier in 7.3.</p>
<p>7.3 Electronic Bill Attachments (b) Medical Billing &amp; Payment Guide</p>	<p>Commenter would like to know what "inscribed on the face of the attachment" means. Does this mean a watermark?</p> <p>Commenter opines that if the data elements are already required to be</p>	<p>Gregory M. Gilbert SVP Reimbursement &amp; Government Relations Concentra April 8, 2013 Written Comment</p>	<p>Disagree with the suggestion that "inscribed on the face of the attachment" needs clarification. "Inscribed" is a word that includes a variety of manners of marking the information on the face of the</p>	<p>Revise 7.3(b) to retain the unique attachment number, but eliminate the requirement to include the patient's name and claim</p>

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	<p>submitted in the header or on a coversheet, why must certain fields be contained on the individual attachments as well?</p> <p>Commenter states that modifying every attachment form to include the unique attachment number requires significant customization and has not been required in all other states doing EDI. For his organization, this <i>may</i> require a new bill generation workflow. Since the unique attachment indicator must be generated for each bill package, attachments may need to be custom generated after the bill number / unique attachment indicator is assessed.</p> <p><b>Recommendation:</b> Remove requirement to include specified data elements on each individual attachment since they are already required to be included in the header or on a coversheet</p>		<p>document. It is intentionally broad so that various methods may be used. Agree with commenter to an extent; since there is a cover sheet, agree that the patient's name and claim number do not need to be on every attachment. However, the unique attachment number appearing on the attachment is important to link the documentation to the electronic bill. In the electronic billing 837 formats, the 2300 Loop, PWK segment (attachment control number) is required when documents support the bill (sent either on paper, or through electronic means). This is the same number that is to be inscribed on the face of the attachment. (Section 7.3(a)(3).)</p>	<p>number on each attachment.</p>
9792.5.1(a)	<p>Commenter notes that the guide, Version 1.1, in its current form appears to apply retroactively to October 15, 2011. Unless that is the intent of the Division, commenter</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association</p>	<p>Disagree. Although the version number is proposed to be changed the language of the regulation does not state that there will be retroactive effect.</p>	<p>No action necessary.</p>

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	recommends making the Guide effective for bills received on or after the date that these permanent regulations become effective.	April 9, 2013 Written Comment		
9792.5.1(a)	<p>Commenter recommends the following revised language:</p> <p>(a) The <i>California Division of Workers' Compensation Medical Billing and Payment Guide</i>, <del>version 1.1</del>, which sets forth billing, payment and coding rules for paper and electronic medical treatment bill submissions, is incorporated by reference. <u>Version 1.1 of this Guide is effective for bills received on and after January 1, 2013 (or the date the regulation is adopted).</u> It may be downloaded from the Division of Workers' Compensation through the Department of Industrial Relations' website at <a href="http://www.dir.ca.gov">www.dir.ca.gov</a> or may be obtained by writing to:</p> <p><i>Commenter notes that, as written, version 1.1 of the Medical Billing and Payment Guide appears to apply retroactive to October 15, 2011. If that is not what the Administrative Director intends, commenter recommends clarifying that version</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	Disagree. See Response to comment re section 9792.5.1(a) above by Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<i>1.1 of this Guide apply to bills received by the claims administrator on and after the effective date of these regulations.</i>			
9792.5.1(b)	<p>Commenter recommends correcting the version number from 1.1 to 1.2.</p> <p>Commenter notes the guide will be retroactive to October 15, 2011. Commenter recommends making the guide effective for bill received on or after the date that these permanent regulations become effective.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Agree that version number should be changed from 1.1 to 1.2.</p> <p>Disagree DWC is unable to discern the basis for the contention that the guide would be retroactive of October 15, 2011.</p>	<p>Revise version number.</p>
9792.5.1(b)	<p>Commenter recommends the following revised language:</p> <p>(b) The <i>California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide</i>, <del>version 1.1</del>, which sets forth billing, payment and coding rules and technical information for electronic medical treatment bill submissions, is incorporated by reference. <u>Version 1.1 1.2 of this Guide is effective for bills received on and after January 1, 2013 (or the date the regulation is adopted).</u> It may be downloaded from the Division of Workers' Compensation website at <a href="http://www.dir.ca.gov">www.dir.ca.gov</a> or may be obtained</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. See Response to comment re section 9792.5.1(b) above by Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013.</p>	<p>No action necessary.</p>

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	<p>by writing to:</p> <p><i>Commenter notes that the Companion Guide proposed for adoption is version 1.2, not version 1.1. This appears to be an inadvertent typographical error. As written, the Companion Guide proposed for permanent adoption also appears to apply retroactive to October 15, 2011. If that is not what the Administrative Director intends, commenter recommends clarifying that version 1.2 of this Companion Guide applies to bills received by the claims administrator on and after the effective date of these regulations.</i></p>			
9792.5.10(a)	<p>Commenter notes that his section does not include a timeframe in which the IBR would be required to request additional information. Commenter recommends that they would have to make the request within 5 days of receipt of the dispute.</p> <p>Commenter opines that it is unclear what happens if the parties do not supply the requested information to the IBR. At some point, will they move forward to resolve the dispute with the information that is available</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association April 8, 2013 Written Comment</p>	<p>Under section 9792.5.14, the IBR reviewer has 60 days from assignment of the dispute in which to review the evidence and issue a determination. An IBR reviewer should be allowed an opportunity to conduct a comprehensive review of the case – which may take significant time based on the nature of the dispute – before finding that additional information may be needed from the parties.</p>	<p>No action necessary.</p>

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	<p>to them? Commenter requests that this be clarified in the regulations.</p> <p>Commenter questions if IBR will be making decisions as to whether a contract rate applies? If so, what happens if there is a dispute as to whether the provider has agreed to the contract terms? How will these disputes be resolved?</p>		<p>If the provider does not submit the mandatory documents under section 9792.5.5, the request will be deemed ineligible. If the claims administrator fails to submit documentation after being provided notice to do so, then the review would likely proceed on the evidence submitted by the provider.</p> <p>IBR only resolves disputes over the amount of the payment. A dispute over whether a contract in fact applies must be resolved in another forum.</p>	
9792.5.10(b)	<p>Commenter recommends the following revised language:</p> <p>(b) If the independent bill reviewer requests information from either the claims administrator or the provider, or both, the party shall <b>file transmit</b> the documents <b>to with</b> the independent bill reviewer at the address listed in the correspondence in Section 9792.5.9(f) within <b>35 30</b> days of <b>receipt of</b> the request <b>and concurrently</b></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agreed in part. The 35/32 day timeframe accounts for the additional time allowed by Code of Civil Procedure section 1013 for responding to requests sent either by mail or electronically. The regulations should be more specific as to when the documents must be received by the IBRO and expressly provide that copy of the documents be concurrently</p>	<p>Amend section 9792.5.10(b) to specify the timeframe in which the documents must be received by the IBRO and to expressly state that copies be served concurrently to the other party.</p>

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	<p>to, if the request is made by mail, or 32 days of the request, if the request is made electronically. The filing party shall serve the non-filing party with the documents requested by the independent bill reviewer.</p> <p><i>Commenter opines that “transmit” is preferable because its meaning is clear. The term “file” may be subject to unnecessary interpretation and dispute.</i></p> <p><i>Commenter opine that if the independent bill reviewer requests additional documents, Labor Code section 4603.6(e) requires the parties to “respond with the documents requested within 30 days.” Additional time would apply only if parties are required to submit the documents within 30 days of the independent bill reviewer serving the request; however this is not what Labor Code section 4603.6(e) requires. Commenter opines that requiring parties to respond within 30 days of receiving the request is simpler, more straightforward and easier to track. Adding the term “concurrently”</i></p>		served on the other party.	
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<i>ensures that the documents will be sent to the other party in a timely fashion.</i>			
9792.5.10(b) and 9792.5.9(c)	<p>Commenter recommends the following revised language for the purpose of clarity:</p> <p>(b) If the independent bill reviewer requests information from either the claims administrator or the provider, or both, the party shall file the documents with the independent bill reviewer at the address listed in the correspondence in Section 9792.5.9(f) within 35 days of the request, if the request is made by mail, or 32 days of the request, if the request is made electronically. The filing party shall <b>concurrently</b> serve the non-filing party with the documents requested by the independent bill reviewer.</p> <p>(c) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(3) must be served <b>concurrently</b> on the other party. Any document that was previously provided to the other party or originated from the other party need not be served if a written description of the document and its date is served.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Agreed. The need for concurrent service should be expressly set forth in the regulations.</p>	<p>Amend sections 9792.5.9(c) and 9792.5.10(b) to expressly require concurrent service.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.10(b)(3) and (d)	Commenter opines that in both subdivisions (b)(3) and (d) the 12 day cycle for electronic transmissions should be deleted because this appears to be a needless complication.	Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment	Disagree. Labor Code section 4603.6(e) requires a response within 30 days of the request for documents. C.C.P. section 1013 provides additional time based on the method of notification.	No action necessary.
9792.5.11	<p>Commenter notes that this section only permits withdrawal of an IBR request upon the consent of both parties. Commenter believes there are scenarios where unilateral withdrawal should be permitted. If the provider chooses to withdraw the request, it should be permitted to do so without consent because parties seeking redress should be free to cease the resolution process on their own. Commenter opines that in this scenario, claims administrators do not suffer harm as long as notice of withdrawal is provided and the provider pays any IBR fees.</p> <p>Commenter opines that claims administrators should also be permitted to withdraw without consent where the disputed fees are paid in full to the provider prior to an IBR determination. Full payment resolves</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation April 9, 2013 Written Comment</p>	Agreed. Providers should be allowed to unilaterally withdraw their IBR requests and, if done prior to the assignment of the request to the IBRO, be reimbursed with a large percentage of their filing fee. Claims administrators cannot be granted the right to unilaterally withdraw a request based on the full payment of the bill as there may be no indication with that request that a resolution over the filing fee has been reached.	Revise section 9792.5.11 to allow a provider to withdraw an IBR request with concurrent written notice to the claims administrator. The provider will be reimbursed the amount of \$270 from the filing fee if the withdrawal is made prior to the assignment of the dispute to the IBRO.

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	the dispute and eliminates the need to continue forward with the IBR process. Commenter states that permitting unilateral withdrawal will reduce costs and delays within the IBR process.			
9792.5.11	<p>Commenter recommends the following revised language:</p> <p>(a) <del>Following the submission of all required documents under section 9792.5.10 or 9792.5.12, the provider may withdraw his or her request for independent bill review, before a determination on the amount of payment owed, if the provider and claims administrator settle their dispute regarding the amount of payment of the medical bill. If the provider and claims administrator settle their dispute, they shall make a written joint request for withdrawal and serve it on the independent bill reviewer. The provider may withdraw his or her request at any time before the determination is issued by submitting a written request to the Administrative Director, the claims administrator, and as applicable, the IBRO and independent bill reviewer. If the claims administrator pays the</del></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See above response to comment regarding this section.</p>	<p>No action necessary.</p>

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	<p><u>disputed amount to the provider before the determination, the claims administrator will notify the provider, Administrative Director, IBRO and/or reviewer and the request will be withdrawn.</u></p> <p><i>Commenter opines that it is reasonable for a provider to withdraw the request before a determination is issued by providing written notice to the Administrative Director, the claims administrator, the IBRO and the reviewer. Commenter states that it is important that the claims administrator notify the Administrative Director, IBRO and independent bill reviewer as applicable, if it pays the disputed amount prior to the determination, otherwise a determination and order of the Administrative Director may unnecessarily require a duplicate payment.</i></p>			
9792.5.11	<p>Commenter notes that this subdivision requires the provider to surrender the total IBR fee if it settles its reimbursement dispute with the employer. Commenter would like to know under what circumstance does the Division expect this subdivision</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written and Oral</p>	<p>See response to above comment regarding this section. The IBR fee is to pay for the reasonable estimated cost of IBR and the administration of the IBR program. To allow a</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>will be put to use.</p> <p>Commenter agrees that the IBRO should retain a processing fee if a request is withdrawn for just cause, such as settlement of the dispute. If there must be a fee surrendered when the dispute is settled by the parties, commenter suggests the same \$65 that is retained when a request is found to be ineligible (9792.5.7 (e)).</p> <p>Commenter opines that it should be shared, 50/50 by the parties.</p> <p>Commenter notes that when a request is found ineligible, the same documentation has been submitted and reviewed by the IBRO that determined eligibility. No additional work is performed when a request is withdrawn.</p> <p>Commenter opines that complete surrender of the IBR fee is unnecessarily punitive especially when the provider and payor have settled the dispute. Commenter opines that there is no incentive to settle.</p>	Comment	significant reimbursement if a request is withdrawn when the only action left to be taken is the issuance of a determination by the IBR reviewer ignores the cost of the review up to that point and the overall program costs. Any settlement reached by the parties over a billing dispute should account for the provider's filing fee.	
9792.5.11(a)	Commenter opines that if a request is jointly withdrawn by the physician/medical group and the carrier, the provider should be	Diane Przepiorski Executive Director California Orthopaedic	See above responses to comment regarding this section.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	reimbursed for the filing fee. Otherwise commenter opines that there will be no incentive on the part of the provider to settle the dispute, once an IBR is filed. Commenter opines that it is in the best interest of all parties if they can come to an agreement on the dispute. The provider, who was forced to file the IBR, should not be penalized and lose their filing fee.	Association April 8, 2013 Written Comment		
9792.5.11(a)	<p>Commenter notes that the proposed regulation requires that, where the provider and claims administrator settle their dispute following submission of the required documents, that "they shall make a written joint request for withdrawal and serve it on the independent bill reviewer."</p> <p>Commenter opines that the need for a joint request for withdrawal is burdensome and unnecessary. The provider is the moving party in this dispute. The claims administrator has already had to go through a number of steps to address their issue, from the initial review decision to the second review. Commenter notes that the decision to move the dispute to IBR comes from the provider. Commenter</p>	<p>Peggy Sugarman Director of Workers' Compensation City and County of San Francisco April 9, 2013 Written Comment</p> <p>Howard Stiskin City and County of San Francisco April 9, 2013 Oral Comment</p>	See above responses to comment regarding this section.	No action necessary.

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	<p>opines that if the provider decides to withdraw from the IBR process, they should be allowed to make that decision independently.</p> <p>Commenter notes that there is no statutory requirement for a joint withdrawal, and there is little chance that a claims administrator will object to a provider withdrawing their request for dispute resolution regardless of the reason. Commenter opines that a notice from the provider to the IBR organization with a copy to the claims administrator indicating that they are withdrawing their dispute should be sufficient.</p>			
9792.5.11(b)	<p>Commenter is concerned that this allows a claims administrator to deny a hospital's reasonable request to reimburse the fee provided with the IBR request under § 9792.5.7(d)(1). Commenter opines that if an IBR submission is withdrawn, the hospital and claims administrator should have the ability to settle for any amount, including the amount of the filing fee. Commenter recommends the following revised language:</p> <p>If a request for independent bill</p>	<p>Amber Ott Vice President, Finance California Hospital Association April 8, 2013 Written Comment April 9, 2013 Oral comment</p>	<p>See responses to above comments regarding this section. The Division agrees that the parties should have the ability to settle for any amount, including the amount of the filing fee. However, as noted, the IBR fee is to pay for the reasonable estimated cost of IBR and the administration of the IBR program.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>review is withdrawn under this section, the provider shall not be <del>reimbursed entitled to a refund from the Division of Workers' Compensation of</del> the fee provided with the request under section 9792.5.7(d).</p>			
9792.5.12	<p>Commenter opines that this entire section should be struck. Commenter states an initial authority issue exists insofar as SB 863 makes no reference to "consolidation" within the context of IBR. Commenter opines that even assuming authority exists that consolidation should still not be permitted within IBR. Commenter notes that there is a process to consolidate matters at the WCAB level; however, it is a rare and extraordinary procedure. This WCAB procedure requires numerous hearings to demonstrate that a common issue exists. Commenter opines that an Independent Bill Review Organization (IBRO) is not equipped to determine this type of threshold issue and perform audits. Commenter believes that as a result, providers may assert numerous different claims that have a common issue, when in actuality each case is factually distinct.</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation April 9, 2013 Written Comment</p> <p>April 9, 2013 Oral Comment</p>	<p>Labor Code section 4603.6(c), which provides that the Administrative Director "may prescribe different fees depending on the number of items in the bill or other criteria determined by regulation...." The consolidation of IBR requests, which cannot reasonably be confused with the WCAB procedure of consolidation, is an efficient, cost-effective means of resolving multiple IBR requests involving similar issues and can reasonably be considered an "other criteria" affecting the amount of the filing fee. To require that disputes over a single billing code on multiple dates of service, or multiple billing codes on a single date of service, or a regular practice of</p>	No action necessary.

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			downcoding billing codes, be treated as separate requests with separate filing fees would be punitive on providers and act as a disincentive for providers to seek IBR.	
9792.5.12	<p>Commenter reiterates that consolidation should not be permitted and this entire section should be stricken; however, if consolidation is permitted then the misconduct of both payers and providers should be captured by these regulations. Commenter notes that this section only addresses payer misconduct as consolidation is permitted where a “pattern and practice of underpayment by a claims administrator” is shown. “Pattern and practice” is defined in this section as “ongoing conduct by a claims administrator that is reasonably distinguishable from an isolated event.” Commenter opines that this definition should be loosened and an additional paragraph should be added to capture misconduct by providers.</p> <p>Commenter recommends the following revised language:</p> <p>(b)(3) “Pattern and practice” means</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation April 9, 2013 Written Comment</p>	<p>IBR is requested by providers, who pay a filing fee that is only reimbursed by the claims administrator if the provider prevails in an IMR determination. As consolidation looks to give providers greater access to IBR through reasonable fees to determining similar disputes in a single determination, allowing the procedure to serve as a vehicle for claims administrators to pursue claims of physician misconduct is inappropriate.</p>	No action necessary.

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	<p>ongoing conduct by a claims administrator <u>and/or a provider</u> that is reasonably distinguishable from an isolated event.</p> <p><i><u>(c)(4) Upon a showing of good cause the Administrative Director may allow the consolidation of requests for independent bill review by a single provider or medical group showing a possible pattern and practice of provider upcoding or unbundling or other billing irregularities.</u></i></p>			
9792.5.12	<p>Commenter notes that several provisions of this section (“Consolidation or Separation of Requests”) include references that limit consolidation requests to aggregate dispute amounts of \$4,000.00 or less. As such, cases that could theoretically have been consolidated based on the merits of the issues being addressed (i.e., cases where “delivery of similar or related services” are involved, etc.), are arbitrarily prohibited from consolidation.</p> <p>Commenter recommends removing the arbitrary dollar limit, and instead utilizing a graduated fee-for-service</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services April 8, 2013 Written Comment</p>	<p>The Division considered graduated fees for consolidation but found the \$4,000.00 cap to be more reasonable since: (1) it will provide the IBR with a reasonable estimate of the amount of work necessary to resolve a consolidated IBR dispute; and (2) a determination of consolidated IBR requests, regardless of amount of cases consolidated, will provide the parties with guidance as how similar cases that are currently in dispute should be paid. That said, to ensure that the consolidation</p>	<p>Amend section 9792.5.12 to allow a maximum of 20 IBR requests to be consolidated.</p>

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	<p>model, where the fee for consolidated IBR increases in proportion to the increase in the aggregate value of the request sought. For example, disputes up to \$4,000.00 in the aggregate could be assessed a fee of \$325, disputes from \$4,001.00 to \$7,500.00 could be assessed a fee of \$450, and so on. The current limits on the types of disputes that may be consolidated would remain intact.</p>		<p>process not be abused by providers, a limit of 20 IBR requests should be imposed.</p>	
9792.5.12	<p>Commenter states that this entire section should be eliminated.</p> <p><i>Commenter opines that the Legislature could have authorized the Administrative Director to permit the consolidation of requests for independent Bill Review (IBR) in Senate Bill 863, but it did not. Commenter believes that adding a process to consolidate requests is an unlawful expansion of Statute that thwarts its purpose. Commenter is also concerned that neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See responses to above comments regarding this section.</p>	<p>No action necessary.</p>
9792.5.12	<p>Commenter opines that consolidation of requests is a practical solution to a very common problem. Commenter</p>	<p>Steve Cattolica Director of Government</p>	<p>A goal of SB 863 in creating the IBR program was to have billing and payment experts</p>	<p>No action necessary.</p>

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	<p>recommends that consolidation should be the norm and be actively encouraged. Commenter opines that the conditions for consolidation should be broadly applicable rather than too prescriptive. For example, since multiple IBROs may be assigned to review requests from a single provider who would otherwise and appropriately want to consolidate reviews, the request to consolidate and the decision to allow consolidation should reside solely with the Administrative Director. Commenter opines that the IBRO has a clear conflict in that it is deciding its own revenue stream when making a consolidation decision. Commenter recommends that a provider's request to consolidate and the AD's subsequent decision, should be made as early in the assignment process as possible. Commenter notes that with the AD is the only point within the IBR process where information is consolidated and present at one time and in one place. Commenter opines that any given provider's reviews may end up being assigned to just as many IBROs as there are requests. Any inherent efficiency from consolidation</p>	<p>Relations AdovCal April 9, 2013 Written Comment</p>	<p>decide medical billing disputes. The appropriateness of consolidation under subdivision (c)(1) and (2) should only be made by billing experts, who are familiar with the coding and payment. As to subdivision (c)(3), the “pattern and practice” provision, the IBRO can only consolidate requests after consultation with the Administrative Director. The IBR process is a new way in which to resolve billing disputes over workers’ compensation medical treatment. If future data regarding the utilization of the consolidation process indicates inefficiencies in the process, the Division may revise the section in future rulemaking.</p>	

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	<p>would be lost. Commenter opines that it would be virtually impossible and surely much more expensive to retrieve and reassign the reviews in order to facilitate the consolidation.</p>			
9792.5.12	<p>Commenter would like clarification regarding when the Administrative Director or the IBR Organization will determine that a request involves a common issue of law in fact or the delivery of similarly related cases. Commenter assumes that these claims will be subject to one filing fee of \$325 but she is not certain and would like confirmation.</p> <p>Commenter notes the proposed regulations state that IBR may only allow consolidation of requests for IBR by a single provider showing a possible pattern and practice of underpayment by the claims administrator for specific billing codes. Commenter requests a definition of the pattern and practice of underpayment and more specificity on this point.</p> <p>Commenter requests clarity on how payment and interest will eventually be distributed to the provider if and</p>	<p>Michelle Rubalcava California Medical Association April 9, 2013 Oral Comment</p>	<p>The section expressly addresses the oral comments. A provider must request consolidation, submit all information necessary regarding each dispute to be consolidated, and pay a single filing fee. The IBRO and Administrative Director, will review the request for eligibility under section 9792.5.9, disaggregate the request as necessary, and then assign the request for an IBR determination.</p> <p>“Pattern and practice” is reasonably in subdivision (b)(3).</p> <p>The IBR determination will include, assuming payment is owed, any additional amount of money owed to the provider on the bill and an order requiring the payment of the</p>	<p>No action necessary.</p>

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	when the IBRO finds in favor of the provider.		filing fee. Interest should be paid if authorized under Labor Code section 4603.2.	
9792.5.12 (a)	<p>Commenter opines that the ability to consolidate disputes will be very important and should continue to be allowed.</p> <p>Commenter recommends that the regulations be clarified to allow “a single provider or medical group” to be allowed to consolidate services rendered on the same day for the same injured worker.</p> <p>Commenter opines that since many providers work as part of an integrated medical group, this would allow all medical services performed on the same date of service for the same injured worker, even if they were not performed personally by the physician, to be consolidated. These additional services could be items such as plain film x-rays or DME performed or dispensed within the medical group.</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association April 8, 2013 Written Comment</p>	<p>The limitation of consolidation to a single provider is a practical limitation on the scope of requests that can be made so that the single fee paid for multiple requests can accurately reflect the cost of the review.</p>	<p>No action necessary.</p>
9792.5.12(b)	<p>Commenter opines that there may not just be one claim administrator at a particular carrier that is</p>	<p>Diane Przepiorski Executive Director California</p>	<p>Consolidation only applies to IBR requests against one claims administrator, which</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>inappropriately reimbursing for a service. Commenter questions what if several claims administrators at the same carrier are inappropriately reimbursing for a particular service for a provider or medical group?</p> <p>Commenter opines that these types of disputes are the hardest for providers to resolve. Commenter states that these disputes should also be allowed to be consolidated if there is a pattern of practice to unjustly deny or reduce payment for a particular service. For instance, in the past commenter has dealt with a bill review company not reimbursing for the professional component of an x-ray if the x-ray report was not a separate report. That was an incorrect interpretation of the Ground Rules. The DWC allowed the x-ray report to also be in a separate section within the physicians report as long as it was clearly identified.</p> <p>Commenter states that the company still refused to reimburse the physicians for their professional service. Commenter notes that this is a company-wide policy, not unique to a particular claims administrator.</p> <p>Commenter opines that providers should be able to consolidate this type</p>	<p>Orthopaedic Association April 8, 2013 Written Comment</p>	<p>aligns with the language of Labor Code section 4603.6, which only references a single provider and a single employer. It is hoped that a consolidated IBR determination on specific billing practice will educate the public and act as a deterrent against those who would engage in the same practice.</p>	

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	of pattern of practice as well.			
9792.5.12(b)(3)	<p>Commenter recommends the following definition for “pattern and practice”:</p> <p>“Pattern and Practices means ongoing conduct by a claims administrator or carrier that is reasonably distinguishable from an isolated event.”</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association April 8, 2013 Written Comment</p>	<p>See above response to comment regarding section 9792.5.12(b).</p>	<p>No action necessary.</p>
9792.5.12(b)(3)	<p>Commenter notes that this subdivision defines a "pattern and practice." Commenter notes that up to now, the ability for providers to muster the resources to prove that a claims administrator is behaving badly in the course of the billing and reimbursement process as a "pattern and practice" (also known as a "business practice") have been extremely limited. Commenter knows of a few such instances and knows that the process works, but far too infrequently. Commenter opines that this is particularly true when Medical-Legal evaluations are reviewed improperly. Commenter trusts that there is no immunity from misconduct, audit or other penalties by simply participating in the IBR process. If, as a result of IBR, a claims</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written and Oral Comment</p>	<p>Participation by a claims administrator in the IBR process does not preclude the Division from assessing administrative or civil penalties under Labor Code sections 129 and 129.5, should the underlying billing practices warrant engaged in by the claims administrator warrant such penalties.</p>	<p>No action necessary.</p>

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	<p>administrator is found to have systematically under reimbursed providers, commenter requests that a swift target audit result and additional penalties and fees be assessed.</p>			
<p>9792.5.12(b)(3) and (c)(3)</p>	<p>Commenter states that it appears that statutory authority is lacking for allowing consolidation in the IBR area. The WCAB has this option, but rarely uses it and only after numerous hearings to determine eligibility for this extraordinary measure. Commenter opines that even if the Division had authority to permit consolidation, an IBRO would not be equipped to determine this threshold issue. Commenter strongly recommends that this section be deleted.</p> <p>If this section is not deleted, commenter recommends the following revised language:</p> <p>(b)(3) "Pattern and practice" means ongoing conduct by a claims administrator <b>or provider</b> that is reasonably distinguishable from an isolated event.</p> <p>(c)(3) Upon a showing of good cause</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See responses to comments by the California Chamber of Commerce regarding this section.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>and after consultation with the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator <b>or upcoding by a provider</b> for specific billing codes. Requests to be consolidated under the subdivision shall involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service, and aggregated amounts in dispute up to \$4,000.00 or individual amounts in dispute less than \$50.00 each.</p> <p>Commenter states that there are constant disputes whether a provider up-codes or the payor down-codes. Commenter is concerned that if this examination solely examines the actions of the payor the provider actions that precipitated those of the payor may be missed. Commenter opines that both entities' actions must be reviewed in order to determine where the fault lies if fault is found.</p>			
9792.5.12(c)	Commenter has concerns, similar to those she addressed when commenting on §9792.5.7(a)(1), regarding the	Amber Ott Vice President, Finance	See above response to comment by Coventry Workers' Compensation	No action necessary.

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	<p>terms “one date of service” and “one billing code” in reference to consolidated billing.</p> <p>Commenter opines that the \$4,000.00 threshold in § 9792.5.12(c)(1) and (3) seems to be much too low for truly effective consolidation, particularly for hospitals.</p> <p>Commenter opines that if the DWC is concerned about the marginal time increase for a large number of bills at issue that are otherwise of “common issues of law and fact” and for “similar or related services,” commenter recommends removing the \$4,000.00 threshold in its entirety and making the adopting the following revised language:</p> <p>§ 9792.5.12(c)(1) Requests for independent bill review by a <b><u>single or multiple provider(s), as permitted under subdivision (c)</u></b>, involving multiple dates of medical treatment services may be consolidated and treated as one single independent bill review request if the requests involve one injured employee, one claims</p>	<p>California Hospital Association April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Services regarding this section. The \$4,000.00 consolidation is reasonable since: (1) it will provide the IBR with a reasonable estimate of the amount of work necessary to resolve a consolidated IBR dispute; and (2) a determination of consolidated IBR requests, regardless of amount of cases consolidated, will provide the parties with guidance as how similar cases that are currently in dispute should be paid.</p>	

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	<p>administrator, and one <b><u>or multiple</u></b> billing code(s) under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, <del>and the total amount in dispute does not exceed \$4,000.00.</del></p> <p>§ 9792.5.12(c)(2) Requests for independent bill review by a single <b><u>or multiple</u></b> provider(s), <b><u>as permitted under subdivision (c).</u></b> involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service <b><u>or multiple service dates of medical treatment service that are consecutive.</u></b></p> <p>§ 9792.5.12(c)(3) Upon a showing of good cause and after consultation with</p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single <b><u>or multiple provider(s), as permitted under subdivision (c),</u></b> showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Requests to be consolidated under the subdivision shall involve <b><u>a single claim administrator and may involve</u></b> multiple injured employees, <b><u>one claim administrator,</u></b> one <b><u>or multiple</u></b> billing code(s), <b><u>and</u></b> one or multiple dates of service, <b><u>and aggregated amounts in dispute up to \$4,000.00 or individual amounts in dispute less than \$50.00 each.</u></b></p>			
9792.5.12(c)(1)	<p>Commenter notes that once again, the requirement for consolidation includes one billing code. Commenter opines that this is an unrealistically simple view of normal health care billing and reimbursement. Commenter urges the Division to allow consolidation surrounding a single claimant's services over multiple dates as well as multiple codes. Commenter states that consolidation restricted to a single code will require multiple IBR requests a large proportion of the time,</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>The limitation of consolidation to a single billing code on multiple dates of service, or multiple billing codes on a single date of service, is a practical limitation on the scope of requests that can be made so that the single fee paid for multiple requests can accurately reflect the cost of the review. The Division acknowledges that a single billing code cannot be</p>	<p>No action necessary.</p>

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	<p>resulting in a loss of any efficiencies or cost savings.</p> <p>Commenter opines that the single code restriction may have the unintended consequence of being an example of "divide and conquer," predominantly in the payor's favor. Commenter states that medical services are rarely delivered in isolation. One modality (coded item) is delivered in conjunction with perhaps several others as a treatment plan, to rule out or establish a diagnosis. To divide an IRB request compels the IBRO to make decisions without any coordination with the other services provided.</p> <p>Commenter opines that consolidation is one of the few ways to realize efficiencies from the IBR process and emphasizes that an IBR on a code by code, episodic, basis will result in higher costs for all involved.</p>		<p>reviewed in isolation; related codes as part of the treatment plan must also be considered. If future data on billing practices after the establishment of IBR show that the consolidation of requests is ineffective, the Division may adjust this section in future rulemaking.</p>	
9792.5.12(c)(1)(1)	<p>Commenter recommends eliminating the dollar limit on consolidation for surgical procedures and for injection, radiation, or chemo therapies.</p>	<p>Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>See response to comment by the California Hospital Association regarding this subdivision.</p>	<p>No action necessary.</p>
9792.5.12(c)(3)	<p>Commenter notes that this section</p>	<p>Brian Allen</p>	<p>Following discussions with</p>	<p>No action necessary.</p>

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	<p>establishes a \$50 threshold for amounts in dispute per bill. Commenter opines that the \$50 threshold is low and will not serve to consolidate and expedite IBRs.</p> <p><b>Commenter recommends that the dollar amount threshold be set at \$200, to more realistically reflect the dispute balances that are experienced by providers, billing agents and assignees in the California workers' compensation system.</b></p>	<p>Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Maximus Federal Services, Inc., the current IBRO, the Division found the \$50.00 threshold to be reasonable for the purpose of consolidation.</p>	
9792.5.12(c)(3)	<p>Commenter states that this section provides the IBRO with the discretion to consolidate multiple requests for independent bill review if it appears that the requests involve common issues of law and fact or the delivery of similar or related services.</p> <p>Commenter opines that the IBRO should not be permitted to make such determinations to consolidate as it is beyond the scope and expertise of the IBRO. Commenter recommends that decisions to consolidate be made by judges based on a broad view of evidence. Commenter opines that the proposed</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 9, 2013 Written Comment</p> <p>Patricia Brown State Compensation Insurance Fund April 9, 2013 Written and Oral Comment</p>	<p>Agreed in part. Consolidation under this section cannot occur without consultation with the Administrative Director and a determination of eligibility under section 9792.5.9. It must be noted that section 9792.5.9(b)(3) has been amended to allow the claims administrator to submit any documents disputing the provider's reason for requesting IBR. This may include the reason for consolidation.</p>	No action necessary.

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	<p>regulations should allow all parties to reasonably submit evidence to give parties a full and fair opportunity to be heard. It appears that the proposed regulations limit the claims administrator to two narrow circumstances of submitting evidence: under §9792.5.9(b)(3) where it appears that a claims administrator is only permitted to submit documents on the issue of eligibility for IBR review; and under §9792.5.10 where the claims administrator may only submit additional information upon the request of the IBRO. If it is determined that the IBRO or AD may consolidate multiple requests for IBR, the parties should at least be allowed to submit additional evidence.</p>			
9792.5.12.(c)(2)	<p>Commenter recommends that this section clarify that consolidation is allowed for a single admission or outpatient hospital stay.</p>	<p>Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>Section 9792.5.7(a)(1) has been amended to allow IBR for one hospital stay. Consolidation is not necessary.</p>	<p>No action necessary.</p>
9792.5.13(a)	<p>Commenter recommends the following revised language:  (a) If the request for independent bill review involves the application of the</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association</p>	<p>The IBR reviewer must apply the current law as it applies to each fee schedule or contract dispute they review. To expressly state this in the</p>	<p>Amend section 9792.5.13(d) to provide that IBR shall apply as necessary all billing,</p>

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	<p>Official Medical Fee Schedule (OMFS) for the payment of medical treatment services or goods as defined in Labor Code section 4600, the independent bill reviewer shall apply the provisions of sections 9789.10 to 9789.111, 9792.5.3 and all other applicable statutes, case law, rules and regulations regarding payment to determine the additional amounts, if any, that are to be paid to the provider or reimbursed to the payor in the case of overpayments.</p> <p>Commenter states that sections 9789.10 through 9789.111 do not cover all rules and requirements for payment. Fee schedules are applied according to date of service. Sections 9790 through 9792.5.3, for example, also must also be applied. Commenter opines that medical treatment payments are affected by numerous other statutes, case law, rules and regulations and independent bill reviewers must apply them all.</p>	<p>April 9, 2013 Written Comment</p>	<p>regulation is unnecessary. That said, a review must apply all billing rules as adopted by the Division, as opposed to those adopted by other jurisdictions, so this requirement should be expressly stated.</p>	<p>payment, and coding rules adopted by the Division.</p>
9792.5.13(a)	<p>Commenter recommends the following revised language:</p> <p>(a) If the request for independent bill review involves the application of the</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013</p>	<p>See response to comment by the American Insurance Association regarding this subdivision.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Official Medical Fee Schedule (OMFS) for the payment of medical treatment services or goods as defined in Labor Code section 4600, the independent bill reviewer shall apply the provisions of sections 9789.10 to <u>9789.111 9792.5.3, relevant statutes, judicial rulings, and other rules and regulations to determine additional amounts or overpayments</u>, if any, that are to be paid to the provider <u>or reimbursed to the claims administrator</u>.</p> <p><i>Commenter states that sections 9789.10 to 9789.111 do not cover all rules and requirements for payment. Fee schedules are applied according to date of service. Sections 9790 through 9792.5.3, for example also must be applied. "Medical treatment" payments are affected by numerous other statutes, as well as case law and rules and regulations, and independent bill reviewers must apply them all.</i></p>	Written Comment		
9792.5.13(b)	<p>Commenter recommends the following revised language:</p> <p>If the request for independent bill review involves the application of a</p>	Steven Suchil Assistant Vice President/Counsel American Insurance Association	To resolve a billing dispute under a contract for reimbursement rates under Labor Code section 5307.11, the IBR reviewer must only	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>contract for reimbursement rates under Labor Code section 5307.11 for the payment of medical treatment services as defined in Labor Code section 4600, the independent bill reviewer shall apply the contract <u>provisions and/or the Official Medical Fee Schedule where that is an option in the contract</u> to determine the additional amounts, if any, that are to be paid to the provider.</p>	<p>April 9, 2013 Written Comment</p>	<p>apply the rates as set forth in the contract.</p>	
<p>9792.5.13(b)</p>	<p>Commenter recommends the following revised language:</p> <p>(b) If the request for independent bill review involves the application of a contract for reimbursement rates under Labor Code section 5307.11 for the payment of medical treatment services as defined in Labor Code section 4600, the independent bill reviewer shall apply the contract <u>and all other statutes, case law, rules and regulations to determine additional amounts, or overpayments,</u> if any, that are to be paid to the provider <u>or reimbursed to the claims administrator.</u></p> <p><i>Commenter opines that when reviewing bills, the independent bill</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See response to comment by the American Insurance Association regarding subdivision (a).</p>	<p>No action necessary.</p>

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	<i>reviewer must at all times consider all relevant statutes, case law, and rules and regulations, and must determine any overpayments as well as underpayments.</i>			
9792.5.13(c)	<p>Commenter recommends the following revised language:</p> <p>If the request for independent bill review involves the application of the Medical-Legal Fee Schedule (M/L Fee Schedule) for services defined in Labor Code section 4620, the independent bill reviewer shall apply the provisions of sections 9793-9795 and 9795.1 to 9795.4, <b>as well as all applicable statutes, case law, rules and regulations</b> to determine the additional amounts, if any, that are to be paid to the provider.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See response to comment by the American Insurance Association regarding subdivision (a).</p>	<p>No action necessary.</p>
9792.5.13(c) and (d)	<p>Commenter recommends the following revised language:</p> <p>(c) If the request for independent bill review involves the application of the Medical-Legal Fee Schedule (M/L Fee Schedule) for services defined in Labor Code section 4620, the independent bill reviewer shall apply the provisions of sections 9793-9795 and 9795.1 to 9795.4 <b>and all other</b></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See response to comment by the American Insurance Association regarding subdivision (a).</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>statutes, case law, rules and regulations to determine additional amounts, or overpayments, if any, that are to be paid to the provider or reimbursed to the claims administrator.</p> <p>(d) In applying this section, the independent bill reviewer shall apply the provisions of the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, and all applicable statutes, case law, rules and regulations as if the bill is being reviewed for the first time; and shall consider each Bill Adjustment Reason Code, associated DWC Explanatory message and Payer Instruction; each Claims Adjustment Reason Code and Remittance Advice Remark Code and associated Description in the explanations of review issued; and the National Correct Coding Initiative and other nationally accepted coding references.</p> <p><i>Commenter opines that it is important that the Independent bill reviewer review and investigate as needed each explanatory message or code to</i></p>			

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	<i>consider whether factors apply that are not obvious from the required submissions. The reviewer must also utilize tools of the trade such as NCCI and other coding references.</i>			
9792.5.13(d)	<p>Commenter recommends the following revised language:</p> <p>In applying this section, the independent bill reviewer shall apply the provisions of the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, <u>along with any other applicable statutes, case law, and/or rules and regulations;</u> as if the bill is being reviewed for the first time. <u>The independent bill reviewer must consider each Bill Adjustment Reason Code, associated DWC Explanatory message and Payer Instruction; each Claims Adjustment Reason Code and Remittance Advice Remark Code and associated Description in the explanations of review issued; and the Nation Correct Coding Initiative and other nationally accepted coding references.</u></p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See response to comment by the American Insurance Association regarding subdivision (a).</p>	<p>No action necessary.</p>
9792.5.14	<p>Commenter states that there is no provision that, if the IBR finds that the claims administrator overpaid</p>	<p>Peggy Thill Claims Operations Manager</p>	<p>Labor Code section 4603.6 does not provide a remedy for a claims administrator who</p>	<p>No action necessary.</p>

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	<p>the provider, the IBR determination shall order the provider to pay the overpaid amount to the claims administrator.</p> <p>Commenter recommends that the Division specify that the IBR determination shall order the provider to pay the overpaid amount to the claims administrator in cases where the IBR reviewer finds that an overpayment was made.</p>	<p>State Compensation Insurance Fund April 9, 2013 Written Comment</p>	<p>believes that they have overpaid a provider on a medical bill. The Division would be acting beyond the scope of its authority to mandate such a recovery.</p>	
9792.5.15	<p>Commenter is concerned with two issues in this section. First, under the emergency regulations, to appeal an IBR determination a party was required to file a “verified petition.” The term “verified” was removed from § 9792.5.15(b) in the current draft regulations. Commenter opines that this creates a conflict between this section and Labor Code § 4603.6 which requires a “verified appeal” when appealing IBR decisions to the Workers’ Compensation Appeals Board (WCAB). Commenter recommends that the DWC cure this inconsistency so parties have a clear understanding of the appeals process.</p> <p>Second, commenter recommends that</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation April 9, 2013 Written Comment</p>	<p>The Division does not have authority to formally establish procedures for the WCAB. The parties should look to the rules and procedures of the WCAB for the manner in which to appeal an IBR determination.</p>	No action necessary.

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	<p>the draft regulations remove the requirement that all interested parties be served with the petition. All interested parties should have notice of an appeal – this is a fundamental concept within both California’s workers’ compensation system and, more broadly, within American jurisprudence. Commenter opines that if the DWC intends for there to be a specific procedure before the WCAB to address these fundamental issues of fairness and due process, it needs to articulate that. The Commenter urges the DWC to reinstate this requirement.</p>			
9792.5.15	<p>Commenter states that this section allows the provider or carrier to appeal the decision of the IBRO/AD, but the language that required service of the appeal on all parties is stricken.</p> <p>Commenter opines that the stricken language should be re-inserted to require service of any appeal upon all parties in order to place them on notice that the decision is being appealed.</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 9, 2013 Written Comment</p> <p>Patricia Brown State Compensation Insurance Fund April 9, 2013 Written and Oral Comment</p>	See above response to comment by the California Chamber of Commerce regarding this section.	No action necessary.
9792.5.15(a)	Commenter urges the division to add the following clause to this section:	Carl Brakensiek California Society of	The additional amounts owed would necessarily include the	No action necessary.

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	<p>“... and the payor shall reimburse the provider for any IBR fees paid pursuant to section 9792.5.14(b)</p>	<p>Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment</p>	<p>reimbursement of the filing fee under section 9792.5.14(b).</p>	
<p>9792.5.15(b)</p>	<p>Commenter recommends the following revised language:</p> <p>(b) Pursuant to Labor Code section 4610.6(f), the provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by filing a petition with the Workers' Compensation Appeals Board</p> <p><i>Commenter opines that since the specifics of Labor Code section 4610.6(f) have been deleted, a citation to that section is appropriate.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agreed. The statutory reference would be appropriate.</p>	<p>Amend section 9792.5.15(b) to refer to the appeal provision of Labor Code section 4603.6(f).</p>
<p>9792.5.15(c)</p>	<p>Commenter states that the Workers' Compensation Appeals Board (WCAB) needs to be an option for an appeal of the decision and as a final remedy.</p> <p>Commenter recommends adding a new subsection (3), language as follows:</p> <p><u>(3) The Administrative Director may revise the appealed final determination</u></p>	<p>Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>The procedure following a remand of an IBR determination is set forth in statute. See Labor Code section 4603.6(g).</p>	<p>No action necessary.</p>

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	<p><u>based on the review of the Workers' Compensation Appeals Board.</u></p>			
9792.5.15(c)(1)	<p>Commenter states that there is a typographic error in this subdivision. It erroneously uses the term "independent medical review" rather than an independent bill review.</p> <p>Commenter opines that this entire subdivision seems to render the entire IBR process moot. Not only is a provider penalized for settling its claim early (§ 9792.5.11), but if they stick with the IBR process to its end, both parties end up bearing the added expense of a lien proceeding, at the end of which, IBR is repeated. Commenter opines that this regulation appears to describe a circular process ... one without an end. There is no winner - employer or provider. Commenter opines that if one emerges, it will be the party with the most financial staying power - advantage payor.</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>As to the typographical error, the subdivision should be corrected. Regarding the remaining comment, see the above response to the comment by Tenet regarding this subdivision.</p>	<p>Amend section 9792.5.15(c)(1) to correct typographical error.</p>
9792.5.15(c)(1)	<p>Commenter notes that the word "medical" should be replaced by the word "bill."</p> <p>Commenter questions when you submit the bill to a second round of</p>	<p>Carl Brakensiek California Society of Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment</p>	<p>The text error is noted. There is no statutory mandate requiring the payment of additional fees following a WCAB remand of an IBR determination.</p>	<p>No action necessary.</p>

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	IBR, does the payer have to pay the filing fee once again or is that still covered by the original filing fee paid.			
9792.5.4	<p>Commenter notes that there is not a definition for a billing agent or assignee. Commenter states that in many instances, especially in the pharmacy arena, a third party billing agent or assignee will accept the assignment of a claim from the provider, pay the provider for the claim, and then assume the responsibility for processing and collecting payment for the claim. Absent those definitions in this rule, the commenter opines that it is unclear if a billing agent or assignee would be afforded standing to pursue a second bill review or an independent bill review.</p> <p>Commenter recommends mirroring or referencing the definitions in 9792.5.0 for “billing agent” and “assignee” and incorporating those terms into this rule in a manner that would extend the SBR and IBR rights and options to billing agents and assignees.</p>	<p>Brian Allen Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Agreed. The Division acknowledges that providers utilize the services of billing agents to submit and process medical bills and that the second bill review and IBR process may be expedited by such agents.</p>	<p>Amend definition of “provider” in section 9792.5.4(i) to allow a provider to use the services of a billing agent, a person or entity that has contracted with the provider to process bills under this article for services or goods rendered by the provider, to request a second bill review or independent bill review.</p>
9792.5.4	<p>Commenter recommends the following revised language:</p>	<p>Steven Suchil Assistant Vice President/Counsel</p>	<p>The Division administers IBR. Labor Code sections 139.5 and 4603.6. Further, Labor Code</p>	<p>No action necessary.</p>

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	<p>This section is applicable to medical treatment pursuant to Labor Code Sections 4600 and 4603.2 bills rendered received, or medical-legal expenses pursuant to 4620 incurred received, on or after January 1, 2013.</p> <p>Commenter states that section 84 of SB 863 applies this act to all pending matters, regardless of date of injury, unless otherwise provided in the act. Accordingly, commenter opines that this regulation should apply to all pending matters. Commenter states that if timelines for payment, second review, and IBR do not all depend on date of receipt, significant programming changes to bill review software will be necessary. Such program changes will be costly and time-consuming. Two different bill review tracks will need to be created - one for dates of service prior to 2013, and one for later dates of service. Commenter opines that this new administrative complexity, and its additional costs and delays, are not necessary and can be avoided by making the changes contingent on the date of receipt of the medical bills. Commenter suggests, if the Division</p>	<p>American Insurance Association April 9, 2013 Written Comment</p>	<p>section 139.5(a)(1) provides that “[t]he [AD] shall contract with one or more independent medical review organizations and one or more independent bill review organizations to conduct reviews.” In turn, section 139.5(a)(2) provides that “[t]o enable the independent review program to go into effect for injuries occurring on or after January 1, 2013, ... independent review organizations under contract with the Department of Managed Health Care ... may be designated by the [AD] to conduct reviews.” Read together, these provisions imply a legislative intent that IBR is inapplicable to injuries prior to January 1, 2013 (see Stats. 2012, ch. 363, § 84 [stating that SB 863 “shall apply to all pending matters, regardless of date of injury, unless otherwise specified in this act”]). The limitation is also necessary to allow claims administrators to establish their second bill review programs,</p>	

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	<p>prefers, the date provided can be the date the permanent regulations become effective.</p>		<p>and for the Division to contract with and designate an independent bill review organization to conduct IBR services, and still comply with the statutory timeframes for conducting a second bill review and initiating IBR.</p>	
9792.5.4	<p>Commenter recommends the following revised language:</p> <p>This section is applicable to <b>billings received on or after January 1, 2013, (or the effective date of these revised regulations) medical treatment for services and goods</b> rendered, pursuant to Labor Code sections 4600 and 4603.2, <b>of and</b> medical-legal expenses incurred, <b>pursuant to Labor Code section 4620 on or after January 1, 2013.</b></p> <p><i>Commenter urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013 (or on the effective date chosen by the Administrative Director, since emergency regulations have been in effect since January 1, 2013) as this will apply the new statutory provisions</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See above response to comment by the American Insurance Association regarding this section.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>to billings and billing disputes as soon as possible, as intended by the Legislature, and under a single set of rules on a going-forward basis.</i></p>			
9792.5.4(a)(1)	<p>Commenter recommends the following revised language:            (1) <del>Medical treatment s</del>Services rendered by a provider or goods supplied in accordance with Labor Code sections 4600 or 4603.2 that <del>was</del> <u>were</u> authorized <del>by pursuant to</del> Labor Code section 4610, and for which there exists <del>an applicable a</del> fee schedule <u>for that category of services, including but not limited to schedules</u> located at sections 9789.10 to 9789.111, or for which-a contract for reimbursement rates exists under Labor Code section 5307.11.</p> <p><i>Commenter opines that these recommended changes clarify that the services include services listed in Labor Code section 4603.2, and must be subject to a fee schedule for that category of services. "Including but not limited to" is added to cover fee schedules that may be adopted in the future.</i></p>	<p>Brenda Ramirez            Claims &amp; Medical Director            CWCI            April 9, 2013            Written Comment</p>	<p>Agreed. The subdivision should be amended to account for fee scheduled that may be adopted by the Division in the near future.</p>	<p>Amend section 9792.5.4.(a)(1) to account for fee schedules that may be adopted in the future.</p>
9792.5.4(a)(1) and (c)	<p>Commenter recommends adding the applicable code sections to further</p>	<p>Steven Suchil            Assistant Vice</p>	<p>For the first part of the comment, see above response</p>	<p>No action necessary.</p>

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	<p>clarify what goods and services are included in the regulation.</p> <p>Commenter suggests the following revised language:</p> <p>(1) Medical treatment services rendered by a provider or goods supplied in accordance with Labor Code section 4600 and <u>4603.2</u> that <del>was</del> <u>were</u> authorized by Labor Code section 4610, and for which there exists an applicable fee schedule located at sections 9789.10 to 9789.111 , or for which a contract for reimbursement rates exists under Labor Code section 5307.11.</p> <p>(c) "Claims Administrator" means a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, <u>or joint powers authority, California Insurance Guarantee Association, or the Uninsured Employers' Fund.</u></p>	<p>President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>to CWCI's comment regarding subdivision (a)(1). As to the comment regarding subdivision (c), the definition is reasonable and corresponds to the definition of "claims administrator" in the Medical Billing and Payment Guide, version 1.2 and includes all regulated entities.</p>	
9792.5.4(a)(2)	Commenter recommends the	Brenda Ramirez	Agreed. The suggestion	Amend section

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	<p>following revised language:</p> <p>(2) Medical-legal expenses, as defined by Labor Code section 4620, where the payments for the services are determined by in accordance with sections 9793-9795 and 9795.1-9795.4.</p> <p><i>Commenter suggests this change for additional accuracy.</i></p>	<p>Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>appears to be more accurate.</p>	<p>9792.5.4(a)(2) to provide that payment for medical-legal services is determined in accordance with that fee schedule.</p>
9792.5.4(b)	<p>Commenter recommends the following revised language:</p> <p>(b) "Billing Code" means those codes adopted by the Administrative Director for use in the -Official Medical Fee Schedule, located at sections that include, but are not limited to 9789.10 to 9789.111, or in the Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).</p> <p><i>Commenter opines that this change will cover other fee schedule sections promulgated by statute or that may be adopted by the Administrative Director.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The term "billing code" is accurate for the fee schedules that have been adopted by the Administrative Director. Should additional fee schedules be adopted in the future, these regulations will be amended to reflect the applicability of SBR and IBR to disputes under the new schedules.</p>	<p>No action necessary.</p>
9792.5.4(c)	<p><i>Commenter recommends adding to this definition other administrators of</i></p>	<p>Brenda Ramirez Claims &amp; Medical</p>	<p>See response to comment by American Insurance</p>	<p>No action necessary.</p>

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	<i>injured employee's claims such as CIGA, SISF and UEF.</i>	Director CWCI April 9, 2013 Written Comment	Association regarding this subdivision.	
9792.5.4(d)	<p>Commenter recommends the following revised language:</p> <p>(d) "Contested liability" means the existence of a good-faith issue which, if resolved against the injured worker, would defeat the right to any workers' compensation benefits or the existence of a good-faith issue that would defeat a provider's right to receive compensation for medical treatment services provided in accordance with Labor Code sections 4600 and 4603.2 or for medical-legal expenses defined in Labor Code section 4620.</p> <p><i>Here and elsewhere in these regulations, commenter opines that if the recommended definition of "medical treatment" is not adopted, additional reference to 4603.2 is necessary, and/or references to "services and goods" in lieu of "medical treatment."</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	The Division notes the exclusion of the word "of." Regarding the rest of the comment, reference to medical treatment provided under Labor Code section 4600 is sufficient to cover all necessary circumstances.	Amend section 9792.5.4(d) to correct grammatical error.
9792.5.4(i)	Commenter states that this section	Kristie Griffin	See response to comment by	No action necessary.

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	states only the “provider” may request SBR and IBR. Commenter states that in order to be consistent with the adopted IAIABC e-Billing rule, DWC’s Medical Billing and Payment Guide and Electronic Medical Billing and Payment Companion Guide, which both define and reference “billing agents” and “assignees”, she recommends that the division add these entities to the regulation or part of the definition of “provider” as they often act on behalf of the provider to bill and seek reimbursement, as well as, communication with the claims administrator in relation to bill processing.	Compliance Manager Express Scripts, Inc. April 4, 2013 Written Comment	Stone River Pharmacy Solutions regarding this section.	
9792.5.4(i)	Commenter opines that the term “Provider,” as defined and used throughout this and subsequent subsections, excludes essential parties from participating in these new claims adjudication processes. Many hospitals currently enlist the assistance of vendors to handle any number of claim billing and adjudication functions for workers’ compensation bills, and many other payers. Similarly, employers and insurers rely on partners to review and process bills (third party administrators, bill review	Amber Ott Vice President, Finance California Hospital Association April 8, 2013 Written Comment April 9, 2013 Oral Comment	See response to comment by Stone River Pharmacy Solutions regarding this section.	No action necessary.

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	<p>companies, etc.) and the DWC recognizes the need to involve specialists (IBROs, IMROs, etc.) for similar functions. Commenter opines that it would be detrimental for the providers to no longer be able to rely on such partnerships.</p> <p>Commenter recommends adding the following sentence to this subsection:</p> <p><u>For the purposes of handling any claim adjudication function described under section 9792.5.4 to 9792.5.15 on behalf of the provider, as defined above, “Provider” shall also mean any agent, contractor or subcontractor utilized by a provider, as defined above, to perform such functions.</u></p>			
9792.5.4(i)	<p>Commenter recommends the following revised language:</p> <p>(i) “Provider” means a provider of medical treatment services or goods whose billing processes are governed by Labor Code section 4603.2 or 4603.4, or a provider of medical-legal services whose billing processes are governed by Labor Code sections</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The inclusion of the language assists in defining provider for the purpose of applying the SBR and IBR regulations.</p>	<p>No action necessary.</p>

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	<p>4620 and 4622, that has requested a second bill review and, if applicable, independent bill review to resolve a dispute over the amount of payment for services according to either a fee schedule established by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11.</p> <p><i>Commenter opines that this definition of “provider” applies whether or not a second bill review and, if applicable, IBR is requested.</i></p>			
9792.5.4(i)	<p>Commenter seeks clarification that the term “Provider” as defined in this section does not include health plans that pay medical bill as delineated in Labor Code §§ 4903.05(c)(7), 4903.5(b) or insured plans as defined in Labor Code §4903.1 (a)(2) and (3)(8).</p> <p>Commenter states that health plans are payors and not providers, and as such do not have access or authority to create the documentation to meet the Medical Bill and Payment Guide requirements set forth in proposed rule §§9792.5.1 et. seq., independent bill review (IBR) in particular. Existing</p>	David Robin The 4600 Group April 9, 2013 Written and Oral Comment	Health plans and insured plans are not expressly within the definition of “provider” under section 9792.5.4(i), since they do not provide medical treatment under Labor Code section 4600. The Division does not believe it is necessary to expressly list those entities that do not fall within the definition of the term.	No action necessary.

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	<p>law allows the "payor" class of lien claimants, as defined in Labor Code §4607(d), to file liens for reimbursement on medical bills that may be work related.</p> <p>The recent amendments to Labor Code §4603.2 identifies the type of providers (and not payors) who are subject to IBR:</p> <p>(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 .... [emphasis added]</p> <p>Commenter notes that currently health plans establish their prima facie case by submitting provider bills and records, and the amounts paid by the health plan, which is the basis of the lien. This is what the California Supreme Court mandated in <i>Silberg v. California Life Insurance Silberg v. Calif. Life Ins. Co.</i> (1974) 39 CCC 947 (en banc) when it ordered health plans to pay the medical bills of</p>			

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>workers whose workers compensation claims were in dispute.</p> <p>Commenter opines that without regulatory clarification that IBR applies to direct providers and not payors of medical treatment, claims administrators will most likely ill abuse the intent of the legislature by forcing health plans, i.e., payors to submit bills to IBR, a program that requires formats with which health plans cannot comply.</p>			
9792.5.4(i)	<p>Commenter notes that this subdivision describes a "provider" as one who, among other issues, may request IBR to resolve a reimbursement dispute based on a contract under Labor Code Section 5307.11. Commenter suggests that the language be amended as follows:</p> <p>" ..... or a contract for reimbursement rates, <i>including discounts for reimbursement below the applicable fee schedule ...</i> "</p> <p>Commenter notes that there are numerous other references to a "contract for reimbursement rates," throughout the proposed regulations</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>The Division finds that a contract for reimbursement rates under Labor Code section 5307.11 would include contracts having discounts for reimbursement below the applicable fee schedule. There is no need to expand the sentence.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	(i.e.: Section 9795.5.5(a)(l)) and urges such references be amended wherever they may appear.			
9792.5.4(j)	<p>Commenter recommends the addition of the following section and language:</p> <p><b>(j) “Medical treatment” means the treatment, goods, and services to which an employee is entitled under Labor Code Sections 4600 and 4603.2.</b></p> <p><i>Commenter states that SB 863 added the following language to clarify the character of related medical services:</i></p> <p><i>“4603.2(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 ...”</i></p> <p><i>Commenter opines that it is essential that the regulation encompass the entire range of medical services and goods to which the employee is entitled, and that the regulation reflect the Legislature’s inclusion of ancillary</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. Medical treatment necessary to cure and relieve an occupational injury is provided under Labor Code section 4600, not Labor Code section 4603.2, which addresses physician selection and billing.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>services provided by pharmacies, interpreters, copy services, transportation services, and home health care services. Commenter states that there is still considerable confusion over whether these ancillary services are within the definition of medical treatment under section 4600, even after the 2011 en banc opinion in <u>Guitron v Santa Fe Extruders</u>, 76 CCC 228. Commenter opines that this definition is necessary to reflect the relevant statutory provisions and to provide a full definition of medical treatment.</i></p>			
9792.5.5	<p>Commenter states that there is currently no provision in the regulations that addresses the situation where a bill that has been reviewed previously is resubmitted by a provider that contains neither the BGW3 marking, or a DWC Form SBR-1. Despite the lack of indication on the provider's part that they are requesting a "Second Review", as contemplated in this regulation, a return response on the vendor/Payers part is required.</p> <p>Commenter recommends the addition of verbiage to this section stating that</p>	<p>Tina Seever Senior Director, Compliance StrataCare April 4, 2013 Written Comment</p>	<p>Disagree. Labor Code sections 4603.2 and 4603.6 only allow a provider a second review of a medical bill prior to a mandatory resolution of the billing dispute through the IBR process. Additional reviews are not authorized based on a provider's failure to formally indicate that they are seeking a second review.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>if a provider resubmits a previously reviewed bill but does not include both the BGW3 marking and the DWC Form SBR-1, the bill will be re-evaluated and a response sent to the provider but the resubmission is not considered a request for a Second Review nor subject to the provisions in this section.</p>			
9792.5.5	<p>Commenter notes that under this section there are two methods for requesting a second bill review: (1) submitting the modified initially reviewed standard billing form; or (2) submitting a Request for Second Bill Review form (DWC Form SBR-1). Commenter urges the DWC to adopt a single method. Commenter opines that the DWC should require the Second Bill Review form (DWC Form SBR-1) to be attached to the modified standard billing form. This would provide both the necessary billing information and prominently distinguish request for second bill reviews. One of the underlying principles of SB 863 was to reduce system friction by streamlining processes. Commenter opines that having one standard process will promote uniformity and efficiency</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation April 9, 2013 Written Comment</p>	<p>The Administrative Director has been tasked with the responsibility to ensure that all health providers and facilities submit medical bills for payment on standardized forms. Labor Code section 4603.4(a). An SBR request on a standardized form should streamline billing processes and assist in the expedient second review of a medical bill.</p>	<p>No action necessary.</p>

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	within the IBR system, which will undoubtedly have initial start-up issues.			
9792.5.5 9792.5.7	Commenter opines that these proposed sections seem to remain in conflict. §9792.5.5 allows 90 days for the submittal of a Second Review from the date of service of the WCAB resolving threshold issues. Yet, §9792.5.7 provides for a time limit of only 30 days from date of resolution of threshold issues for an IBR.	Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment	A SBR must be performed before IBR can occur. Labor Code section 4603.6(a). The two timelines are mutually exclusive.	No action necessary.
9792.5.5(a)	<p>Commenter notes that Labor Code section 139.5(a)(2) states that for the “independent review program to go into effect for injuries occurring on or after January 1, 2013,” the administrative director may designate independent review organizations under contract with the Department of Managed Health Care.</p> <p>Commenter notes that this proposed section indicates that the second review process and IBR program will be for medical treatment services rendered, and medical-legal expenses incurred, on or after January 1, 2013.</p> <p>Commenter opines that that aforementioned statute clearly states</p>	Michael E. Lents Director of Lien Defense Lien On Me, Inc. March 23, 2013 Written Comment	See above response to comment by American Insurance Association regarding section 9792.5.4.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the independent review program is for <b>injuries</b> occurring on or after January 1, 2013--not for <b>dates of service</b> on or after January 1, 2013. (There is no distinction in the statute between IMR or IBR. Commenter believes the intent is for both programs, i.e., the entire independent review program.)</p> <p>Commenter notes that from a bill review standpoint, date of service or the date of injury is not that significant for commencing the second review process or IBR program. However, from a litigation perspective, if a provider is rendering treatment over a period of time that includes some dates of service that fall into 2013, then which route should be followed to address a possible fee schedule dispute? Litigation at the WCAB level or proceed through the IBR program or a hybrid?</p> <p>Commenter, from a lien litigation position, would like to avoid a Rule 30 situation and have a clean starting point for the IBR program--date of injury on or after January 1, 2013.</p>			
9792.5.5(a)	Commenter recommends the following revised language:	Steven Suchil Assistant Vice	See above response to comment by American	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services <del>rendered that is received</del> on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses <del>incurred that is received</del> on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.</p> <p>Commenter references his discussion of date of application of the regulations provided under Section 9792.5.</p>	<p>President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Insurance Association regarding section 9792.5.4.</p>	
9792.5.5(a)	<p>Commenter recommends the following revised language:</p> <p>(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment <del>services rendered that is received</del> on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or <del>a</del> bill for medical-legal</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See above response to comment by American Insurance Association regarding section 9792.5.4.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>expenses <b>incurred that is received</b> on or after January 1, 2013, submitted pursuant to Labor Code section 4622, the provider may request the claims administrator to conduct a second review of the bill.</p> <p><i>Commenter urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013 (or the effective date of these regulations) as this applies the new provisions at the soonest possible time, as intended by the Legislature, and under a single set of rules on a going-forward basis.</i></p>			
9792.5.5(b)	<p>Commenter notes that the proposed regulations provide specified timeframes by which a second review and subsequent request for IBR must occur. Commenter opines that when a claim is first subject to an appeal of the utilization decision the regulations need to clarify that the timeline for the second claims review and IBR are triggered after receiving the final independent medical review (IMR) decision.</p> <p>Commenter recommends adding a subsection (3), language as follows:</p>	<p>Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>Labor Code section 4603.2(e) expressly provides that the request for second bill review be made “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” submitted in response to the initial billing. There is no authority to expand the timeframe for seeking a SBR based on the completion of the UR or IMR process.</p>	<p>No action necessary.</p>

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	<p><u>(3) The latest occurrence of:</u>  <u>(A) The date of notification of resolution of any utilization review decision pursuant to §9792.9.1 or §9792.10.1,</u>  <u>(B) The determination of assignment to an independent medical review pursuant to §9792.10.3,</u>  <u>(C) The date of notification from the Administrative Director regarding the decision of an independent medical review,</u>  <u>(D) Outcome of an appeal of the independent medical review as specified under §9792.10.7.</u></p>			
9792.5.5(b)	<p>Commenter opines that the 90 day timeframe for a hospital to request a second review of a payment dispute is woefully inadequate. Commenter states that the two listed options for triggering the deadline are not mutually exclusive.</p> <p>Commenter urges the DWC to make the following change in order to specify the latter of the two trigger deadlines will be used when determining timeliness:</p>	<p>Amber Ott  Vice President,  Finance  California Hospital  Association  April 8, 2013  Written Comment  April 9, 2013  Oral Comment</p>	<p>The 90-day timeframe in which to seek a SBR is mandatory. See Labor Code section 4603.2(e).</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>The second review must be requested within 90 days of <u>the latter of</u>:</p> <p>Commenter also requests, that in the same spirit as § 9792.5.5(f)(1), that the provider and claims administrator be given an opportunity to mutually agree to extend the 90-day time limit for requesting a second review.</p>			
9792.5.5(b)(1)(A) (B) and (b)(2)	<p>Commenter recommends the following revised language:</p> <p>(1) <del>The date of s</del>Service of the explanation of review provided by a claims administrator in conjunction with the payment, adjustment, or denial of the initially submitted bill, <del>if a proof of service accompanies the explanation of review. The explanation is served when it is placed in the U.S. mail, faxed, or emailed to the provider, or when it is personally served on the provider.</del></p> <p>(A) <del>The date of receipt of the explanation of review by the provider is deemed the date of service, if a proof of service does not accompany the explanation of review and the claims administrator has documentation of receipt</del></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	The subdivision reasonably accounts for most, if not all, circumstances regarding the receipt of the Explanation of Review (EOR) and the timeframe for filing an SBR. The Division understands that claims administrators do not attach proof of services to their EORs, and the date an EOR was actually mailed is sometimes difficult to discern. The regulation takes into account the extended time to act as set forth in Code of Civil Procedure section 1013 and should assist the parties in limiting disputes over the timeliness of a second review. If future data indicates that the regulatory timeframe is either overly confusing or inhibiting	No action necessary.

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	<p>(B) If the explanation of review is sent by mail and if in the absence of a proof of service or documentation of receipt, the date of service is deemed to be five (5) calendar days after the date of the United States postmark stamped on the envelope in which the explanation of review was mailed.</p> <p>(2) The date of service of an order of the Workers' Compensation Appeal Board resolving any threshold issue that would preclude a provider's right to receive compensation for the submitted bill. The explanation is served when it is placed in the United States mail, faxed, or emailed to the provider, or when it is personally served.</p> <p><i>Commenter states that a document is served when it is placed in the U.S. mail, faxed, emailed, or personally served. If served by mail, fax, email, or any method other than personal service, the time for exercising or performing any right or duty to act shall be extended by five calendar days from that date of service if the service is in California, by ten</i></p>		<p>providers from requesting an SBR, the Division will consider revising this provision in future rulemaking.</p>	
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<i>calendar days if outside California but within the United States, and by twenty calendar days if outside the United States. See CCR section 10507 and California Code of Civil Procedure Section 1013.</i>			
9792.5.5(c)	Commenter strongly recommends that the request for non-electronic medical bills include both the original bill, and the DWC Form SBR-1. Commenter opines that it is possible and likely that the written BGW3 could be overlooked on a bill, especially on non-conforming bills. Commenter states that with a SBR-1 form attached, in addition to the BGW3 marking, the request and intent cannot be overlooked.	Tina Seever Senior Director, Compliance StrataCare April 4, 2013 Written Comment	See above response to the comment by the California Chamber of Commerce regarding this section.	No action necessary.
9792.5.5(c)(1)	<p>Commenter recommends the following revised deletions and insertions:</p> <p>(1) For a non-electronic medical bills, the <b>request for</b> second review shall be... -</p> <p>Commenter states that deleting the “s” on bills keeps this sentence consistent with the singular use of bill in the rest of the rule, and adding “request for” clarifies the use of the form.</p>	Brian Allen Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment	The Division agrees that a singular form of the word “bill” should be used. Use of the word “written” is reasonable and should not impede the SBR process.	Amend section 9792.5.5 to use a singular form (i.e., bill and not bills).

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>(A) ... the words “Request for Second Review” may be <del>written</del> <b>included</b> on the form.</p> <p>Commenter opine that using the word included rather than written is less limiting and clarifies that the information can be inscribed digitally or by manual means.</p>			
9792.5.5(c)(1)	<p>Commenter is concerned that having alternatives for requesting a second review for non-electronic treatment bills may lead to delays as a result of missing documents. Commenter opines that it would be preferable to specify only one method, but the best method may be to attach the SBR-1 to the modified standardized billing form.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See above response to the comment by the California Chamber of Commerce regarding this section.</p>	<p>No action necessary.</p>
9792.5.5(c)(1)(A)	<p>Commenter recommends the following revised language:</p> <p>(1) For <b>a</b> non-electronic medical treatment bills, the second review shall be on <b>either</b>:</p> <p>(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The <b>Second Review Bill bill</b> shall be</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The identification of the standardized billing form, such as the CMS 1500, should be sufficiently clear for a provider to comply with the SBR procedure described in the regulation.</p>	<p>No action required.</p>

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	<p>marked <b>on the standard billing forms as further specified in the Medical Billing and Payment Guide version 1.1</b>, using the National Uniform Billing Committee (NUBC) Condition Code Qualifier “BG” followed by NUBC Condition Code “W3” in the field designated for that information to indicate a request for second review, or, for the ADA 2006 form, the words “Request for Second Review” will be marked in Field 1, or for the NCPDP WC/PC Claim Form, the words “Request for Second Review” may be written on the form.</p> <p><i>Commenter states that this change clarifies that the Medical Billing and Payment Guide version 1.1 can be consulted for additional information.</i></p>			
9792.5.5(c)(1)(A) and (B)	<p>Commenter notes that as proposed, these subsections permit providers to submit a second request for review for non-electronic bills in several different ways, depending on the bill type. For bills submitted via the CMS-1500 or UB04 forms, the Division has indicated a condition code qualifier is used to clearly identify the bill as a second request. Commenter agrees</p>	<p>Sandy Shtab Senior Government Affairs Manager Healthsystems April 8, 2013 Written Comment</p>	<p>See above response to the comment by the California Chamber of Commerce regarding this section. Standard pharmacy bills are addressed in subdivision (c)(3). Certainly, a provider who submits a non-electronic paper bill can choose to utilize a DWC Form SBR-1.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>with this recommendation, specifically the need to utilize condition qualifier codes to identify a bill as a second request. Commenter states that condition qualifier codes are only applicable on the CMS-1500 and UB04 forms and therefore will not apply to all pharmaceutical billings. Despite the availability of real time claim processing for pharmacies, some pharmacies choose to bill on paper. Pharmacies are required to use the NCPDP Universal Claim Form, Workers' Compensation/Property &amp; Casualty (UCF-WC/PC) version 1.1. Commenter states that neither the standard electronic format nor the paper UCF-WC form currently support codes which would signify a bill is a 2<sup>nd</sup> request for review. This creates a gap between the proposed regulation and the available national standard for pharmacy transactions. Commenter opines that one potential solution would be to require a completed SBR-1 form with each and every paper bill that is being submitted for a second review. Commenter opines that the mandatory use of a SBR-1 form will ensure there is a consistent vehicle that identifies</p>			

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	<p>the bill as a second request and that required data is provided in the field marked "<i>Reason for Requesting Second Bill Review.</i>" Commenter opines that making this form mandatory with each request for second review would permit payers to more efficiently make a final determination and will reduce the number of bills which would later be subject to the Independent Bill Review process as described in §9792.5.7 et al.</p>			
9792.5.5(c)(1)(B)	<p>Commenter recommends the following revised language:</p> <p><b>(B) Requested on the The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6, shall be attached to the Second Review Bill.</b></p> <p><i>Commenter state that the Administrative Director has proposed two methods for requesting a second bill review: (1) submitting the initially reviewed standard billing form modified by the second request code; or (2) submitting a Request for Second Bill Review form (DWC Form SBR-1). Commenter recommends adopting a</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agreed. If the DWC Form SBR-1 is utilized for a non-electronic standardized bill, it should be attached as the first page of the request to ensure that there are no delays in processing.</p>	<p>Amend section 9792.5.5(c)(1)(B) to provide that if the request is made on the DWC Form SBR-1, the form should be the first page of the request.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>single method for paper medical treatment bills. Specifically, require the Second Bill Review form (DWC Form SBR-1) to be attached to the modified standard billing form. This provides both the necessary billing information and prominently identifies requests for second bill review for rapid processing. It also will ensure second review bills are not delayed, especially during the inevitable learning curve period when billing providers are still learning where to place the second request code, and how to fill out the SBR-1 form. One of the underlying principles of SB 863 was to reduce system friction by streamlining processes. Commenter opines that having one standard process will promote uniformity and efficiency within the IBR system.</i></p>			
9792.5.5(d)	<p>Commenter notes that in addition to a properly modified bill, the proposed SBR rules list other contents required as part of a complete/compliant request for SBR under this subsection.</p> <p>Commenter seeks clarification if it is the intention of DWC that those other contents be included on a separate piece of paper (for paper bills) or a</p>	<p>Kevin C. Tribout Executive Director of Government Affairs PMSI March 19, 2013 Written Comment</p>	<p>Labor Code section 4603.2(e), as well as this subdivision and the DWC Form SBR-1, plainly allow for the submission of supporting documentation. For electronic billing requirements, see section 2.11.4 of the California Division of Workers' Compensation Electronic</p>	<p>No action necessary.</p>

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	<p>separate attachment (for electronic bills)?</p> <p>Commenter cannot envision how a standard CMS-1500 can be modified to include all of the additional content required under the rules without including a separate document, even though the proposed rules use the word "either" instead of "both" when discussing the options for how to submit the request for SBR under 9792.5.5(c)(1) in relation to a paper bill. Similarly, the proposed rules on how to submit a request for SBR in relation to an electronic professional bill <i>only</i> indicate modification of the electronic bill (837 format) and not inclusion of an attachment including the additionally require content. Commenter states that clarification on this is greatly appreciated.</p>		<p>Medical Billing and Payment Companion Guide, version 1.2. No additional clarification is necessary.</p>	
9792.5.5(d)(1)	<p>Commenter recommends the following revised language:</p> <p>The original dates of service and the same itemized services rendered as the original bill. No new dates of service or <b>additional codes</b> may be included.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Agreed.</p>	<p>Amend sciton 9792.5.5(d)(1) to provide that no additional billing codes may added during a SBR.</p>
9792.5.5(d)(2)(A)	<p>Commenter notes that this section requires that a copy of the explanation</p>	<p>Brian Allen Vice President</p>	<p>The requirement that the date of EOR be included in a</p>	<p>No action necessary.</p>

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	<p>of review (EOR) be included in the request for second review. Commenter opines that this section does not address how to handle requests when no EOR was received by the entity submitting the bill.</p> <p>Commenter recommends the following revision:</p> <p>(A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review, <b><u>if received. If not received, an indication that the explanation of review was not received by inserting “Not Received” in the Date Explanation of Review Received by Provider section of the SBR-1 form.</u></b></p> <p>Commenter opines that it is understood that EORs are required to be sent with payment but he sometimes experiences situations where no payment, no EOR or any other indication that his bill was received by the payor is sent back to him. Commenter would like to use the second review process to give the payor one more opportunity to pay the</p>	<p>Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>request for second review is statutory. Labor Code section 4603.2(e)(1)(A). As the statute is silent regarding the consequences of a claims administrator’s failure to provide an EOR, the Division may be exceeding its authority to craft a remedy through regulation.</p>	

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	bill before invoking payment rights under California Labor Code 4603.2.			
9792.5.5(f)	<p>Commenter opines that 14 days is an extremely tight turn around period based upon current bill processing requirements. Commenter notes that a 15 day timeframe is currently allowed on an electronically submitted bill which is a much simpler process.</p> <p>Commenter understands that the 14 day period is a statutory requirement, not subject to regulatory change; however, she recommends that the definition of “working days” be included in the regulations to reflect a more manageable time frame.</p>	<p>Tina Seever Senior Director, Compliance StrataCare April 4, 2013 Written Comment</p>	<p>The 14-day period in which a claims administrator must respond to a request for SBR is statutory. Labor Code section 4603.2(e)(3). The Legislature did not modify the period with “working” or “business.”</p>	No action necessary.
9792.5.5(f) 9792.5.7(c)(1)-(3)	<p>Commenter states that the word “receipt” is used but is not defined in section 9792.5.5(f). Commenter states that in 9792.5.7 the rule defines the timing of the IBR process based on various indications of when the final written determination is received.</p> <p><b>Commenter recommends that the word “receipt” be added to the definitions and those same standards in 9792.5.7 (c) (1), (2) &amp; (3) be used in the definition to add consistency and clarity to the intent of the rule and establish appropriate</b></p>	<p>Brian Allen Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Labor Code section 4603.2(e)(3) requires a claims administrator to issue a written determination on an SBR “within 14 days of a request...” The language of the regulation reasonably interpreted this mandate to be 14 days from the receipt of this request, especially since the subdivision requires the payment of any undisputed balance within 21 days of receipt of the request for</p>	No action necessary.

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	<p><b>protections and expectations on both sides of the dispute.</b></p>		<p>second review . Since the timeframe begins upon receipt, further clarification is unnecessary.</p>	
<p>9792.5.5(f)</p>	<p>Commenter states that there is a discrepancy between the language used in proposed Independent Review Regulation 9792.5.5(f) and Labor Code 4603.2(e)(3) which leads to the potential for different deadlines for a response to a request for second review.</p> <p>As proposed, and as stated in the current Emergency Regulations, 8 CCR 9792.5.5(f) states, in part, <u>“Within 14 days of receipt of a request for second review, the claims administrator shall respond to the provider with a final written determination on each of the items or amounts in dispute by issuing an explanation of review.”</u> [Emphasis added.]</p> <p>Labor Code 4603.2(e)(3) states, in part, <u>“Within 14 days of a request for second review, the employer shall respond with a final written determination on each of the items or</u></p>	<p>Ellie Bertwell, Esq. Rules Attorney Aderant April 9, 2013 Written Comment</p>	<p>See above response to comment by Stone River Pharmacy Solutions regarding this subdivision. While the Division cannot amend the Labor Code provision, it can reasonably interpret the provision.</p>	<p>No action necessary.</p>

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	<p>amounts in dispute. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review.” [Emphasis added.]</p> <p>Commenter notes that Section 9792.5.5(f) requires a response within 14 days of receipt of a request for second review, however, Labor Code 4603.2(e)(3) requires a response within 14 days of a request. Commenter opines that although the date of receipt of the request and the date of the request may be the same date in some cases, this is not necessarily so. When the dates are different, the calculation of the 14-day response period will result in different deadlines.</p> <p>Commenter states that the deadline to make payment of the balance is not in dispute, also set forth in Labor Code 4603.2(e)(3), is 21 days from receipt of the request for second review. Commenter suggests that this Code section be revised so that the deadline to respond to the request for second review is also triggered from receipt of the request.</p>			
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	<p>Commenter recommends that Section 9792.5.5(f) be revised to align with the language currently used in Labor Code 4603.2(e)(3).</p>			
<p>9792.5.5(f) 3.0 Paper Explanation of Review Medical Billing &amp; Payment Guide</p>	<p>Commenter notes that there is a timing conflict found in the proposed rule and the availability of certain data elements which are required to be printed on the explanation of review. Section §9792.5.5(f) requires the payer to send an explanation of review (EOR) within 14 days receipt of a request for second review; however subsection (g) indicates the payer has 21 days from the receipt of the request to issue the payment. Commenter states that this creates an administrative problem in that check numbers and EFT tracer data are often not available until the day payments are actually issued. For this reason commenter recommends removing the situational requirement to print the EFT or check number detail in the <i>Medical Billing and Payment Guide Table 3.0 Paper Explanation of Review</i>.</p>	<p>Sandy Shtab Senior Government Affairs Manager Healthsystems April 8, 2013 Written Comment</p>	<p>The timing requirements are statutory, see Labor Code section 4603.2(e)(3), and do not conflict as they relate to different obligations, i.e., the timeframe to issue a written determination and the timeframe to pay any undisputed amount.</p>	<p>No action necessary.</p>
<p>9792.5.5(f)(1)</p>	<p>Commenter notes that this section states that the "14-day time limit for responding to a request for second</p>	<p>Kevin C. Tribout Executive Director of Government Affairs</p>	<p>Agreed. The subdivision should be clarified regarding the extension of time for the</p>	<p>Amend section 9792.5.5(g) and (h) to allow for agreed-</p>

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	<p>review may be extended by mutual written agreement between the provider and the claims administrator." However, commenter states that the equivalent amended sections in the proposed Medical Billing and Payment Guide (6.5 and 7.4) repeat this provision concerning extending the time limit but are somewhat more generic in that they do not specify whether it is the 14-day response (EOR) time limit or the 21-day time limit for payment of any undisputed balance.</p> <p>In order to avoid potential ambiguity and conflict between the two documents, commenter requests that division provide clarification on this.</p> <p>Is it only the 14-day time limit that may be extended, is it the 21- day time limit, or is it both? Commenter recommends more closely aligning those relevant sections in the rules and the Guide to match.</p>	<p>PMSI March 19, 2013 Written Comment</p>	<p>two obligations.</p>	<p>upon extensions of time in which a claims administrator can issue a written SBR determination and the payment of undisputed amounts.</p>
<p>9792.5.5(f)(1) 6.5 and 7.4 Medical Billing &amp; Payment Guide</p>	<p>Commenter would like to know if there is a mutual agreement to extend the 14 day time limit to respond to an SBR request, does this agreement also extend the timeframe to issue payment</p>	<p>Kristie Griffin Compliance Manager Express Scripts, Inc. April 4, 2013 Written Comment</p>	<p>See response to above comment by PMSI regarding this subdivision.</p>	<p>No action necessary.</p>

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	<p>in accordance with the final determination. If so, will the extension of the timeframe for payment be clarified in this section or addressed by the mutual agreement? Commenter notes that in the proposed Medical Billing and Payment Guide (6.5 and 7.4), the time extension is addressed but she is unclear whether it relates to the 14 day timeframe for review, the 21 day timeframe for payment or both. Commenter requests clarification of the intent and implementing language in both the rules and Medical Billing and Payment Guide to ensure consistency.</p>			
9792.5.5(f)(2)	<p>Commenter would like to know if there interest payment is made on a bill for services rendered and there was not a line item for the interest payment how would these payments be reported to the DWC. Is there specific coding (to identify the interest payment) that should be used to submit this payment as a line item vs. adding to the line item for the service rendered?</p>	<p>Kristie Griffin Compliance Manager Express Scripts, Inc. April 4, 2013 Written Comment</p>	<p>See response to below comment by CWCI regarding this subdivision. The subdivision will be deleted.</p>	<p>No action necessary.</p>
9792.5.5(f)(2)	<p>Commenter recommends deleting this subsection.  <i>Commenter states that the Legislature</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI</p>	<p>Agreed. The Division does not have statutory authority to impose this subdivision.</p>	<p>Delete section 9792.5.5(f)(2).</p>

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	<p><i>could have provided authority in SB 863 to assess a penalty and interest retroactive to the date of receipt of the initial bill for a claims administrator's failure to respond to a final written determination within 14 days of a request for second review, but chose not to do so. Commenter opines that the imposition of specific penalties and interest is a legislative policy determination and must have a specific statutory foundation. Commenter opines that the Administrative Director may not implement penalties and interest without this specific authority; however, audit penalties are applicable for failure to comply with the provision.</i></p>	<p>April 9, 2013 Written Comment</p>		
9792.5.5(g)	<p>Commenter states that it appears that the payment time frame is 7 days longer than the time frame for the response to the request for second review. Commenter opines that it may be easier and more cost effective to tie the two time-frames together and have amounts not in dispute accompany the explanation or response to the request for second review.</p>	<p>Brian Allen Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment</p>	<p>The timeframe requirements are statutory. See Labor Code section 4603.2(e)(3).</p>	<p>No action necessary.</p>
9792.5.5(g)	<p>Commenter notes that this subdivision</p>	<p>Steve Cattolica</p>	<p>Agreed in part. Implicit in the</p>	<p>Amend section</p>

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	<p>appears to require that payment for undisputed amounts must be made within 21 days of a request for second review. A request for second review would only be necessary if the provider receives either a partial payment or no payment after the initial submission. How does the payment of undisputed amounts pursuant to this subdivision, coordinate with the existing 45 day requirement for payment of undisputed amounts found in CCR Title 8, Section 9795 (b )? Commenter suggests the language be amended as follows:</p> <p>"Based on the results of a second review, payment of any balance <i>no longer in dispute or payment of any additional amounts determined to be payable</i>, shall be made within 21 days of receipt of the request for second review <i>unless the second review is submitted in accordance with subdivision 9795.5.5 (c )(2), in which case, payment shall be made within 10 days of receipt of the request for second review.</i>"</p>	<p>Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>language of Labor Code section 4603.2(e)(3) is that the undisputed amounts would be those determined after the second bill review. That said, the subdivision (now (h)), will be amended to clarify that the undisputed amounts are those determined after the second review.</p>	<p>9792.5.5(h) to clarify that the undisputed amounts owed are those determined after the second review.</p>
<p>9792.5.6 DWC Form SBR-1</p>	<p>Commenter states that the form and rule are silent on who can sign the</p>	<p>Brian Allen Vice President</p>	<p>Section 9792.5.4(i) has been amended to expressly allow a</p>	<p>No action necessary.</p>

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	<p>form – the provider, billing agent, or assignee. Additionally, there is no indication that the form can be signed electronically by printing the appropriate name on the form.</p> <p><b>Commenter recommends that the rules clarify that the entity submitting the bill for second review and entitled to payment is authorized to sign the form and that the name of the person submitting the form can be electronically generated on the form and that a physical, original signature does not have to be affixed to the form.</b></p>	<p>Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>provider to utilize the services of a billing agent to request SBR or IBR. If there is any further confusion regarding this provision, the Division will amend the SBR and IBR form in future rulemaking to clarify this point.</p>	
9792.5.6 DWC Form IBR-1	<p>Commenter notes that the Instruction Sheet in the How to Apply section provides two methods of requesting the Second Bill Review. Commenter references his comment for 9792.5.5(c)(1).</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See above response to comment by American Insurance Association regarding section 9792.5.5(c)(1).</p>	No action necessary.
9792.5.7	<p>Commenter notes that this section contains several references to “date of service”. Commenter opines that from a legal perspective, “date of service” generally refers to the date on which legal documents are provided to a party. However, in the context of Workers’ Compensation, “date of service” generally refers to the date</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services April 8, 2013 Written Comment</p>	<p>The Division is unaware of any confusion regarding the use these terms in the two vastly different contexts in which they are generally used. To attempt to distinguish the two through additional regulation may prove more confusing.</p>	No action necessary.

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	<p>that a provider provided services to an injured employee. Commenter opines that the conflicting definitions may create confusion when interpreting the rules.</p> <p>Commenter recommends amending Section 9792.5.4, “Definitions”, to include a definition of “date of service”, if the term is used consistently throughout the rules. Alternatively, modify the language of 9792.5.7 (and any other sections referencing the term, “date of service”) to replace “date of service” with the phrase “date of medical or ancillary services to the claimant”, or similar language, if referencing the date medical or ancillary services were provided or “date on which service of documentation upon the parties was effectuated”, or similar language, if referencing the legal interpretation of the term.</p>			
9792.5.7	<p>Commenter recommends that this section be amended to provide that upon making a demand on the claims administrator pursuant to 8 CCR § 10451( c ), the provider shall be deemed to have conclusively waived its rights to independent bill review</p>	<p>Mark Webb Vice President &amp; General Counsel Pacific Compensation Insurance Company March 27, 2013 Written Comment</p>	<p>The requested procedure is not authorized by Labor Code section 4603.6. The Division would be exceeding its statutory authority to impose this requirement.</p>	<p>No action necessary.</p>

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	pursuant to this Section.			
9792.5.7	<p>Commenter notes that based on exclusions found in subdivisions (b) (1) and (2), the applicability of IBR may turn out to be very narrow. Commenter opines that this could severely diminish IBR's effect on the proliferation of liens.</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>With the adoption of additional fee schedules in near future (i.e., copy services, home health care, interpreters), the Division finds that IBR will cover most medical services in workers' compensation.</p>	<p>No action necessary.</p>
9792.5.7(a)	<p>Commenter recommends the following revised language:</p> <p>It the provider further contests the amount of payment made by the claims administrator on a bill for medical treatment services <del>rendered</del> <b>received</b> on or after January 1, 2013, submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses <del>incurred</del> <b>received</b> on or after January 1, 2013, submitted pursuant to Labor Code section 4622 following the second review conducted under section 9792.5.5, the provider shall request an independent bill review. <del>Unless consolidated under section 9792.6.12, a</del> <b>A</b> request for independent bill review shall <b>only</b> resolve:</p> <p>Commenter references his comments</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See response to comments by American Insurance Association in regard to sections 9794.5.4 and 9792.5.12.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.7(a)	<p>regarding 9794.5.4 and 9792.5.12.</p> <p>Commenter states that there is no clarity as to whether the IBR shall resolve a dispute wherein certain codes are included in another code (e.g. Comprehensive Coding Initiative “CCI” edits); and as to whether the IBR shall resolve a dispute over healthcare provider codes not within the OMFS, but which are similar to “By Report” codes for which the OMFS has instructional language to reimburse.</p> <p>Commenter recommends that the Division clarify that the IBR shall resolve disputes involving codes within other codes, and disputes involving healthcare provider codes that are not within the OMFS but are similar to “By Report” codes.</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 9, 2013 Written Comment</p>	<p>IBR will apply as necessary all billing, payment, and coding rules adopted by the Division. See section 9792.5.13(d). A dispute over a code that is not within an applicable fee schedule is not subject to IBR For example, there is currently no provision in either the Medical-Legal fee schedule or OMFS that covers missed appointments. This would not be covered by IBR, although it could be billed under the OMFS “by report.”</p>	<p>No action necessary.</p>
9792.5.7(a)	<p>Commenter recommends the following revised language:</p> <p>(a) If the provider further contests the amount of payment made by the claims administrator on a <u>medical treatment bill submitted pursuant to Labor Code sections 4603.2 or 4603.4 and, for medical treatment services rendered received</u> on or after January</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See response to comment by American Insurance Association regarding section 9792.5.4, and response to comment by California Chamber of Commerce regarding section 9792.5.12.</p>	<p>No action necessary.</p>

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	<p>1, 2013 (or effective date of these regulations), submitted pursuant to Labor Code sections 4603.2 or 4603.4, or a medical-legal bill submitted pursuant to Labor Code section 4622, for medical-legal expenses incurred and received on or after January 1, 2013 (or the effective date of these regulations), submitted pursuant to Labor Code section 4622, following the second review conducted under section 9792.5.5, the provider shall request an independent bill review. Unless consolidated under section 9792.5.12, a request for independent bill review shall only resolve:</p> <p><i>Commenter urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013 (or the effective date of these regulations), as this applies the new provisions as soon as possible, as intended by the Legislature, and under a single set of rules on a going-forward basis.</i></p> <p><i>Commenter states that the Legislature could have authorized the Administrative Director to permit</i></p>			

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	<p><i>consolidation of requests for independent Bill Review (IBR) in SB 863, but did not. Adding a process to consolidate requests is an unlawful expansion of the scope of the statute that thwarts its purpose. Neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.</i></p>			
9792.5.7(a)(1)	<p>Commenter opines that the limitations of “one date of service” and “one billing code” seem to be unnecessarily restrictive and are not adequately addressed by the options under § 9792.5.12. Commenter urges the DWC to make the following revision:</p> <p>For a bill for medical treatment services, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, one date of service <b><u>or multiple service dates that are consecutive,</u></b> and one <b><u>or multiple</u></b> billing code(s) under the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.</p>	<p>Amber Ott Vice President, Finance California Hospital Association April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Agree in part. The Division finds that the “one date of service” and “one billing code” limit will cover essentially all billing disputes will allow IBR to be conducted in an efficient, cost-effective manner. To open up the review process to multiple billing codes may tax the resources of the IBRO and result in possibly higher filing fees. As an option, a provider is allowed to consolidate related requests for IBR under section 9792.5.12.</p> <p>Regardless, the subdivision should be amended to allow for the review of “one hospital stay,” since billing disputes over inpatient stays are rarely limited to one code.</p>	<p>Amend section 9792.5.7(a)(1) to allow IBR or one hospital stay.</p>

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9792.5.7(a)(1)	<p>Commenter recommends the following revised language:</p> <p>For a bill for medical treatment services, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, one date of service, and one billing code <u>or one hospital stay</u> under the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates. <u>One billing code shall be identified for the objection but it shall be reviewed in combination with all other codes from that single provider for that date of service or hospital stay.</u></p> <p>Commenter recommends this change because reviewing a single code in isolation would preclude the independent bill reviewer from considering the totality of fee schedule ground rules where many codes are interdependent, or not allowed at the same date of service. It would encourage unbundling by providers</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>See response to above comment by the California Hospital Association regarding this subdivision. The Division recognizes that a billing code cannot be meaningfully reviewed without consideration of the context in which it was billed, i.e., consideration of the other codes billed by the provider. To mandate this by regulation would be unnecessary.</p>	<p>No action necessary.</p>

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	and prevent use of the CMS National Correct Coding Initiative that efficiently handles "code pair edits" and "medically unlikely edits", as well as "never events."			
9792.5.7(a)(1)	<p>Commenter recommends the following revised language:</p> <p>For a bill for medical treatment services, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, <i>and</i> one date of service or one <i>hospital stay</i>, <del>and one billing code</del> under the applicable fee schedule adopted by the Administrative Director; or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates.</p> <p><i><u>One billing code shall be identified for the objection but it shall be reviewed in combination with all other codes from that single provider for that date of service or hospital stay. Sufficient billing detail shall be provided to the independent bill reviewer to address fee schedule ground rules, global fees, bundling/unbundling, CMS' National</u></i></p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation April 9, 2013 Written Comment</p>	See above response to comment by the American Insurance Association regarding this subdivision.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><u>Correct Coding Initiative “code pair edits” and “medically unlikely edits,” as well as “never events.”</u></p> <p>Commenter opines that the term “one billing code” should be struck from this subdivision. Commenter opines that limiting reviews to one billing code will open IBR to abuse and manipulation. Payments for a single service can vary depending on whether other services were provided on the same day. Commenter opines that by having to submit only one code, providers can circumvent coding rules that apply when certain other codes are billed.</p>			
9792.5.7(a)(1)	<p>Commenter opines that notwithstanding the opportunity to consolidate services to be reviewed, the requirement that a review involve only one code is a significant cost and process barrier to providers seeking timely resolution of a fee schedule or reimbursement contract dispute. Commenter suggests that the "only one code per review" requirement be stricken while retaining the other parameters described in this subdivision. Commenter states there is no statutory authority for the "one code per review" mandate. Commenter</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>See response to comment by the California Hospital Association regarding this subdivision. The IRB process is new to the workers' compensation system; the dispute resolution procedures are relatively untested. Should data indicate that the one code limit is impractical or limiting access to IBR, the Division will consider revising the regulation in future rulemaking.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>opines that this restriction will make IBR prohibitively expensive with the unintended consequence that physicians will be systematically driven away from IBR though they are owed reimbursement. On a code by code basis, the amount of money tied up in IBR fees will be prohibitively expensive. Commenter urges the Division to also keep in mind that more than 80% of the health care delivered in California's comp system is by MPN providers and requests that access to IBR be kept as simple and easy as possible.</p>			
<p>9792.5.7(a)(1) and (2)</p>	<p>Commenter recommends the following revised language:</p> <p>(1) For a bill for medical treatment services, a dispute over the amount of payment for services <b>and goods</b> billed by a single provider involving one injured employee, one claims administrator, <b>and</b> one date of service <b>or discharge, and one billing code under in accordance with</b> the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The Division notes that referring to “goods and services” will improve accuracy. As to the remaining comment, note the above responses to the California Hospital Association and the American Insurance Association regarding this section.</p>	<p>Revise section 9792.5.7 to refer to “services or good.”</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>range of effective dates.</p> <p>(2) For a bill for medical-legal expenses, a dispute over the amount of payment for <b>any</b> services <b>and goods</b> billed by a single provider involving one injured employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation, if any.</p> <p><i>Commenter states, that at a minimum, every independent bill review must encompass all goods and services provided on the same date of service that are billed by a single provider on a single claim. If not, commenter opines that a provider can easily manipulate the process and evade fee schedule rules and the Correct Coding Initiative (CCI) edits in order to obtain undeserved payment, leaving the claims administrator without recourse. Payment for a particular single service on a bill often depends on the payment for other services provided on the same day. If only one service code is reviewed, a provider will be able to evade the CCI edits and other rules that apply when certain</i></p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<i>other codes are billed; such behavior will negatively impact the injured employee's quality of care and result in higher costs.</i>			
9792.5.7(a)(2)	Commenter opines that the meaning of the phrase "including supplemental reports based on the same evaluation if any" is unclear. Commenter states that it is ambiguous whether the intent of this language is to provide that an IBR can be requested for a supplemental report, or to review the initial medical-legal report along with subsequent supplemental report(s). Commenter states that this subdivision requires clarification.	Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment	Agreed. The subdivision should be clarified to align with the reports compensable under the Medical-Legal fee schedule at sections 9793 through 9795.	Amend subdivision 9792.5.7(a)(2) to provide that for a bill for medical-legal expenses, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, and one comprehensive, follow-up, or supplemental medical legal evaluation report as defined in section 9794.
9792.5.7(b)	Commenter recommends adding a subsection (3), text as follows:  <u>(3) Where the contract reimbursement under Labor Code section 5307.11 is determined at a rate other than that of a fee schedule established by the Administrative Director.</u>	Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment	A contract under Labor Code section 5307.11 by definition contains reimbursement rates different than those set forth in the fee schedule. No additional regulatory language is necessary.	No action necessary.
9792.5.7(b)	Commenter requests that a definition	William J. Heaney III	IBR is only available to	No action necessary.

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9792.5.4	<p>be incorporated into 9792.5.4 describing a “dispute between the provider and the claims administrator.”</p> <p>Commenter states that if a physician sends a RFA for physical therapy and the request is completely ignored by the carrier, the service then gets provided and when it is billed an EOR is issued stating “services were not authorized.” Commenter states that in this scenario the treatment was not authorized but was also not denied in compliance with the regulations. Commenter would like to know in this situation should the EOR go to secondary bill review. If it does would the lack of authorization and the lack of a UR denial be considered a dispute? Where does that dispute get resolved? Commenter opines that it cannot proceed to IMR as there was no UR done. Commenter requests clarification regarding these situations in reference to these proposed regulations.</p>	April 9, 2013 Written Comment	resolve disputes over the amount of payment for a bill for medical treatment services or medical-legal services. If a claims administrator has contested liability for any issue other than the reasonable amount payable for services, the issue must be resolved prior to the time IBR is initiated. Labor Code section 4603.2(a). Disputes regarding medical treatment should be resolved through the IMR process on Labor Code section 4610.5 before IBR is initiated.	
9792.5.7(b)(1)	Commenter opines that many billing codes exist that may be utilized by providers, but are not technically a part of a fee schedule, so it is unclear	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’	The requirement that IBR is available only for disputes where that category of services is covered by a fee schedule is	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>what dispute resolution process would be utilized for these types of disputes. Commenter states that one of the key strategic goals of the reform bill was to reduce litigation and that carving out small numbers of billing disputes that would not fall within the scope of the IBR process would serve to undermine that purpose.</p> <p>Commenter recommends redefining Subsection (1) to include all code-related billing disputes, regardless of whether a particular code is technically covered by a fee schedule or not. As a second option, commenter recommends defining an alternative dispute resolution mechanism similar to IBR that would resolve disputes of this type without resorting to traditional litigation before the WCAB.</p>	<p>Compensation Services April 8, 2013 Written Comment</p>	<p>appropriate to insure that IBR reviewers are limited to only resolving disputes over the amount of payment. In the absence of a fee schedule, an IBR reviewer must consider evidence and act as an arbiter over issues that extend beyond a review and determination regarding the amount of payment on a medical bill. (See Kunz v. Patterson Floor Coverings (2002) 67 Cal Comp. Cases 1588. These may include consideration of the provider's usual fee, the usual fee of other providers in the geographical area in which the services were rendered, other aspects of the economics of the medical provider's practice that are relevant, and any unusual circumstances in the case. To extend IBR to consider those factors will result in higher fees, addition burdens on the parties to provide evidence that was not envisioned to be provided under section 4603.2, and additional appeals of IBR</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			determinations to the WCAB.	
9792.5.7(b)(1)	<p>Commenter asks if this section indicates that the necessity to request secondary bill review for a service that is not covered by the OMFS unnecessary? If no, then what does the provider do after the second bill review, if it does not come back as the provider believes it should? Does the provider then wait for the case in chief to resolve and then file a DOR? Commenter states that this is not an uncommon scenario and would like for the Division to provide guidance.</p>	<p>William J. Heaney III April 9, 2013 Written Comment</p>	<p>An SBR is necessary for all disputes regarding the amount paid on a bill. Labor Code section 4603.2(e). If a request for IBR is deemed ineligible, the WCAB procedures applicable to lien claims should be utilized, including the filing of a lien claim under Labor Code section 4903(b).</p>	<p>No action necessary.</p>
9792.5.7(b)(1)	<p>Commenter recommends deleting this proposed subsection.</p> <p><i>Commenter opines that the proposed regulation is too restrictive and is an unlawful alteration of the scope of the statute. IBR will cover the disputes where resolution is least needed (those covered by fee schedules) and will leave the disputes where resolution is most needed (those not covered by fee schedules) to judges who do not have the training and expertise required to make reasonable determinations in this complicated area.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See above response to comment by Coventry Workers' Compensation Services regarding this subdivision.</p>	<p>No action necessary.</p>

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	<p><i>Legislative intent from section 1 of SB 863 states:</i></p> <p><i>“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”</i></p> <p><i>Commenter states that nothing in section 4603.6 restricts the independent bill review to a category of services covered by a fee schedule adopted by the Administrative Director. Commenter opines that that Administrative Director has no authority to adopt a regulation that restricts the scope of the statute. Mendoza v Huntington Hospital, WCAB (2010) 75 CCC 634.</i></p>			
9792.5.7(b)(1)	Commenter notes that this subsection	Steve Cattolica	IBR is only available to	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>specifically excludes contract disputes from IBR. Commenter wonders if this means that the provider must first file a lien to resolve the contract issue before IBR can begin. Commenter states that it is relatively common for a provider to identify both an IBR eligible dispute and a contract-based dispute on the same service. After submitting a bill the first time and then using the Second Review process, this provider must suspend his request for IBR and file a lien to resolve the contract dispute - paying the \$150 lien filing fee. Commenter notes that this type of lien may only resolve after the case in chief is settled – an indeterminable length of time that could be years. Only after lien resolution can the provider apply for IBR - paying the \$335 fee to do so. At this point, the IBR process would go forward. Commenter opines that this common situation presents a substantial barrier to participating in IBR. Commenter states that rather than speeding up resolution, it slows it down significantly and increases costs to both the provider and employer. By its nature, these compounded disputes would not be eligible for</p>	<p>Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>resolve disputes over the amount of payment for a bill for medical treatment services or medical-legal services. An IBR reviewer does not have the authority to decide whether the provider and the claims administrator are bound to the terms of a contract for reimbursement under Labor Code section 5305.11. In this regard, Labor Code section 4603.6(a) requires that if a claims administrator has contested liability for any issue other than the reasonable amount payable for services, the issue must be resolved prior to the time IBR is initiated.</p>	

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	<p>consolidation, costing both parties even more. Rather than both issues being completed when the lien is settled, the IBR issue will have just begun. This results in a claim that must be left open and reserves encumbered longer than necessary. Commenter states that providers with legitimate \$100 dollar disputes will be out of pocket more than four times that amount in fees and collection expenses whether they gain recovery or not, and the employer will ultimately pay for the impact of a claim that can't be closed in a timely fashion.</p>			
9792.5.7(b)(2)	<p>Commenter recommends that this subsection be deleted.</p> <p>Commenter states that this provision deals with fee schedule issues that are not eligible for independent bill review, but the Labor Code does not provide authority for the deletion of certain codes or sections from review. Further, the first bill review and the reconsideration would have dealt with analogous coding issues and Labor Code Section 4603.2 (e)(4) directs providers to request IBR if their disputed payment has not been</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>The Division agrees that a bill reviewer's job is to evaluate the documentation and determine if the code billed by the provider accurately matches the code expressly provided for that service under the applicable fee schedule. Unless a fee schedule allows for that procedure, providers should not bring a non-covered service within an adopted fee schedule by using an otherwise valid, analogous code within the fee schedule.</p>	<p>No action necessary.</p>

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	<p>resolved by the second Request for Review.</p> <p>Commenter opines that the language in subdivision (b)(2), if adopted, will put into question whether the independent bill reviewer can determine proper level of service coding, a heavily disputed area. A bill reviewer's job is to evaluate the documentation and determine if it matches the code that was billed. If not, the reviewer must determine what the correct payment must be.</p> <p>Commenter opines that if there is a lack of clarity in the regulation there will be increases in disputes, and if certain fee schedule issues are walled off from the IBR process they will then be shunted back to the WCAB, thwarting the intent of the Legislature to remove medical issues from the WCAB.</p>			
9792.5.7(b)(2)	<p>Commenter recommends deleting this proposed subsection.</p> <p><i>Commenter states that determining the reasonable amount of payment is most definitely part of a bill reviewer's duties. Just as a bill reviewer must examine a report to verify that it</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>See above response to comment by American Insurance Association regarding this subdivision.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>supports the level of service or code billed and to determine the code under which it should be paid, examining the report that must support a “by report” code or other code that is not assigned a value, and identifying an analogous code or value for payment is reasonable and proper. Commenter opines that it should not be forbidden; whether or not the methodology is specifically addressed in a schedule.</i></p>			
9792.5.7(c)	<p>Commenter states that the request for an IBR is allowed after a bill has gone through the second review process as stated in 9792.5.7(a). However, the timeline for requesting the IBR is 30 days from events prior to the 90 days allowed for the second review process as stated in 9792.5.7(c)(1) through (5).</p> <p>Commenter recommend adding a new subsection (6), language as follows:</p> <p><u>§ 9792.5.7. (c) (6) The date of notification of the determination of the second review pursuant to §9792.5.5.</u></p>	<p>Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>A request for IBR must be made within 30 calendar days of the date of the SBR. Labor Code section 4603.6(a). This is accounted for in subdivision (c)(2), which should refer back to subdivision (g).</p>	<p>No action necessary.</p>
9792.5.7(c)	<p>Commenter opines that the 90 day timeframe established for requesting a second review is woefully inadequate; however the 30 day timeframe</p>	<p>Amber Ott Vice President, Finance California Hospital</p>	<p>The requirement is statutory. See Labor Code section 4603.6(a).</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>established for requesting an IBR is completely unreasonable. Commenter notes that in California, AB1455 established a one year floor for submitting appeals to Knox Keene licensed plans, and any less of a timeframe does not adequately allow hospitals time to review the accuracy of payments on the large volume of claims generated each month. Commenter urges the DWC, at a minimum, to specify the latter of the five trigger deadlines will be used when determining timeliness.</p> <p>§ 9792.5.7(c) The request for independent bill review must be made within 30 days of <b>the latter of:</b></p> <p>Commenter states that within the same spirit as § 9792.5.5(f)(1), the provider and claims administrator should be given an opportunity to mutually agree to extend the 30 day time limit for requesting IBR.</p>	<p>Association April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>		
9792.5.7(c)	<p>Commenter recommends the following revised language:</p> <p>(c) The request for independent bill review must be made within 30 <b>calendar</b> days of:</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	Agreed.	Amend section 9792.5.7(c) to read “30 calendar days.”

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>Commenter states that Labor Code section 4603.6(a) specifies “within 30 calendar days of service of the second review.”</i></p>			
<p>9792.5.7(c)(1), (2) and (3)</p>	<p>Commenter recommends the following revised language:</p> <p>(1) <del>The date of s</del>Service of the final written determination issued by the claims administrator under section 9792.5.5(f), <del>if a proof of service accompanies the final written determination. The final written determination is served when it is placed in the United States mail, faxed, or emailed to the provider, or when it is personally served.</del> If served by mail, fax, email, or any method other than personal service, <del>the time to request independent review is extended by 5 calendar days to allow for time until receipt.</del></p> <p>(2) <del>The date of receipt of the final written determination by the provider, if a proof of service does not accompany the final written determination and the claims administrator has documentation of</del></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The subdivision reasonably accounts for most, if not all, circumstances regarding the receipt of the SBR written determination and the timeframe for filing an IBR request. The Division understands that claims administrators do not attach proof of services to their EORs, and the date an EOR was actually mailed is sometimes difficult to discern. The regulation takes into account the extended time to act as set forth in Code of Civil Procedure section 1013 and should assist the parties in limiting disputes over the timeliness of an IBR request. If future data indicates that the regulatory timeframe is either overly confusing or inhibiting providers from requesting IBR, the Division will consider</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><del>receipt.</del></p> <p><del>(3) The date that is five (5) calendar days after the date of the United States postmark stamped on the envelope in which the final written determination was mailed if the final written determination is sent by mail and there is no proof of service or documentation of receipt.</del></p> <p><i>Commenter states that a document is served when it is placed in the United States mail, faxed, emailed, or personally served. If served by mail, fax, email, or any method other than personal service, the time for exercising or performing any right or duty to act shall be extended by five calendar days from that date of service if the service is in California, by ten calendar days if outside California but within the United States, and by twenty calendar days if outside the United States. See CCR section 10507 and California Code of Civil Procedure Section 1013.</i></p>		revising this provision in future rulemaking.	
9792.5.7(d)(1)(A)	Commenter notes that the Division is asking for a \$335 fee for each request. Commenter states that in the pharmacy arena, amounts in dispute	Brian Allen Vice President Government Affairs Stone River	The IBR fee is to cover the reasonable estimated cost of an IBR review in addition to the administration of the IBR	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>can often be less than the \$335 fee.  <b>Commenter recommends a stepped fee system based on the dollar amount of the dispute.</b> For example: Amounts in dispute \$0-\$300, the IBR fee would be \$100. Amounts in dispute \$300.01-\$500, the IBR fee would be \$250. Amounts in dispute \$500.01 and greater, the IBR fee would be \$335.</p> <p>Commenter opines that this type of fee structure would provide access to justice for smaller providers and would make the filing fee risk commensurate with the dollar amount at risk in the dispute.</p>	<p>Pharmacy Solutions  April 8, 2013  Written Comment  April 9, 2013  Oral Comment</p>	<p>program. The amount of the IBR filing fee was negotiated between the Administrative Director and the current IBRO, Maximus Federal Services, under Labor Code section 139.5(a)(2). The cost was based on an estimated number of IBR reviews, the administrative cost of selecting a sufficient number of IBR reviewers, and the cost of building a reliable infrastructure to conduct IBR for the California workers' compensation system. The Division notes section 9792.5.12), which allows providers to consolidate several IBR requests if they involve the similar or related issues. The Division, along with the IBRO, will review the fee on an ongoing basis. If date indicates that the fee is an impediment to providers initiating IBR, the Division may revise the fee in future rulemaking.</p>	
9792.5.7(d)(1)(A)	Commenter's major concern regarding the IBR Regulations is that the IBR	Diane Przepiorski Executive Director	See above response to comment by Stone River	No action necessary.

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	<p>filing fee is too high and will be a major deterrent to providers being paid for their services.</p> <p>Commenter notes that carriers are being unreasonable when the physician submits the "Provider's Request for Second Bill Review." Instead of doing the second review of the disputed amount in a meaningful way to resolve the dispute at that level, they are telling physicians to file the IBR. Commenter opines that they know that providers will not be able to afford to pay such high filing fees to pursue the collection of smaller disputed amounts.</p> <p>Commenter urges the Division to develop a scaling scale filing fee schedule based on the amount that is disputed.</p>	<p>California Orthopaedic Association April 8, 2013 Written Comment</p>	<p>Pharmacy Solutions regarding this subdivision.</p>	
9792.5.7(d)(1)(A)	<p>Commenter objects to the \$335.00 fee. Commenter notes that it is more expensive than most UR costs. Commenter opines what if the bill for service is \$90 and the carrier pays you \$50 – who is going to spend \$335 to capture \$40? Commenter opines that this fee promotes low pay and non-payment by insurers and is completely</p>	<p>William J. Heaney III April 9, 2013 Written Comment</p>	<p>See above response to comment by Stone River Pharmacy Solutions regarding this subdivision.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.7(d)(1)(A)	<p>unfair.</p> <p>Commenter states that the referenced page link: <a href="https://ibr.dir.ca.gov">https://ibr.dir.ca.gov</a> has errors that she suggests can be corrected as follows:</p> <p><i>“You must send in the application request within thirty (30) days from the date you received the final <del>utilization review decision</del> written determination was sent to you. An additional five (5) calendar days are allowed to account for delivery time.”</i></p> <p><i>Commenter notes that the website link for the online form is not yet available on that page.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agreed that the website link in the subdivision has errors and it should be corrected.</p>	<p>Amend section 9792.5.7(d)(1)(A) to correct the DWC website link.</p>
9792.5.7(d)(1)(A)	<p>Commenter opines that the required processing fee is excessive and should be more in line with the fee used for filing a lien - \$100. Commenter states that the high fee places the burden of billing practices on the provider and makes clarifying gray areas (interpretation of OMFS) costly for the provider.</p> <p>Commenter would like the Division to institute fines and/or penalties and interest when carriers are found to be purposely abusing the IBR process.</p>	<p>Michael Chang February 28, 2013 Written Comment</p> <p>Shannon Carlson February 28, 2013 Written Comment</p>	<p>See above response to comment by Stone River Pharmacy Solutions regarding this subdivision. The Division has not been given statutory authority to assess administrative penalties for billing practices outside of those authorized in Labor Code section 129 and 129.5.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.7(d)(1)(A)	Commenter's organization receives thousands of complaints related to arbitrary and capricious down coding of evaluation in management services by bill review companies. Commenter notes that many of these billing issues are for small amounts. Commenter would like to see a more reasonable filing fee akin to those used by the DMHC in their IDR process.	Michelle Rubalcava California Medical Association April 9, 2013 Oral Comment	See above response to comment by Stone River Pharmacy Solutions regarding this subdivision.	No action necessary.
9792.5.7(d)(1)(A)	Commenter opines that the amount of the fee - \$335 is extraordinarily high for computerized process. Commenter urges the division to reconsider the fee in light of the fact that many billing disputes are substantially less than the \$335 fee.	Carl Brakensiek California Society of Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment	See above response to comment by Stone River Pharmacy Solutions regarding this subdivision.	No action necessary.
9792.5.7(d)(2)	<p>Commenter recommends the following revised language:</p> <p>(2) The provider <b>will shall</b> include with the request form submitted under this subdivision, either by electronic upload or by mail, a copy of the following documents:</p> <p><i>Commenter opines that "shall" is the term used to denote a requirement.</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	Agreed.	Revise section 9792.5.7(d)(2) to replace "will" with "shall."
9792.5.7(d)(2)(C)	Commenter notes that this section requires that a provider include a copy	Barbara Hewitt Jones Regulatory Analyst	If a provider requests IBR because their bill was paid at	No action necessary.

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	<p>of the Labor Code section 5307.11 contract if applicable.</p> <p>Commenter opines that the provider cannot comply with the subdivision if the right to a discount is contested or the patient receives a preferred rate that the provider does not know is contracted. Commenter states that this practice is known as silent PPOs. Commenter states that under the Insurance and Health and Safety Code the burden is on the payor to demonstrate that a discount is warranted.</p> <p>Commenter recommends that the interpretation of contracts is only applicable where both parties are in agreement that the OMFS is the term of payment under the contracted relationship.</p>	<p>Tenet April 2, 2013 Written Comment</p>	<p>the rates of reimbursement set forth in a Labor Code section 5307.11, the relevant provisions of the contract must be provided. Providers and claims administrators should, upon the reduction of a bill based on a contract, meaningfully communicate to ensure that the rates are known and have been correctly applied.</p>	
9792.5.7(d)(2)(C)	<p>Commenter notes that this section requires, if applicable, that hospitals submit the relevant managed care contract provisions used for calculating reimbursement rates under Labor Code 5307.11. Commenter recognizes that in some circumstances it may be necessary to submit the contract; however, she urges the DWC</p>	<p>Amber Ott Vice President, Finance California Hospital Association April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>In order to issue a decision regarding the application of rates in a contract for reimbursement, the Division only requires the relevant contract provision, i.e, the rate in dispute. Other provisions of the contract which may contain confidential information need</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to provide for specific confidentiality measures and warranties within this subdivision. For example, commenter opines that by no means should the contract, even if heavily redacted, be made a matter of public record.		not be provided. Unless an appeal is filed with the WCAB, confidential information provided to the Division is protected from public disclosure under Labor Code section 138.7.	
9792.5.7(d)(2)(C)	<p>Notwithstanding the exclusion found in (b) (1), commenter notes that this subdivision requires that a provider include a copy of the Labor Code Section 5307.11 contract if applicable. Commenter asks why? Commenter notes that IBR cannot resolve the contract issue and the contract issue must be resolved by lien before IBR can commence. In addition commenter states:</p> <ul style="list-style-type: none"> <li>• The provider cannot comply with this subdivision if he/she asserts that a contract discount was improperly taken because no contract exists. What is he/she to produce?</li> <li>• If the employer is alleged to have taken a discount based on their contention that a contract does exist, it is the employer's burden to produce the document, not the provider's.</li> </ul>	Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment	As noted in the response to the comment by AdvoCal in regard to section 9792.5.7(b)(1), issues regarding whether or not the contract applies to the parties must be resolved before IBR can occur. Labor Code section 4603.6(a). If the parties agree they are bound by the contract's terms, a copy of the rate in dispute should be provided for review. If future data indicates that the IBR process as required by these regulations is not effective in resolving billing disputes between parties bound by a Labor Code section 5307.11 contract, the Division may revise this provision in future rulemaking.	No action necessary.

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9792.5.7(e)	<p>Commenter recommends the following revised language:</p> <p>The provider <del>may</del> shall include on a single request for bill review the billing codes for all disputed payments for services or goods provided to a single injured employee on a single date of service or discharge, <del>that two or more disputes that would each constitute a separate request for independent bill review be consolidated for a single determination under section 9792.6.12.</del></p> <p>With respect to consolidation, commenter does not find statutory authority for consolidation by the Administrative Director or IBRO. Commenter references his comment regarding 9792.5.12.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Disagree. See response to comment by California Chamber of Commerce in regard to section 9792.5.15.</p>	<p>No action necessary.</p>
9792.5.7(e)	<p>Commenter recommends the following revised language:</p> <p>(e) The provider <del>may</del> shall include in a single request for bill review the billing codes for all disputed payments for services or goods provided to a single injured employee on a single date of service or discharge <del>that two or</del></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Disagree. Regarding the request for review of multiple codes, see response to comment by Coventry Workers' Compensation Services in regard to section 9792.5.7(b)(1). In regard to consolidation, see response to comment by California</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>more disputes that would each constitute a separate request for independent bill review be consolidated for a single determination under section 9792.5.12.</p> <p><i>Commenter opines that all disputed billings for a single date of service for services provided to a single injured employee must be reviewed in concert, and therefore must be submitted for review on a single form. Commenter state that they must be considered together because billing and payment rules that apply to a single billing code are often different from those for multiple codes on the same date of service. For example, payment for one code may be included in the payment for another billed for the same service date. In fact, when considering the proper payment amount, a reviewer must consider <u>all</u> the services documented and billed for a single service date; the amount already paid and the explanations for the payment; and the statutes, rules and regulations that affect payment.</i></p> <p><i>Alternatively, commenter opines that if</i></p>		<p>Chamber of Commerce in regard to section 9792.5.15.</p>	

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	<i>independent bill review for all disputed billings services to one injured employee provided on a single date of service are not required to be requested together, then all such disputes submitted separately must be identified and reviewed together.</i>			
9792.5.8 DWC Form IBR	<p>Commenter states that the form and rule are silent on who can sign the form – the provider, billing agent, or assignee. Additionally, there is no indication that the form can be signed electronically by printing the appropriate name on the form.</p> <p><b>Commenter recommends that the rules clarify that the entity submitting the bill for second review and entitled to payment is authorized to sign the form and that the name of the person submitting the form can be electronically generated on the form and that a physical, original signature does not have to be affixed to the form.</b></p>	<p>Brian Allen Vice President Government Affairs Stone River Pharmacy Solutions April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Section 9792.5.4(i) has been amended to expressly allow a provider to utilize the services of a billing agent to request SBR or IBR. If there is any further confusion regarding this provision, the Division will amend the SBR and IBR form in future rulemaking to clarify this point</p>	<p>No action necessary.</p>
9792.5.8 DWC Form IBR-1	<p>Commenter recommends the following revision to the Bill Information Section:</p> <p>Applicable Fee Schedule(s) or <b>Contract Reimbursement Rates</b></p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Agreed in part.</p> <p>The form is clear as to the box to check if there is dispute regarding contractual rates.</p>	<p>Revise DWC Form IBR-1 to state that the supporting documents must be included with the request and must be concurrently</p>

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	<p>Commenter recommends deleting the entire Consolidation portion of the form. Commenter references his comment regarding 9792.5.12.</p> <p>Commenter recommends the following revised language to the last bullet point under Form Instructions:</p> <p>A copy of the documents listed at the bottom of the form <del>should</del> <b>must</b> be provided with your request. These documents must be served <b>concurrently</b> on the claims administrator with a copy of this form. Any document that was previously provided to the claims administrator or originated from the claims administrator need not be served if a written description of the document and its date is served.</p> <p>On the Instruction pages, commenter recommends deletion of the "analogous codes" directions and the entire sections on Consolidation and Disaggregation. Commenter finds no statutory authority for these sections.</p>		<p>As noted above, consolidation is appropriate. See response to comment by California Chamber of Commerce regarding section 9792.5.12. Further exclusion of IBR as a remedy for billing under an analogous code is reasonable. See response to comment by Coventry Workers' Compensation Services in regard to section 9792.5(b)(1).</p> <p>The Division agrees on the word changes in the instructions.</p>	provided to the claims administrator.
9792.5.9	Commenter opines that both the emergency and proposed final IBR regulations, the only period for active	Lisa Anne Forsythe Senior Compliance Consultant	Labor Code section 4603.6 does not expressly require a claims administrator to submit	Amend section 9792.5.9(c)(3) to allow a claims

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	<p>involvement on the part of the carrier in the IBR process is the 15-day period for the carrier to object to assignment of IBRO/IBR eligibility, upon notification of an intention to assign an IBR reviewer. Commenter states that this is not the same as allowing the carrier a defined opportunity to raise substantive objections and/or dispute any of the points raised in the provider's request for IBR. (e.g. What if a provider is alleging that a particular contract was governing the bill but, in fact, a different contract was actually in effect. How would the carrier raise this issue and defend the position?)</p> <p>Commenter recommends modifying the regulations to indicate that the carrier is permitted to respond substantively to an IBR Application and address the merits on an IBR Application during the 15-day timeframe to object to IBRO eligibility/assignment. Ideally, as indicated in Section 4 <i>supra</i>, the DIR would provide a standardized Response Form.</p>	<p>Coventry Workers' Compensation Services April 8, 2013 Written Comment</p>	<p>documents to the IBR reviewer. Instead, document would only be provided by the claims administrator if requested by the IBR reviewer. Labor Code section 4603.6(e). That said, the claims administrator should have the opportunity to submit substantive arguments regarding the merits of the request.</p>	<p>administrator to dispute the provider's reason for requesting IBR.</p>
9792.5.9	<p>Commenter recommends that this section be amended to state that a</p>	<p>Mark Webb Vice President &amp;</p>	<p>Labor Code section 4603.2 and 4603.6 mandate that IBR, as</p>	<p>No action necessary.</p>

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	request for IBR will be denied if the bill that is the subject of the IBR request has previously been or is currently the subject of a petition for costs pursuant to 8 CCR § 10451 regardless of the status of the petition. Commenter notes that this is the reverse of proposed 8 CCR§ 10451(b)(2) which, in part, states that a petition for costs, " ... may raise all issues, including the amount payable under an official fee schedule <i>whether or not</i> independent bill review was previously pursued." (Emphasis supplied)	General Counsel Pacific Compensation Insurance Company March 27, 2013 Written Comment	required by statute and as implemented by Division, be the exclusive remedy for medical treatment and medical-legal billing disputes. The Division does not intend to dismiss an IBR request based on the filing of a petition for cost with the WCAB over the same issue. In the regard, the Division cannot order the WCAB to act likewise.	
9792.5.9(a)	Commenter states that this subsections provides criteria for a preliminary review to determine whether a request is not eligible for review. Commenter is concerned that, with an IBRO acting as the Administrative Director's designee in the initial review for eligibility of requests for IBR, there is a potential for conflict of interest as the IBRO has a financial interest in the outcome of these reviews. Commenter opines that language to avoid conflicts of interest should be added.	Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment	There is no statutory provision prohibiting the IBRO from acting as the Administrative Director designee and conducting a preliminary review of a request for IBR. It is noted that under subdivision (e), it is the Administrative Director that issues determinations regarding ineligibility. That function has not been delegated.	No action necessary.
9792.5.9(a)(2)	Commenter recommends the following revised language:	Brenda Ramirez Claims & Medical Director	Agreed. Eligibility for IBR in regard to the SBR should consider when the SBR was	Amend section 9792.5.9(a) to include consideration of

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	<p>(2) The date of <b>receipt of</b> the billing and whether- a second request for review of the bill was <b>timely requested and was</b> completed;</p> <p><i>Commenter opines that to determine eligibility due to timely request, the date of billing receipt is needed.</i></p>	<p>CWCI April 9, 2013 Written Comment</p>	<p>requested by the provider and whether it was timely completed by the claims administrator.</p>	<p>when an SBR was requested and if it was timely completed.</p>
9792.5.9(a)(3)	<p>Commenter recommends the following revised language:</p> <p>(3) Whether, for a bill for medical treatment services, the medical treatment was <b>provided or referred by the primary treating physician and</b> authorized by the claims administrator under Labor Code section 4610 <b>and, if authorized, whether the written authorization was submitted together with the billing.</b></p> <p><i>Commenter opine that the DWC also needs to know whether the treatment was provided or referred by the primary treating physician and whether a written authorization was submitted with the billing.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The suggestion in the comment would complicate a simple consideration. The DWC Form IBR-1 contains a checkbox where the provider can state whether the treatment was authorized. If the treatment was not authorized, the claims administrator can submit evidence on its behalf.</p>	<p>No action necessary.</p>
9792.5.9(a)(4)	<p>Commenter states that the provision incorrectly ends with a semi-colon “;” which connotes further text or meaning.</p>	<p>Peggy Thill Claims Operations Manager State Compensation</p>	<p>Agreed.</p>	<p>Revise section 9792.5.9(a) to correct punctuation.</p>

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	Commenter recommends ending the provision with a period “.”	Insurance Fund April 9, 2013 Written Comment		
9792.5.9(a)(4)	<p>Commenter recommends the following revised language:</p> <p>(4) If the required fee for the review was <b>not</b> paid;</p> <p><i>Commenter opines that the condition is better stated in the affirmative.</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	Agreed.	Revise section 9792.5.9(a)(6) to consider whether the fee was paid.
9792.5.9(b)	<p>Commenter recommends the following revised language:</p> <p>If the request appears eligible for review, the Administrative Director, or his or her designee, shall notify the provider and the claims administrator <b>within 5 days</b> by the most efficient means available that request for independent bill review has been submitted and appears eligible for assignment to an IBRO.</p> <p>Commenter opines that the addition of this five day time period is necessary in order to allow sufficient time for completion of the entire process within the prescribed time frames.</p>	Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment	Upon receipt of a request for IBR, the Administrative Director has 30 days to assign the request to the IBRO. A 15 day period is reasonable for notifying the parties after a decision is made that a request is eligible for review.	Revise section 9792.5.9(b) to allow the Administrative Director up to 15 days from an eligibility decision to notify the parties of an assignment to an IBRO.
9792.5.9(b)	Commenter recommends the following revised language:	Brenda Ramirez Claims & Medical	See responses to above comments by American	No action necessary.

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	<p>(b) If the request appears eligible for review, the Administrative Director, or his or her designee, shall notify the provider and the claims administrator <b>within 5 days from receipt of the request</b> by the most efficient means available that request for independent bill review has been submitted and appears eligible for assignment to an IBRO. The notification shall contain:</p> <p><i>Commenter recommends specifying a timeframe here. Commenter recommends five days to allow time for the other steps in the process.</i></p> <p><i>Because the IBRO has a direct financial conflict of interest, commenter does not believe it proper to designate Maximus to receive or to perform any initial review of the form before the request is determined to be eligible and is assigned for review.</i></p>	<p>Director CWCI April 9, 2013 Written Comment</p>	<p>Insurance Association regarding subdivision (a) and (b) of this section.</p>	
9792.5.9(b)	<p>Commenter notes this subdivision does not provide any timeframe within which the Administrative Director must act to decide eligibility for review.</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p>	<p>See response to above comment by American Insurance Association regarding this subdivision.</p>	<p>No action necessary.</p>

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9792.5.9(b)(1)	<p>Commenter recommends the following revised language:</p> <p>(1) An independent bill review case or identification number;</p> <p><i>Commenter states that this corrects a minor typographical error.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agree.</p>	<p>Revise section 9792.5.9(b)(1) to correct the typographical error.</p>
9792.5.9(b)(3)	<p>Commenter notes that this section provides that if a request for IBR is determined to be eligible for IBR review, the Administrative Director shall notify the provider and claims administrator, and the claims administrator may dispute eligibility by submitting a statement with supporting documents to the AD or her designee within the prescribed timeframe.</p> <p>Commenter opines that this provision should be clarified to specify whether the submission of documents by the claims administrator is limited to the issue of eligibility for IBR review or whether the claims administrator may submit documents on other payment or billing issues.</p>	<p>Peggy Thill Claims Operations Manager State Compensation Insurance Fund April 9, 2013 Written Comment</p> <p>Patricia Brown State Compensation Insurance Fund April 9, 2013 Written and Oral Comment</p> <p>Lisa Anne Forsythe April 9, 2013 Oral Comment</p>	<p>See response to comment by Coventry Workers' Compensation Services regarding this section.</p>	<p>No action necessary.</p>
9792.5.9(b)(3)	<p>Commenter recommends the following revised language:</p>	<p>Brenda Ramirez Claims &amp; Medical</p>	<p>As noted above, Labor Code section 4603.6 does not</p>	<p>No action necessary.</p>

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	<p>(3) A statement that the claims administrator may dispute eligibility for independent bill review under subdivision (a) by submitting a statement with supporting documents, and that the Administrative Director or his or her designee must receive the statement and supporting documents within fifteen (15) calendar days of the date <b>the Administrative Director received the Request as designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date designated on the notification if the notification was provided electronically.</b></p> <p><i>Commenter suggests counting these timeframes from the date the Administrative Director received the Request, which date can be designated on the notification.</i></p> <p><i>Section 10507 specified the same additional five days, whether notification is by mail, fax or email.</i></p>	<p>Director CWCI April 9, 2013 Written Comment</p>	<p>expressly require a claims administrator to submit documents to the IBR reviewer. That said, the timeframe for accepting documents is reasonable and considers the notification extensions of time in Code of Civil Procedure section 1013. 8 C.C.R. section 10507, while relevant, does not apply to the IBR process.</p>	
9792.5.9(c)	<p>Commenter recommends the following revised language:</p>	<p>Brenda Ramirez Claims &amp; Medical Director</p>	<p>Agreed.</p>	<p>Amend 9792.5.9(c) to provide that submitted documents</p>

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	<p>(c) Any document filed with the Administrative Director, or his or her designee, under subdivision (b)(3) must be <b>concurrently</b> served on the other party. Any document that was previously provided to the other party or originated from the other party need not be served if a written description of the document and its date is served.</p> <p><i>Commenter opines that stating that the documents must be concurrently filed on the other party will ensure timely receipt.</i></p>	<p>CWCI April 9, 2013 Written Comment</p>		<p>must be concurrently served on the other party.</p>
<p>9792.5.9(d)</p>	<p>Commenter recommends the following revised language:</p> <p>(d) Upon receipt of <b>the</b> documents <b>requested in pursuant to</b> subdivision (b)(3), or, if no documents have been received, upon the expiration of fifteen (15) days of the date <b>the Administrative Director received the Request as</b> designated on the notification, <b>if the notification was provided by mail, or within twelve (12) days of the date designated on the notification if the notification was provided electronically,</b> the Administrative Director, or his or her designee, shall conduct a further</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The subdivision is sufficiently clear as to when the Administrative Director shall conduct a further eligibility review if no documents are provided; from the time in which to submit documents has expired.</p>	<p>No action necessary.</p>

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	<p>review in order to make a determination as to whether the request is ineligible for independent bill review under subdivision (a).</p> <p><i>Commenter suggests counting these timeframes from the date the Administrative Director received the Request, which can be the date designated on the notification.</i></p> <p><i>Section 10507 specified the same additional five days, whether notification is by mail, fax or email.</i></p>			
9792.5.9(d)(1)	<p>Commenter states that this subsection allows for a provider to be "...partially reimbursed the fee provided [with an IBR] request..." if the request is deemed to be ineligible for participation in IBR. However, there are no specific consequences associated with filing multiple "ineligible disputes" and no defined disincentives to prevent such filings. Commenter opines that filing an "ineligible dispute" could be utilized as a negotiation tactic with a payer/carrier.</p> <p>Commenter recommends that the DWC define consequences for</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services April 8, 2013 Written Comment</p>	<p>The IBR statute, Labor Code section 4603.6, does not provide a remedy for a provider's purported misuse of the IBR process. That said, \$270, out of the filing fee of \$335, is reimbursed following an ineligibility determination. Section 9792.5.9(e)(1). The loss of \$65 per ineligible request should act as a disincentive from further filing.</p>	<p>No action necessary.</p>

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	inappropriate invocation of the IBR process. Provide a mechanism to identify patterns of misuse. Refuse to refund IBR fees in the event that the IBR process is invoked inappropriately.			
9792.5.9(e)	<p>Commenter recommends the following revised language:</p> <p>(e) If the review conducted under either subdivision (a) or subdivision (d) finds that the request is ineligible for independent bill review, the Administrative Director shall, within <del>fifteen</del> <b>thirty (1530)</b> calendar days following receipt of the documents requested in subdivision (b)(3) or, if no documents are received, the expiration of the time period indicated above of the date the Administrative Director received the Request as designated on the notification, issue a written determination informing the provider and claims administrator that the request is not eligible for independent bill review and the reasons therefor.</p> <p><i>Commenter opines that allowing 15 days from the date the Administrative Director (AD) received the Request</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Upon receipt of a request for IBR, the Administrative Director has 30 days to assign the request to the IBRO. Considering the amount of time in which the claims administrator has to submit documents challenging eligibility, the additional 15 day period in which to issue an ineligibility decision is reasonable. If future data or evidence shows this timeframe to be impractical, the Division may revise the timeframes in future rulemaking.</p>	<p>No action necessary.</p>

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	<i>for documents disputing eligibility, and 30 days from the same date for the AD to issue the determination, is a simpler, easier to track timeframe.</i>			
9792.5.9(e)(2)	Commenter recommends that this section clarify that a third party administrator can request a bill review on behalf of a provider.	Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment	Section 9795.5.4(i) allows a provider to utilize a billing agent to request both SBR an IBR.	No action necessary.
9792.5.9(f)	<p>Commenter recommends the following revised language:</p> <p>(f) If the Administrative Director or his or her designee determines from the review conducted under subdivision (a) or (d), whichever applies, that the request is eligible for independent bill review, the Administrative Director shall assign the request to an IBRO for an independent bill review <b>within thirty (30) calendar days of the date the Administrative Director received the Request</b>. Upon assignment of the request, the <b>IBRO</b> shall notify the parties in writing that the request has been assigned to that organization for review. The notification shall contain:</p> <p><i>Commenter opines that the statute requires this timeframe.</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	Agreed. The statute requires this timeframe. There is no need to duplicate the timeframe in the regulation.	No action necessary.

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9792.5.9(f)(3)	<p>Commenter recommends the following revised language:</p> <p>(3) Identification of the <b>claim and</b> disputed amount of payment made by the claims administrator on a bill for medical treatment services submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses submitted pursuant to Labor Code section 4622<del>2</del><sub>3</sub></p> <p><i>Commenter opines that the claim number is also needed.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agreed.</p>	<p>Amend section 9792.5.9(f)(3) to require the IBRO to identify the claim, and to correct punctuation.</p>
9793(e)	<p>Commenter recommends the following revised language:</p> <p>(e) "Disputed medical fact" means an issue in dispute, <b>including where there has been</b> an objection under Section 4062 of the Labor Code to a medical determination made by a treating physician concerning: (1) the employee's medical condition; (2) the cause of the employee's medical condition; (3), For injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30, 2013</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The language of the existing regulation, which has not been amended in the regard, is sufficiently clear. The Division agrees that the provision regarding an employee's eligibility for rehabilitation services is no longer necessary; it will be deleted in future rulemaking.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>treatment for the employee's medical condition; or (4) the existence, nature, duration or extent of temporary or permanent disability caused by the employee's medical condition, <del>or (5) the employee's medical eligibility for rehabilitation services.</del></p> <p><i>Commenter notes that the first recommended change is for accuracy.</i></p> <p><i>Commenter opines that since the vocational rehabilitation benefit was repealed in 2003, it is no longer relevant or necessary for treating doctors to address medical eligibility for vocational rehabilitation.</i></p>			
9793(f)	<p>Commenter recommends the following revised language:</p> <p>"Explanation of review" means the document described in Labor Code sections 4603.3(a) and 4622 that is provided to a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician when the claims administrator <del>pays, reduces, and/or objects to a bill for</del> <del>has objected to</del> the cost of a medical-legal expense.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>Labor Code section 4622 only requires a claims administrator to use the Explanation of Review as set forth in section 4603.3 if they contest the medical-legal expense. In this circumstance, the phrase "objected to the cost" is reasonable.</p>	No action necessary.
9793(f)	<p>Commenter recommends the following revised language:</p>	<p>Brenda Ramirez Claims &amp; Medical</p>	<p>See response to above comment by American</p>	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>(f) "Explanation of review" means the document described in Labor Code sections 4603.3(a) and 4622 that is provided to a Qualified Medical Evaluator, Agreed Medical Evaluator, or the primary treating physician <u>when by the claims administrator has objected to the cost of upon payment, adjustment or denial of a billing for a medical-legal expenses.</u></p> <p><i>Commenter makes these recommended changes for accuracy.</i></p>	<p>Director CWCI April 9, 2013 Written Comment</p>	<p>Insurance Association regarding this subdivision.</p>	
9793(h)(2)	<p>Commenter recommends the following revised language:</p> <p>2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing <u>in the report</u> additional related medical issues <u>other than issues concerning</u></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>QMEs are prohibited from addressing treatment issues falling within Lab. Code section 4610.5(See. Lab. Code § 4062.) Treating physicians, however, may be required to address disputed medical treatment issues.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><u>disputes over utilization review decisions pursuant to Labor Code section 4610.5.</u></p> <p><i>Commenter states that according to Labor Code section 4610.5(b), disputes over utilization review decisions described in Labor Code section 4610.5(a) shall be resolved only in accordance with the IBR track specified in Labor Code section 4610.5.</i></p>			
9793(m)	<p>Commenter recommends the following revised language:</p> <p>(m) "Supplemental medical-legal evaluation" means an evaluation <u>including an evaluation in response to a request for factual correction pursuant to Labor Code section 4061(d).</u> which (A) does not involve an examination of the patient, (B) is based on the physician's review of records <del>test results</del> or other medically relevant information which was not available to the physician at the time of the initial examination <u>except for the results of laboratory or diagnostic tests which were ordered by the physician as part of the original evaluation, or a request for factual</u></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>The original language is clear. The factual correction procedure does not include an evaluation; rather it happens after the initial comprehensive evaluation. This section defines terms, but does not implicate whether payment is appropriate, which is covered by section 9705(c) of these regulations.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>correction pursuant to Labor Code section 4061(d), (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.</p> <p><i>Commenter states that the evaluator may not profit from failing to address records and other medically relevant information which was available to the evaluator at the time of the initial examination, or the results of tests ordered by the physician as part of the original evaluation. This is also consistent with the procedure description of supplemental medical-legal evaluations in section 9795(c) that clearly states:</i></p> <p><i>“Fees will not be allowed under this section for supplemental reports</i></p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation."</i></p>			
9793(m)	<p>Commenter states that there are situations where the Primary Treating Physician is requested to issue a Medical-Legal report by a party, the Administrative Director or the WCAB. In most situations these reports do not include an actual physical examination, but would require record review, evaluation of test results, etc. and would most closely resemble a supplemental medical-legal evaluation. Commenter states that the current language of the definition indicates that a supplemental medical-legal evaluation follows a comprehensive medical-legal evaluation. Commenter opines that since PTP evaluations are generally not comprehensive medical-legal evaluations by definition, a medical-legal report issued by a PTP</p>	<p>Suzanne Honor-Vangerov Honor Systems April 9, 2013 Written Comment</p>	<p>As described by the commentator, the report of the treating physician is an initial comprehensive medical/legal report and not a supplemental report because the cause of the dispute is a treating physician's report issued pursuant to 9785 which is the subject of an objection by the claims administrator or the injured worker. (Cal. Code of Regs., tit. 8, § 9785 (b)(3) , (b)(4).) As defined in the regulation, a supplemental report must come after a physician issues a comprehensive medical report; by definition the treating physician's report described in the comment is not</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	without a physical exam would not qualify. Commenter suggests that the definition of supplemental medical-legal evaluation include a medical-legal evaluation obtained at the request of a party, the AD, or the WCAB where there is no current physical examination or previous comprehensive medical-legal evaluation.		medical/legal report.	
9794(c)(4)	<p>Commenter recommends the following revised language:</p> <p>(4) A statement pursuant to Labor Code section 4622(b)(1) that the physician may seek a second review by the claims administrator of the <del>reduction of</del> billing <del>submitted for of</del> the medical-legal expense under California Code of Regulations, title 8, section 9792.5.5.</p> <p><i>Commenter recommends these changes for accuracy and clarity.</i></p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	The rule is already clear.	No action necessary.
9794(f)	<p>Commenter recommends the following revised language:</p> <p>(f) If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid</p>	Brenda Ramirez Claims & Medical Director CWCI April 9, 2013 Written Comment	The section requires the physician be informed of the reason for the denial of the bill. The comment suggests if a denial was previously issued, the physician need not be informed of the reason for the	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>pursuant to the fee schedule set forth in section 9795, <b>unless a denial has previously been issued,</b> the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which shall also contain the following statements:</p> <p><i>Commenter opines that it is only necessary to issue a written denial of liability once.</i></p>		denial.	
9794(f)(1)	<p>Commenter recommends the following revised language:</p> <p>(1) The physician may object to the denial of the medical-legal expense issued under this subdivision by notifying the claims administrator in writing of <b>their his or her</b> objection within ninety (90) days of the service of the explanation of review; and</p> <p><i>Commenter states that this correction is suggested to address a minor grammatical error.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	The term “physician” is gender neutral and the suggested language is unnecessary.	No action necessary.
9794(f)(2)	<p>Commenter opines that the 90 day time limit to respond to a partial or non-payment is just not fair. Commenter opines that the secondary bill request should have time frames</p>	<p>William J. Heaney III April 9, 2013 Written Comment</p>	The timeframe to act is statutory. (Lab. Code § 4603.2 (c)(1).)	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9794(f)(2)	<p>similar to those that guide lien filing.</p> <p>Commenter recommends the following revised language:</p> <p>(2) If the physician does not file a written objection with the claims administrator <b>within ninety (90) days of the service of the explanation of review</b> challenging the denial of the medical-legal expense issued under this subdivision, neither the employer nor the employee shall be liable for the amount of the expense <b>that</b> was denied.</p> <p><i>Commenter opines that the objection must be made timely.</i></p> <p><i>Adding "that" corrects a minor typographical error.</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	Accepted	That is inserted at the place suggested.
9794(i)	<p>Commenter recommends the following revised language:</p> <p>Physicians shall keep and maintain for <b>three five</b> years, and shall make available to the administrative director by date of examination upon request, copies of all billings for medical-legal expense.</p> <p>Commenter opines that for</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	Accepted	Amend section 9794(i) to change three years to five years.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>consistency the provider and claims administrator should both be required to maintain records for the same period of time. The Physician is required to maintain records for 3 years while in subdivision (k) the claims administrator must keep records for five years. The Initial Statement of Reasons states that the five year requirement in new subdivision (k) is needed to make the retention of the bill for medical legal-services identical to medical-legal retention requirement for QMEs in Tit. 8 CCR Section 39.5.</p>			
9794(i)	<p>Commenter recommends the following revised language:</p> <p>(i) Physicians shall keep and maintain for <b>three five</b> years, and shall make available to the administrative director by date of examination upon request, copies of all billings for medical-legal expense.</p> <p><i>Commenter opines that it appears that the Administrative Director intended to revise section (i) and not (k) to make the time required for physicians to retain medical-legal bills consistent with the five year retention period</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	Accepted	Amend section 9794(i) to change three years to five years.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>required for QMEs in section 39.5. The Initial Statement of Reasons states:</i></p> <p><i>“The five year requirement in new subdivision (k) is necessary to make the retention of the bill for medical legal-services identical to the medical-legal retention requirement for QME’s which appears at section 39.5 of these regulations.”</i></p>			
9794(j)	<p>Commenter recommends the following revised language:</p> <p>A physician may not charge, nor be paid, any fees for services in violation of Section 139.3 <b>or 139.32</b> of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;</p> <p>Commenter opines that the addition of Section 139.32 is necessary to conform to SB 863.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	Accepted	Amend section 9794(j) to include Labor Code section 139.32.
9794(j)	<p>Commenter recommends the following revised language:</p> <p>(j) A physician may not charge, nor be paid, any fees for services in violation of Section 139.3 <b>or 139.32</b> of the Labor Code or subdivision (d) of Section 5307.6 of the Labor Code;</p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	Accepted	Amend section 9794(j) to include Labor Code section 139.32.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p><i>Commenter states that section 139.32 of the Labor Code needs to be added here to conform to this new provision of Senate Bill 863.</i></p>			
9794(k)	<p>Commenter recommends the following revised language:</p> <p>k) Claims administrator shall retain, for <b>five three</b> years, the following information for each comprehensive medical evaluation for which the claims administrator is billed:</p> <p><i>Commenter opines that it appears that the Administrative Director intended to revise section (i) and not (k) to make the time required for physicians to retain medical-legal bills consistent with the five year retention period required for QMEs in section 39.5. The Initial Statement of Reasons states:</i></p> <p><i>“The five year requirement in new subdivision (k) is necessary to make the retention of the bill for medical-legal services identical to the medical-legal retention requirement for QME’s which appears at section 39.5 of these regulations.”</i></p>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Rejected. The intent is to make the retention period five years.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9795 – Code ML106 – RV 5	<p>Commenter proposes eliminating option (B).</p> <p>Commenter provides three reasons for the removal as follows:</p> <ul style="list-style-type: none"> <li>• In internal medicine/cardiology, quite often additional testing such as echocardiogram, nuclear testing, CAT scan angiogram, cardiac MRI, prolonged cardiac monitoring up to a month or more, invasive testing such as coronary angiogram and electrophysiology testing are required to finish the evaluation. Such testing is expensive and at times invasive requiring authorization from the carrier. It is impossible to perform the testing at the time of evaluation or even within a short period of time such as 30 days after the evaluation.</li> <li>• The results of such testing are often quite complicated and requires extensive discussion and explanation of such result.</li> </ul>	Jonathan Ng, M.D. March 13, 2013 Written Comment April 9, 2013 Oral Comment	Billing to for test can be done during the billing for the initial comprehensive medical legal evaluation. The test if missing from the medical records previously provided can be ordered prior to the physical examination of the worker and be reviewed after the physical examination if necessary. The QME/AME can also request a timeframe extension of 15 days to accommodate delays in receiving test results. (Cal Code of Regs., tit. 8, § 38(b)(1).)	No action necessary.

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	<ul style="list-style-type: none"> <li>The effort of reporting the testing is simply measured by the time spent for the reporting. This is no different than reporting on additional medical record received <u>after</u> the evaluation.</li> </ul>			
9795(c) – Code ML 103 (5)	<p>Commenter seeks clarification in reference to whether or not time must be spent in each of the three areas of 1) face-to-face time, 2) record review and 3) medical research or if it's just the total of six hours that controls. Commenter opines that if it is the Division's intention that only six or more hours is the controlling factor, then complexity factor #4's description should be changed to read "four to six hours in any factors 1-3" to avoid confusion.</p>	Suzanne Honor-Vangerov Honor Systems April 9, 2013 Written Comment	The section clearly requires the physician to have a specific time distribution to meet the specific requirements of the rule.	No action necessary.
9795(c) – Code ML 103 (9)	<p>Commenter opines that this number should be amended to eliminate the possibility that PTPs can write a report that would be considered medical-legal just to appeal a UR delay, denial or modification. Currently, when a UR decision for delay, denial or modification is sent to the PTP, the doctor is issuing a report rebutting the denial and billing for a medical-legal evaluation. Commenter states that this</p>	Suzanne Honor-Vangerov Honor Systems April 9, 2013 Written Comment	We cannot understand the comment and therefore cannot reply to it. To the extent, however, the comment indicates that treating physician cannot bill for certain kinds of reports see the prior response to a comment by Honor Systems. Note that a physician cannot be reimbursed for spontaneously	No action necessary.

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	<p>was not the intent of the original addition of this complexity factor, but was an unintended consequence of the change in definitions. Commenter opines that if the UR denial is not subject to the IMR process, only an AME or QME under 4062 should be able to issue a medical-legal report addressing the dispute.</p>		<p>responding to a UR denial.</p>	
<p>9795(c) – ML103 - 5</p>	<p>Commenter notes that the current language allows for three complexity credits for having six or more hours spent on any combination of the three complexity factors of face-to-face time, records review, and research. Commenter notes that the interpretation by the Medical Unit is that in order to obtain those three credits, a physician must spend some time on all three of those elements. Commenter opines that he was involved in the creation of the Medical-Legal Fees schedule and that was not the intent of the Industrial Medical Council when they made their recommendation to the Administrative Director. Commenter states that the correct interpretation is that you have six hours total time in any of those three categories but you don't have to do all three.</p>	<p>Carl Brakensiek California Society of Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment</p>	<p>The commentator confuses the recommendation of the now extinct Industrial Medical Council with the intent of the Administrative Director who ultimately adopted the regulation.</p>	<p>No action necessary.</p>

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	<p>Commenter recommends that the Division delete the word “three” in the definition so that any combination of one through three in ML-103 would give the credits.</p>			
DWC Form IBR-1	<p>Commenter submitted a revised version of the proposed form [Copy available upon request]. The recommended changes are summarized as follows:</p> <ul style="list-style-type: none"> <li>• <i>Some fields are reordered into a more logical order and spacing</i></li> <li>• <i>Some prompts are abbreviated for brevity and space</i></li> <li>• <i>Some prompts, such as for addresses, are merged for clarity</i></li> <li>• <i>In the Provider Type section, the single prompt and box for Treating Physician has been replaced by separate prompts and boxes for the Primary Treating Physician, and the Secondary Treating Physician because some rules and payments are affected by these different treating physician</i></li> </ul>	<p>Brenda Ramirez Claims &amp; Medical Director CWCI April 9, 2013 Written Comment</p>	<p>Agreed in part. The form should be slightly reordered and several prompts, such as for addresses, should be shortened for clarity. While some rules and payments may differ for a primary treating physician as opposed to a secondary treating physician, a distinction between the two is not necessary at this stage. The reference to “procedures/service/item” should be changed to “service/good” for consistency and accuracy. As noted multiple times, the section for consolidation, and also disaggregation, should be retained, and the address for Maximus Federal Services should be retained as the Administrative Director can properly delegate the responsibility of document</p>	<p>Amend DWC Form IBR-1 to: (1) reorder employee information to delete Social Security Number and add Claim Number and Employer Name; (2) shorten address prompts; (3) change reference from “procedures/service/item” to service/good”; (4) specify provider signature on form; (5) simplify language of instruction sheet; and (6) revise instruction page correct website address, change references to “services and goods,” advise providers that they must index and order supporting</p>

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	<p><i>categories. An additional prompt and box has been added for “other Practitioner – specify_____” to capture other types of providers</i></p> <ul style="list-style-type: none"> <li>• <i>The consolidation section has been deleted because the Institute believes that consolidations are not supported in SB 863</i></li> <li>• <i>The signature line clarifies that the provider’s original signature is required</i></li> <li>• <i>The mailing information for Maximus is deleted because the commenter believes that the forms should not be sent to Maximus until they are reviewed by the DWC or a designee with no financial interest in the outcome of an eligibility determination</i></li> <li>• <i>The instructions are modified for clarity and accuracy</i></li> <li>• <i>The Consolidation and Disaggregation paragraphs have been deleted for the reason described above</i></li> <li>• <i>Commenter recommends adding an additional five days</i></li> </ul>		<p>intake to the IBRO. The timeframe in the “When to apply” section aligns with the language of section 9792.5.7(c). The language of the “How to Apply by Mail” section is reasonable to advise providers that the application must be sent to the Maximus address.</p>	<p>documents, advise providers that they must concurrently serve the application on the claims administrator, and advise providers that they must limit consolidation requests to 20.</p>

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	<p><i>to the 30 days from the date of service of the final written determination and including an explanation for the additional days</i></p> <ul style="list-style-type: none"> <li><i>In the How to Apply by Mail section, the injured employee is instructed to copy the claims administrator and is advised that forms not sent as instructed will not be considered filed. The language that says the form will be returned if it is not sent as directed is deleted in case it does not go to a location that will return it.</i></li> </ul>			
DWC Form IBR-1 - Instructions	<p>Commenter notes that the instructions indicate that IBR will not determine a reasonable fee for a category of services that are not covered by a fee schedule. Commenter questions what of the many procedure codes that are coded by a report. Commenter states that those services are under the fee schedule, but they are by report. Commenter inquires if the IBRO will determine whether the charge for an IBR report code was appropriate or is that open. Commenter asks if this is</p>	<p>Carl Brakensiek California Society of Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment</p>	<p>See responses to comments by: (1) State Compensation Insurance Fund in regard to section 9792.5.7(a); (2) William J. Heaney III in regard to section 9792.5.7(b)(1); CWCI in regard to section 9792.5.5(f)(2); and (3) Coventry Workers' Compensation Services in regard to section 9792.5(b)(1).</p>	<p>No action necessary.</p>

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	<p>not covered under IBR, what is the process for the billing to be resolved? Is there a separate bill review process for that issue? If so, commenter requests that these regulations clarify what action should be taken. Commenter would like to know if a dispute over penalties and interest is covered under IBR or some other process.</p> <p>Commenter would like to know what happens when a provider send in a bill and receives no response – there is no EOB or EOR. How does that type of situation get resolved?</p> <p>Commenter notes that the instructions also indicate that IBR will not determine the appropriate reimbursement – or just resolve issues of the use of analogous codes. How do you resolve an issue regarding analogous codes?</p>			
DWC Form SBR-1	<p>Commenter states that title of the form is causing confusion. Commenter opines that it is really not the physician’s request for a “second” bill review. This is the “first” time that the reduction has been appealed. To avoid confusion and people thinking that</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association April 8, 2013 Written Comment</p>	<p>The form is appropriately titled; Labor Code section 4603.2(e) clearly provides that the procedure is a “second” bill review. Neither the statute nor the proposed regulations envision more than the initial</p>	<p>No action necessary.</p>

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	<p>there's something else they need to do before filing the SBR-1, commenter recommends that the Division rename the form, "Provider's Request for Bill Review."</p> <p>Commenter notes that these regulations are unclear whether the physician can have their bill reviewed more than one time before invoking the IBR process or is it a one-time review and then the parties are forced into the IBR process.</p>		and second review before the IMR process is invoked.	
DWC Form SBR-1	<p>Commenter notes that the proposed Final Regulations include two different tracks for providers when requesting Second Bill Review: (1) one for medical-legal bills (for which use of Form SBR-1 is required), and (2) another for medical treatment bills (for which use of a modified CMS-1500 or UB-04 alone is acceptable, OR use Form SBR-1). Commenter opines that having two separate and distinct processes depending upon bill type is cumbersome for payers to administer, and confusing for providers to request.</p> <p>Commenter recommends modifying the regulations to require a consistent</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services April 8, 2013 Written Comment</p>	See response to the comment by the California Chamber of Commerce regarding section 9792.5.5.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>process for requesting Second Bill Review regardless of the type of bill. Treatment bills as well as medical-legal bills should be required to have a completed SBR-1 Form attached to help payers identify a Request for Second Bill Review. The SBR-1 Form must be complete, and have all required data elements populated.</p>			
DWC Form SBR-1	<p>Commenter opines that the rules as proposed do not provide clear instructions to payers as to how to respond in a situation where an incomplete Request for Second Bill Review is received (<i>e.g.</i>, missing data elements, missing documentation, <i>etc.</i>) Commenter states that the rules do not indicate how, if at all, the 90-day timeframe for submission is impacted if an incomplete Request is received.</p> <p>Commenter recommends that the Division: (1) Modify the regulations to clearly define what obligations, if any, a payer has to respond to an incomplete Request for Second Bill Review, (2) modify the regulations to clearly indicate that a provider is under an affirmative duty to submit all information necessary to render a</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Labor Code section 4603.2(e) is silent on the options claims administrator have if a provider submits an incomplete SBR and the Division. Although a claims administrator can issue a written determination rejecting the SBR, there is nothing that prohibits the claims administrator from requesting additional information. A provision should be added that would allow claims administrator to respond to a non-compliant SBR but not be held to the rigid 14-day timeframe.</p>	<p>Amend section 9792.5.5 to provide a new subdivision (f) allowing claims administrators to respond to non-compliant SBRs.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Second Bill Review decision (including population of all required fields on the form and/or modified CMS-1500/UB-04, as appropriate), and (3) modify the regulations to state that if a provider submits an incomplete Request for Second Bill Review, the request is deemed null and void and the timeframe for submission is not tolled.</p>			
DWC Form SBR-1	<p>Commenter states that both the emergency regulations and the final rules as proposed do not provide clear instructions to payers or providers as to whether the providers have only one opportunity during the 90-day timeframe to submit a Request for Second Bill Review or multiple opportunities with modified/duplicate requests within the 90-day timeline. [Commenter provides 2 detailed scenarios in her formal comments.]</p> <p>Commenter recommends modifying the regulations to clearly indicate (1) if a provider can submit a bill for Second Bill Review multiple times during the 90-day timeline or if he only has one opportunity to re-submit the bill with additional documentation regardless of the situation, or (2) if a</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>The statute provides guidance. Labor Code section 4603.2(e) does not allow providers the opportunity to submit multiple requests for an SBR within the 90 day timeframe. This can be seen in subdivision (e)(1)(D), which requires providers to include in their request "additional information provided in response to a request in the first explanation of review...." This provision would have been expanded by the Legislature to indicate the possibility of additional reviews if more than two bill reviews were intended. Additional regulations are not necessary.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>provider can resubmit ONLY in certain circumstances, define what those circumstances are, (3) outline what, if any, duty a payer has to notify a provider of a faulty Request for Second Bill Review, and finally (4) clearly outline how a payer is to proceed if requests for Second Bill Review are received subsequent to the issuance of the Final EOR Determination.</p>			
<p>DWC Form SBR-1; Paragraph 7 of Instructions</p>	<p>Commenter would like to know if the physician actually has to sign this form, or if his/her representative can on his behalf. This is a question that has been asked by the commenter's clients. Commenter inquires what if the provider is a hospital or a medical clinic? Commenter states that most physicians' billing and collection is done by a front-end office or administrative staff. Hospitals have patient billing/financial services departments that manage bills, and in many cases, will have other organizations manage the formal second bill review process because the time-frame to contest the second review is only 30 days.</p>	<p>Alice Branch Hearing Representative Law Offices of T. Mae Yoshida April 5, 2013 Written Comment</p>	<p>The definition of "provider" in section 9792.5.4(i) has been amended to allow a billing agent to submit requests for SBR and IBR on behalf of the provider.</p>	<p>No action necessary.</p>
<p>DWC Form SBR-I</p>	<p>Commenter submitted a revised version of the proposed form [Copy</p>	<p>Brenda Ramirez Claims &amp; Medical</p>	<p>Agree in part. The SBR form should be clarified as</p>	<p>Amend DWC Form SBR-1 to: (1) delete</p>

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	<p>available upon request]. The recommended changes are summarized as follows:</p> <ul style="list-style-type: none"> <li>• <i>Some fields are reordered into a more logical order and spacing</i></li> <li>• <i>Some prompts are abbreviated for brevity and space</i></li> <li>• <i>Some prompts, such as for addresses, are merged for clarity</i></li> <li>• <i>The prompt for authorization status is added to listings of disputed services</i></li> <li>• <i>The signature line clarifies that the provider’s original signature is required</i></li> <li>• <i>The instructions are modified for clarity and accuracy.</i></li> </ul>	<p>Director CWCI April 9, 2013 Written Comment</p>	<p>necessary while still retaining the information necessary to initiate a meaningful second review by the claims administrator.</p>	<p>Social Security Number and move Employer Name to Employee Information section; (2) shorten address prompts; (3) replace “procedure/service/item” with “service/good”; (4) specify provider signature at bottom of form; and (5) clarify language of instructions as necessary.</p>
<p>Explanation of Review (EOR) and Timeframe SBR and/or IBR</p>	<p>Commenter opines that the rules are unclear if the issuance of a subsequent EOR on the part of a payer (whether intentional or inadvertent) would effectively “reset the clock” for compliance with the 90-day timeframe to request Second Bill Review or the 30-day timeframe to file an</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services April 8, 2013 Written Comment</p>	<p>The manner in which a provider requests SBR is set forth in section 9792.5.5. The regulation does not distinguish between the many and varied EORs that a claims administrator may sent to the provider. Over-regulation by</p>	<p>No action necessary.</p>

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	<p>Application for IBR. In other words, if a payer sends a Final EOR Determination on Jan 1st, and then sends another EOR in response to a subsequent billing statement on February 1st, would the provider then be entitled to argue that the 30-day period to apply for IBR begins afresh on February 1st, upon receipt of the subsequent EOR?</p> <p>Commenter requests that the regulations be modified to indicate that the 90-day timeframe request Second Bill Review and the 30-day timeframe to request Independent Bill Review start running upon issuance of the Initial EOR and Final EOR, respectively. Commenter opines that the regulations should indicate that the issuance of any subsequent EOR will not toll the timelines.</p>		the Division in this area is not necessary.	
General	Commenter opines that he legislature did a terrible job when inserting SBR language into SB 863. Commenter opines that there is a need to fill in the gaps that the legislature left when considering that the objective of SB 863 was to reduce litigation.	Carl Brakensiek California Society of Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment	The Division believes the proposed SBR and IBR regulations effectively implement the mandates of SB 863.	No action necessary.
General Comment 9792.5.4(i)	Commenter notes that the proposed SBR and IBR rules state that a	Kevin C. Tribout Executive Director of	See response to comment by Stone River Pharmacy	No action necessary.

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	<p>"provider" may request SBR or IBR. Consistent with the IAIABC model eBilling rule, DWC's Medical Billing and Payment Guide and Electronic Medical Billing and Payment Companion Guide both define and recognize the existence of "billing agents" and "assignees." Commenter states that the definition proposed for "provider" in the SBR and IBR rules does not specifically include these entities.</p> <p>Commenter opines that it is important to note that "billing agents" often, by definition, act on a provider's behalf to bill, seek reimbursement and communicate with a claims administrator in relation to bill processing. If they are not afforded the right to seek SBR or IBR, the rendering provider his/herself may be forced to do so despite the fact that their original bill processing was completely handled by their agent acting on their behalf.</p> <p>Commenter notes that "assignees" often 'purchase' the right to reimbursement from the actual rendering provider at face value or a</p>	<p>Government Affairs PMSI March 19, 2013 Written Comment</p>	<p>Solutions regarding this section.</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>contracted rate and subsequently submit a compliant bill to the claims administrator for reimbursement. Under the "assignee" definition, the assignee is "authorized by law to collect payment from the responsible payer." Commenter opines that in this scenario, it is the assignee and not the original rendering provider whose bill would have been adjusted or denied. At that point, the rendering provider would have no interest in the assignee's dilemma (short payment or lack of payment from the claims administrator) and would never avail his/herself of the SBR or IBR processes.</p> <p>Commenter strongly recommends that the Division specifically permit in the rules the ability of a billing agent or assignee to avail themselves of the SBR and IBR processes. This could be accomplished either by adding", billing agent or assignee" after "provider" where noted in the SBR and IBR rules, or by including billing agents and assignees in the definition of "provider" in proposed Section 9792.5.4(i) of the rules.</p>			
General Comment	Commenter opines that the	Barbara Hewitt Jones	The provisions of Labor Code	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Administrative Director does not have the authority to resolve payment disputes under contract arrangements and also believes that the Workers Compensation Appeals Board has no authority over contracts.</p> <p>Commenter cites the following:</p> <p>LC 5307.11 gives authority to independently contract.</p> <p>LC 5304 The appeals board has jurisdiction over any controversy relating to or arising out of Sections 4600 to 4605 inclusive, unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment as such treatment is described in those sections has been made between the persons or institutions rendering such treatment and the employer or insurer.</p> <p>Commenter opines that an acceptable use of the Independent Bill Review (IBR) would be when the contract refers to the Official Medical Fee Schedule (OMFS) for determining payment of claims for Workers' Compensation when both parties agree</p>	<p>Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>section 4603.2(e) and 4603.6 do not exclude Labor Code section 5307.11 contracts from the IBR dispute resolution procedures. In fact, the provisions of Labor Code sections 4603.6 and 5304 align since both remove jurisdiction from the WCAB to decide the amount of payment for medical treatment. Note Labor Code section 4603.2(f), which removes WCAB jurisdiction over billing disputes subject to SBR. See also the limited grounds for the appeal of an IMR determination in Labor Code section 4603.2(f), and subdivision (g) of that section, which provides in pertinent part "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."</p>	

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	to an IBR.			
General Comment	<p>Commenter requests that the final draft of the regulations contain provisions that any contractual disputes (e.g. PPO or specialty network arrangements) are handled outside of the IBR process – either at the WCAB or via civil litigation.</p>	<p>Steve Kline General Counsel EK Health Services April 3, 2013 Written Comment</p>	<p>Disagree. See above response to comment by Tenet regarding this issue.</p>	<p>No action necessary.</p>
General Comment	<p>Commenter opines that the proposed regulations should also include provisions requiring that Maximus reviewers have the training and experience necessary to review California workers' compensation bills.</p> <p>Commenter notes that the opinion of Independent Bill Reviewers opinion will be presumptively correct, but the proposed rules do not include requirements for prior experience in the qualifications that candidates must have. Commenter strongly suggests that, at a minimum, prior to beginning their duties, such reviewers be required to achieve the certification provided in Insurance Code Section 2592 required for workers' compensation bill reviewers. Since the Independent Bill Reviewers will be reviewing the work of reviewers</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association April 9, 2013 Written Comment</p>	<p>The requirement is statutory. See Labor Code section 139.5(d)(3)(C). Regulation in this area is not necessary.</p>	<p>No action necessary.</p>

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	<p>who comply with this requirement, the commenter anticipates seeing more stringent employment qualifications and certifications as the program develops.</p>			
General Comment	<p>Commenter would like to know if there is a case where a UR is not timely, what does that trigger? Does one have to start secondary bill review when they receive an EOR stating UR denied the service? Commenter states that if the UR is untimely, then It cannot be subject to IMR, so what happens? Does the provider wait until the case in chief resolves and then the provider can file a DOR?</p> <p>Commenter opines that the DWC has a duty to address various scenarios as they are more common than uncommon in the day to day business of treating injured workers.</p>	<p>William J. Heaney III April 9, 2013 Written Comment</p>	<p>The comment is not relevant to the IBR process. That said, The consequences of an untimely UR decision by a claims administrator has been addressed by the California Supreme Court in State Compensation Insurance Fund v. WCAB (Sandhagen) (2008) 44 Cal.4th 230. Since Labor Code section 4610 is silent as to the effect of an untimely decision, the Division believes that determinations regarding this issue are best left to the Legislature or the judicial process.</p>	<p>No action necessary.</p>
General Comment	<p>Commenter opines that these regulations effectively eliminate the physician's ability to collect from the judicial system. Commenter state that when a party provides services for another party without them having to pay for it, it is unjust enrichment. Commenter states that in this type of breach of contract action, the plaintiff</p>	<p>Jonathan Roven April 9, 2013 Oral Comment</p>	<p>The SBR and IBR dispute resolution procedures are mandated by statute. Labor Code sections 4603.2(e) and 4603.6. The goal of these procedures is to have medical billing disputes be decided by medical billing experts in an expeditious manner rather than</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>is usually able to take a defendant to court to try and get reimbursed for the reasonable value of their services. Commenter notes that the lien and Declaration or Readiness to Proceed System helps doctor and medical providers in use the quasi-judicial workers' compensation court system to get paid for reasonable value. Commenter notes that the normal statute of limitations for a breach of written contract action in California is four years from the date of the breach. Commenter notes that the new IBR regulations are reducing that amount of time to 90 days.</p> <p>Commenter states that insurance companies are currently recommending zero allowance for thousands of dollars in services provided by medical providers. It is the commenter's understanding that if these providers don't file the requisite documents within the 90 day period that the Explanation of Benefits is deemed to be satisfied. Commenter notes that this grants insurance companies thousands of dollars of services for free.</p>		<p>having such decisions be in the hands of judges who may not be familiar with the correct billing standards and rules.</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter opines that complying with these extremely limited time statute is onerous, costly, and goes against the public policy of allowing a plaintiff to go after the reasonable value of their services within a reasonable time frame.</p>			
<p>General Comment – Fines for non-payment</p>	<p>Commenter notes that the one issue that has stood out the most after attending various meetings and hearings are the number of providers - medical providers, interpreters or copy services who claim that they do not get paid for their services. Commenter notes that they submit bills and they may get substantially less than they amount billed or nothing at all. Commenter questions when it became acceptable for insurance companies not to pay providers.</p> <p>Commenter opines that the problem is that we are currently in a system where the insurance company refuses to pay any bills and deliberately waits until the case ends up in court and offers half of the amount owed.</p> <p>Commenter opines that the division has a responsibility to help end this.</p>	<p>Mark Gerlach California Applicants' Attorneys Association April 9, 2013 Oral Comment</p>	<p>The Division agrees that a pattern and practice of underpayment of bills by claim administrators should be subject to addition penalties. However, the Division has not been given statutory authority to assess penalties for billing practices outside of the administrative and civil penalties authorized in Labor Code section 129 and 129.5.</p>	<p>No action necessary.</p>

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	<p>Commenter notes that the language in section 9792.5.12(c)(3) states:</p> <p>“Upon showing of good cause and after consultation with the Administrative Director, the IBRO may allow the consolidation of requests or independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes.”</p> <p>Commenter opines that if this is the remedy for a pattern and practice of underpayment of bills that the Division needs to do something more about it. At the public hearing commenter produced examples of letters from the Department of Managed Health Care issuing fines to providers for late payment of bills in the amount of \$350,000 and up. [Copies of those letters are available upon request.]</p>			
General Comments	<p>Commenter requests that the Division disclose copies of all IRB decisions. Commenter suggests that in order to protect the anonymity of the reviewers and the confidentiality of the patients and providers, she suggests that they</p>	<p>Michelle Rubalcava California Medical Association April 9, 2013 Oral Comment</p>	<p>The Division intends to post redacted IBR determination on its website to educate the community about appropriate billing practices in workers’ compensation. As to the</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>not be identified.</p> <p>Commenter urges the Division to consider including a preference for contracting with California owned and operated copies to provide IBR services. Commenter opines that California based providers and companies are in the best position to provide the most relevant experience and analysis in the adjudication of payment disputes.</p>		<p>second comment, although an IBRO must certainly be familiar with billing practices in the California workers' compensation system, there is no statutory requirement in Labor Code section 139.5 that the IBRO be California owned and operated.</p>	
IBR and e-Billing	<p>In his correspondence, commenter outlines many difficulties that providers are experiencing navigating the e-billing process. Difficulties encountered include:</p> <ul style="list-style-type: none"> <li>• Clearinghouse claim number matching errors prevent bills for accepted claims from reaching carriers.</li> <li>• Bills are submitted with all appropriate supporting documentation, but clearinghouses are failing to properly forward the submitted documentation.</li> <li>• Clearinghouses are rejecting bill by imposing carrier-specific edit for information</li> </ul>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Written Comment</p> <p>April 9, 2013 Oral Comment</p>	<p>Commenter provides a list of perceived difficulties with the e-billing process, all of which allege non-compliance of system participants with the existing ebilling rules. Commenter does not make suggestions directed at the regulatory proposal that is pending in this comment period.</p>	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>that is not mandated by the division.</p> <ul style="list-style-type: none"> <li>• Bills are not being responded to within the 15 day working day time limits as required by the regulations.</li> <li>• Clearinghouses are not accepting electronic submission of properly revised bills.</li> <li>• Despite the mandated date of October 18, 2012, many carriers are not accepting electronically submitted bills which forces providers to submit bills via paper.</li> <li>• The vast majority of carriers are not sending electronic EORs (the"835").</li> </ul> <p>Commenter stresses that in order for IBR to work and be available, that the problems with e-billing must be addressed.</p>			
IBR Response – general comment	Commenter states that although forms have been proposed by the WCAB to ensure that consistent information is received from a provider when invoking the IBR process, no comparable form for a reply on the part of the carrier/payer is included.	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services April 8, 2013	The Division believes that prescribing a specific form for a response by a claims administrator to an IBR request would be over-regulation. It is noted that section 9792.5.9(b)(3) has	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Furthermore there is no formal mechanism for carrier response to IBR inquiries within the defined process flow.</p> <p>Commenter recommends that inclusion of a standardized form for carriers/payers to respond to IBR requests.</p>	<p>Written Comment April 9, 2013 Oral Comment</p>	<p>been amended to allow the claims administrator to submit any documents disputing the provider's reason for requesting IBR.</p>	
<p>IBRO Contract interpretation</p>	<p>Commenter is concerned about IBROs interpreting MPN contracts.</p> <p>Commenter questions what happens when there are multiple contracts, there is no contract and or the contract is silent on the billing in dispute.</p>	<p>Steve Cattolica Director of Government Relations AdovCal April 9, 2013 Oral Comment</p> <p>Carl Brakensiek California Society of Industrial Medicine and Surgery (CSIMS) April 9, 2013 Oral Comment</p>	<p>See the above response to comments by AdvoCal in regard to section 9792.5.7(d)(2)(c). It would be impossible for the Division, by regulation, to address every factual permutation that may exist. As noted above, issues regarding whether or not a contract applies to the parties must be resolved before IBR can occur. Labor Code section 4603.6(a). If the parties agree they are bound by the contract's terms, a copy of the rate in dispute should be provided for review. Meaningful communication between a provider and the claims administrator, rather than over-regulation, would be the best manner in which to</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
			resolve these questions.	
IMR & IBR Connection	<p>Commenter cites the following section from the IMR regulations:</p> <p>9792.10.6(a) The independent medical review process may be terminated at any time upon notice by the claims administrator to the independent review organization.</p> <p>Commenter questions how does a terminated IMR link into the payment process? If the IMR has been withdrawn, presumably the IMR is not under dispute and the claim payment will be processed.</p> <p>Commenter would like to know how the Administrative Director proposes to resolve disputes over down-coding, bundling or unbundling of claims where presumably a review of the medical procedure and billed claim may be under dispute.</p>	<p>Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment</p>	<p>If a request for independent medical review has been terminated under section 9792.10.6, it may be that either the requested treatment has been authorized (and subject to payment when rendered) or the injured worker has accepted the UR decision denying or modifying the treatment request. If a claims administrator has contested liability for any issue other than the reasonable amount payable for services, the issue must be resolved prior to the time IBR is initiated. Labor Code section 4603.2(a). Disputes regarding medical treatment should be resolved through the IMR process on Labor Code section 4610.5 before IBR is initiated</p>	No action necessary.
Labor Code section 4603.2(b)(2)	<p>Commenter notes that this section of the labor code prescribes the process and timelines for employer payments to a provider that serves as the first step in any IBR process. Prior to SB 863, employers were required to make</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition</p>	<p>Labor Code section 4603.2(b)(2) expressly provides in pertinent part that “payment shall be made by the employer with an explanation of review pursuant to Section</p>	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>payments within 45 days after receipt of an itemization of services from the provider along with other required reports and authorizations. SB 863 did not alter this timeline, but it added an additional requirement: employers must also submit an explanation of review (EOR) to providers within 45 days. Specifically, LC § 4603.2(b)(2) states:</p> <p>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.</p> <p>Commenter opine that the term “with” is problematic for employers and we urge the DWC to clarify. This term seemingly requires that both the payment and EOR be submitted together and/or received contemporaneously by the provider. As a practical matter, payments and EORs are generally not produced or sent from the same location. EORs are</p>	<p>on Workers’ Compensation April 9, 2013 Written Comment</p> <p>April 9, 2013 Oral Comment</p>	<p>4603.3 within 45 days after receipt of each [complete medical bill].” The plain meaning of the statute is clear and reflects the intention of the Legislature that the payment and the EOR be sent together.</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>often created and sent from where the claim is handled while payments are issued from a centralized payment center. Commenter opines that this new requirement creates a logistical burden which may result in increased cost through payment and/or audit penalties.</p> <p>Commenter opines that sending both the payment and EOR together is not the intent of the statute and would lead to illogical outcomes. For example, an employer who issues payment with the EOR on day 44 would be in compliance with LC § 4603.2(b)(2) but an employer who issues payment on day 11 and submits the EOR on day 14 would not be in compliance despite the provider having received both the payment and EOR a month earlier. Commenter states that the purpose of this statute is to ensure that the provider receives both items within 45 days; it is not to ensure that both items arrive on the same day. Commenter requests that the DWC clarify, pursuant to its authority under Government Code § 11342.600, that employers meet the statute's timing requirement as long as both the</p>			

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	payment and the EOR are submitted within 45 days regardless of whether they are submitted together.			
Medical Billing & Payment Guide and DWC Form RFA - General Comment	<p>Commenter is concerned about the requirement in Section 3.0 of the Medical Billing Guide, related to complete billing packages. Commenter opines that the requirement to submit any evidence of authorization and the referral or prescription information with the billing is burdensome and duplicative. The Request for Authorization form (RFA) is the established process, however, approval information may not be available to be used at the time of billing. Since this information is already available to the payor who granted the authorization, why ask the provider to supply again?</p> <p>Commenter opines that because this is in the section with other forms and documentation, it seems to suggest that an image of some evidence of authorization has to be sent? Commenter recommends that the Division simply require the payor to provide an authorization number in the RFA process and then allow for the authorization number to be provided</p>	<p>Gregory M. Gilbert SVP Reimbursement &amp; Government Relations Concentra April 8, 2013 Written Comment</p>	<p>The requirement is statutory. See Labor Code section 4603.2(b)(2).</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>by the provider, if needed, on the HCFA in box locater 23 instead of requiring some type of scanned document.</p> <p>Commenter opines that the same logic should be used regarding the prescription or referral information since the approval to treat has already been granted with the RFA process? Again, this data could be covered by just having the provider use box locater 23 for an authorization number. Also, since referring provider is required to be supplied in the HCFA, why would that not be sufficient for this requirement?</p>			
Medical Billing & Payment Guide and Lien Filing Regulations – General Comment	<p>Commenter states that prior to implementation of SB863, certain 3rd party lien claimant billing organizations would purchase aged balance billing receivables (or “write-off”s) from providers, and reassert claims to payment from payers, often many years after the files had been closed, leaving defendants ill-equipped to defend said claims. Many of these claims were then filed as liens before the WCAB, contributing to a surge of lien claims and a back-log of lien proceedings.</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Labor Code section 4603.2 does not contain a deadline by which providers are to submit their medical bills to claims administrators for payment. The Division would be exceeding its statutory authority if it were, by regulation, to impose such a deadline. It must again be noted that IBR is only to resolve disputes over the amount of payment on a bill. Other disputes regarding</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>In an effort to reign in this practice, SB863 passed timely filing rules for lien eligibility, providing only 3 years from a date of service to assert a lien for dates of service on/after 1-1-2013, starting 1-1-2013, and only 18 months to assert a lien for dates of service on/after 7-1-2013. Commenter states that this provision successfully prevents aged lien claims from being re-asserted long after-the-fact.</p> <p>Commenter opines that a new loophole has now been potentially opened, seeing as jurisdiction for IBR attaches after issuance of an EOR. Commenter states that although any type of billing dispute that is subject to a lien is restricted to 3 years/18 months from the date of service respectively to initiate a dispute, theoretically, any dispute that would fall within the parlay of IBR would have no such time constraint, potentially exposing defendants once again to aged bills, as defendants are still subject to the 30/35-day rule to respond to billing statements with an EOR, without regard to the date of service provided.</p>		<p>liability, such as whether the submission of a bill was untimely, must be resolved prior the initiation of the IBR procedure. Labor Code section 4603.6(a).</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter recommends revising the regulations to create parity between the lien filing regulations and the Medical Billing and Payment Guide, Version 1.1, such that a provider is given 18 months (starting 7-1-2013) to submit and send his initial billing statement to the carrier, and if submitted after that timely filing deadline, the carrier/payer may then deny the services as they would then be deemed “satisfied in full” as an operation of law. Commenter opines that the addition of this language would also create consistency with the other provisions contained within SB863 that deem bills to be “paid in full” after prescribed timelines have been exceeded.</p>			
New Evidence during IBR and/or SBR	<p>Commenter opines that when applying for IBR, if a provider has the ability to submit additional evidence/documentation directly to the AD and IBRO reviewer to substantiate a bill that was not previously presented to the payer at either first bill submission or when requesting Second Bill Review, the payer is in a compromised position, as the payer did not have benefit of all documentation/evidence at the time he</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services April 8, 2013 Written Comment April 9, 2013 Oral Comment</p>	<p>Labor Code section 4603.6 expressly authorizes only the initial submission of documents from the provider and any documents that may be requested by the IBR reviewer. See Labor Code section 4603.6(b) and (e), and section 9792.5.10. Under section 9792.5.9(b)(3), claims administrator are allowed to submit any documents</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 45 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>was required to make an Initial and Final EOR Determination. Commenter opines it would then be unfair for the IBRO to make an adverse determination based on said evidence and award IBR fee reimbursement to the provider.</p> <p>Commenter recommends modifying the regulations to indicate that discovery is closed after Second Bill Review is requested, and that the only new additional evidence that is admissible would be any new information <i>requested by the IBRO directly</i>. Alternatively, if the submission of additional documentation after Second Bill Review is permitted, and the carrier did not have access to that information during their initial and second reviews, if an adverse determination is reached by the IBRO in reliance on said new evidence, the carrier would then NOT be responsible for reimbursement of the filing fee.</p>		<p>disputing the provider's reason for requesting IBR. There is no other provision in the regulations that allow for the submission of evidence.</p>	
Payer Bill Review Service – Official Address List	<p>Commenter opines that given the relatively tight response timeframes for Second Bill Review, <i>etc.</i>, once a 3rd-party bill review entity acting on behalf of a payer is identified as a</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation</p>	<p>The claims administrator should forward a copy of any document they deem relevant to those entities they hire to conduct bill review.</p>	<p>No action necessary.</p>

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	party to a case, said entity should be added to the official address list at the AD to ensure receipt of any IBR-related correspondence.	Services April 8, 2013 Written Comment		
Prudent Layperson Standard	<p>Commenter submitted comments under the IMR proposed rule to the effect that recognition of the industry standard for the prudent layperson's use of the emergency department is important to be recognized by the Workers' Compensation Program. Commenter states that the use of the emergency room in non-emergent situations is a recognized occurrence in our medical system. The prudent layperson standard has been adopted in most government and commercial health coverage. Workers' compensation needs to provide for a similar occurrence. This is a situation that should not give rise to an independent medical review but that it needs to be incorporated into coverage provisions. Commenter states that in the situation of a workplace injury, it may be the employer directing the employee to the emergency room to ensure that the employer is prudent in seeking appropriate care for an injured employee or when after hour care is needed.</p>	Barbara Hewitt Jones Regulatory Analyst Tenet April 2, 2013 Written Comment	The industry standard for the prudent layperson's use of the emergency department, while important, is not an issue with direct relevance in the IBR process where only billed amounts in dispute are resolve.	No action necessary.

<b>INDEPENDENT BILL REVIEW</b>	<b>RULEMAKING COMMENTS 45 DAY COMMENT PERIOD</b>	<b>NAME OF PERSON/ AFFILIATION</b>	<b>RESPONSE</b>	<b>ACTION</b>
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