STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

PUBLIC HEARING

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

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PUBLIC HEARING

OAKLAND, CALIFORNIA

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

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

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

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

MS. GRAY: Gray.

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

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

The purpose of our hearing is to receive comments on the proposed amendments to the IBR, Independent Bill Review, and our billing regulations, and we welcome any comments that you may have. All your
comments, both given here today and written, will be considered by the Acting Administrative Director in determining whether to adopt the regulations as written or to change them. Please restrict the comments, the subject of your comments, to the regulations and any suggestions you may have for changing them.

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

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

So, let me go to our list to see who signed in. We'll start from there, and I apologize in advance if I somehow mangle your name. I do have a tendency to do that. Our first speaker today will be Patricia
MS. BROWN: Thank you. My name is Patricia Brown, and I am a Deputy Chief Counsel at State Compensation Insurance Fund. Thank you for your tireless efforts in drafting these thoughtful and thorough regulations. Your successful efforts will play a key role in streamlining the system and building a solid framework to ensure prompt and fair payment of medical bills.

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

Today we offer three recommendations on the proposed regulations.

The first is proposed section 9792.5.9(b)(3) which 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 Administrative Director or her designee within the prescribed time frame.

State Fund recommends clarification of the language 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.

Second, proposed section 9792.12(c)(3) 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.

State Fund recommends that the IBRO not be permitted to make such determinations. We believe it is beyond the scope and expertise of the IBRO. As much as State Fund is in favor of streamlining the process to every extent possible, there are stringent limits governing the submission of documents in the IBR process. In fact, it appears that the proposed regulations allow the claims administrator to submit documents in only two narrow circumstances. The first is the one I just mentioned under section
9792.5.9(b)(3). It appears that the claims administrator is only permitted to submit documents on the issue of eligibility of IBR review. The second is under section 9792.5.10 in which the claims administrator may only submit additional information upon request of the IBRO. That means that the claims administrator would have no meaningful opportunity to be heard or submit evidence on the issue of consolidation. Consolidation attempts can be contentious and fact specific, but more importantly, consolidation may substantially affect the rights of the parties. Decisions regarding whether to consolidate should allow a broad view of the evidence under the domain of judges to give parties a full and fair opportunity to be heard. We agree that consolidation could be a beneficial option if there was a mechanism by which a judge could refer a consolidated case to IBR. If the IBRO may consolidate with multiple requests for IBR, then the party should be permitted to submit additional evidence.

Item 3, proposed section 9792.5.15 allows the provider or carrier to appeal the decision of the IBRO Administrator Director, but the language that required service of the appeal on all parties is stricken.

State Fund recommends that the stricken language 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.

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

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

DAVID ROBIN

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

Our question is really limited to the definition, and specifically on 9792.54(i), which is defining provider. No one in our industry believes that we're a provider and thinks of this as a no brainer, but we know from experience we are payers. We don't provide. And there's a huge difference in that. We in this
industry have no ability to -- to comply with standardized documentation that IBR requires that second billings require. We can't change the forms that come in. We have -- we've always had a different type of proof for proving up a lien, whether it's related, and how it interplays with the OMFS. I've covered this in our documentation that we've given to Ms. Gray, but we really want if, and we believe this to be the truth, if -- what you mean by it, but we know that, if we don't get something, an express clarification that the group health industry who pays claims are not providers for IBR, two things will happen. We're always going to have an argument at the Appeals Board whether we are subject to second review and IBR. If we go into IBR, we can't comply. We'll get bounced out, and we'll be subject to the whims of the workers' compensation claims administrators, whether they choose to pay or not, and, if they don't pay with the time constraints for going up the ladder on IBR, we'll effectively have that right that the health industry has to file a lien on claims that become work related without a remedy because there won't be a -- there won't be any payment on the liens. The other factor will be that those -- those lawyers who represent the health plans, such as I do and my
partner Nancy, will be at the Board all the time arguing this issue when the purpose of this litigation is to streamline and get some of the issues out of the Board. We just can't get away from the Board on this one because we can't comply with those issues. So, we really hope that you can find a way to expressly clarify who a provider is, and that we as a payer in the health industry on non-industrial claims that become workers' compensation liens, are not part of that provider. Thank you.

MR. PARISOTTO: Thank you. Howard Stiskin.

HOWARD STISKIN

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

Per this section, withdrawal requires a joint written request submitted to IBR from the medical provider and the claims administrator. For the sake of efficiency, considering that the medical provider requests IBR, we propose that the medical provider should be able to withdraw from IBR independently with
simply a copy to the claims administrator. Otherwise there would be an increased burden on the claims administrator regarding coordination of this joint letter which is not required by statute.

Thank you for this opportunity.

MR. PARISOTTO: Thank you. Brian Allen.

BRIAN ALLEN

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

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

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

In section 9792.5.6 the -- where you outline what
the SBR-1 form looks like, there isn't anything that
talks about how that should be signed or could be signed. It sounds almost like the way the rule is written that you want a handwritten signature on each of those forms. We recommend some allowance for being able to digitally reproduce a name or a signature or something on that form so that you can somewhat automate a very manual process.

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

And then in section 9792.5.12 regarding the consolidation or separation of requests, you established a $50 threshold per bill. Again we think
that's a little bit of a small number if you really want to encourage consolidation to help expedite things. And I note what the State Fund said, and I suspect that there's something that can be done in rule making to address their concerns and address ours, but we think that the consolidation is an effective tool and it could be used to help handle some of these smaller disputes, but we'd certainly like to see that threshold raised to maybe like $200 to make it more realistic and more, I think, adequate reflect some of the smaller amounts that are in dispute. It's pretty rare we get bills that are under $50 or a payment amounts that are $50 off that we're disputing. So, that would be our one recommendation. And I think just in general, as a final note, there's -- you're making a lot of changes to the Electronic Billing Companion Guide to conform to these rules and requirements, and we just want to note that the more that changes, the further adrift you're getting from the national standards that are being established by IAIABC and other standards organizations. We'd just give you a note of warning about that. We'd hate to see California become an anomaly in the world. And I think two good examples are the requirement of a prescription to be submitted with copies of this
documentation which we hope is going to get fixed with SB 146. But additionally I think there's a requirement on -- to send copies of request for authorization, which should already be in files somewhere because they were generated by the payers. So it doesn't make sense for a provider to send something that was generated by the other side. But just those kinds of things I think as you go through these rules and you look at how that relates to the Electronic Billing Guides. If you could harmonize those, that would be great.

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

MR. PARISOTTO: Thank you. Michelle Rubalcava.

MICHELLE RUBALCAVA

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

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

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

In addition, the proposed regulations state the IBR only may allow for the consolidation of requests for Independent Bill Review by a single provider showing a possible pattern and practice of underpayment by the claims administrator for specific billing codes. In the regulations it's not evident how you are going to be defining possible pattern and practice of underpayment. CMA would ask for a better definition or perhaps more specificity on this point.
Also, we would like to see additional clarity on how payment and interest will eventually be distributed to the provider if and when the IBRO finds in favor of the provider.

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

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

That's it. Thank you for your time.

MR. PARISOTTO: Thank you. Steve Cattolica.

STEVE CATTOLICA

MR. CATTOLICA: Good morning. My name is Steve Cattolica. I represent the California Society of Industrial Medicine and Surgery, the California Society of Physical Medicine and Rehabilitation, and the California Neurology Society. We will provide
actually a number of written comments, but I wanted to
draw your attention to three issues that we think are
among many but nonetheless are very important. First
of all, we understand the legislative intent was that
Independent Bill Review essentially check and decide
issues where the dollar amount is at issue. Now
there's certainly lots and lots of different ways that
that can happen, but our interpretation of the intent
and having been in discussions about this concept for
a number of years prior to this, is that it's a fee
checker. If the MAT said one thing and the bill said
another and the reimburer a third, somebody does that
checking and the decision is made. To broaden the
scope of what IBR is actually going to end up
deciding, is to put the IBRO in a position where they
have no authority nor expertise. One of the issues,
which may sound a little off track, but I want to go
down the road simply because it's going to be
extremely critical, is the decision of whether or not
a contract applies. Contracted -- excuse me. Due to
the proliferation -- is that the right word,
proliferation of leased PPO networks combined with
arm-length relationships between bill review software
vendors and claims administrators and the actual
payer, sometimes the existence of a contract may be in
dispute, the existence of the contract. IBR does not have the legal jurisdiction or the infrastructure to decide these issues. With respect to PPO or MPN provider contracts, new Labor Code 4616(a)(3) provides that all MPN physicians must by January 1st of 2014 affirmatively elect to be a member of the MPN. This would seem to provide a positive documentation of a contract relationship and help with the aforementioned contract problem, but it won't. The manner and process that networks will use to collect these affirmative elections is critical. While we support this initiative, compliance with this statute may become a classic example of be careful of what you ask for. There are roughly seventeen hundred MPNs certified by the DWC. Most have hundreds, if not thousands, of physicians, thousands of physicians, and except for networks custom built by primary -- by -- primarily by self-insured providers, these MPNs are based on PPO contracts for a relatively small number of large networks that have been in business for a long time much prior before -- prior to when MPNs were in existence. We have firsthand knowledge that one of the largest network plans to send its providers one single blanket acknowledgment letter meant to meet the Labor Code 4616(a)(3) requirement. A provider signing

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

We respectfully request that the Division immediately take an active role in guiding MPNs and their parent PPOs through this huge administrative project that must be accomplished by the end of this year. The intent of SB 863 in this regard was to provide physicians with a means to acknowledge participation in MPNs to which they are admitted.
Blanket, non-specific letters from large PPOs do not meet that intent, and, as mentioned above, will likely compound reimbursement issues based on contracts or the lack of.

The second issue I'd like to raise has to do with section 9792.5.11 where there's a process for the provider and the payer to withdraw from the process. And our basic question is, under what circumstances does the Division actually expect this to take place? We understand that the IBR -- IBRO may be due a processing fee if a request is withdrawn. They've done a little bit of work; they should get paid for that. We suggest the same $65 that's retained when a request is found to be ineligible under 9792.5.7(e). Why does this particular subdivision, point 11, require more than that? At the point when a request is found ineligible, the same documentation has been submitted and reviewed by the IBRO. No more work is performed when that request is withdrawn. This appears to be unnecessarily punitive, especially when the provider and the payer has settled the dispute. Where is the incentive for a provider to settle if they lose the entire $335 simply because they've settled the dispute with the payer? Of course, the payer doesn't pay anything.
Lastly, but not in our written comments, but here, under 9792.5.12(b)(3) subdivision points out one of the most critical benefits of IBR from our perspective, and one we urge the Division to take seriously. 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 have been extremely limited. We know of a few and they've been effective, and we applaud the process when it works. But far fewer than have likely occurred so far. This is particularly true when med-legal evaluations are reviewed improperly. We trust that there will be no immunity for misconduct, audit, or other penalties by simply participating in the IBR process. If as a result of IBR, a claims administrator is found to have systematically under reimbursed providers, we would expect a swift target audit would result, and the additional penalties and fees would be assessed. As mentioned before, there's little incentive in the IBR process for claims administrators to stop the kind of mischief that they've practiced in the reimbursement process. The financial burden falls totally on the provider who, when the process is over, under section point 15 has
very little practical resource and no effective alternative. The Department of Industrial Relations has rightfully prided itself on coordination of effort among its operating departments with the goal of slowing the underground economy. Providing data from one department to another is the cornerstone of that effort. We see IBR as a similar opportunity. We again urge the Division to implement steps to take advantage of the finding that IBR may provide, and that goes, of course, both ways, to the provider community as well.

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

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

JONATHAN NG, M.D.

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

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

MR. PARISOTTO: Thank you. Lisa Anne Forsythe.

LISA ANNE FORSYTHE

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

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

She had mentioned use, perhaps, of the 15-day objection period for assignment to the IBRO as the possibility for us to be able to supply a substantive comment or substantive response. We'd even suggest
that perhaps a standardized response form might make sense to keep in the idea of it being mechanized and consistent.

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

Thirdly, we've had a lot of internal discussions about what we as a payer should do if a second bill review request comes to us that's incomplete, inadequate, doesn't have enough documentation, etc.
We're wondering what we as a payer are supposed to do with that. Is there some sort of a duty for us to say, hey, you gave us something that doesn't cut it or -- and then what happens if we do that, and then they respond back, is that a third request for second bill review or what is that? You know, if there are multiple requests that occurred during that 90-day time frame, what is that? Do we say it comes in once, you get one bite at the apple, that's it, your remedy is IBR, or what is that? We would love the regs to be a little bit tighter with that, so we have clear direction on how to respond to that. Because a lot of times we get reduce, reuse, recycle, over and over and over during that time period.

Thirdly -- or I guess fourthly, the handwritten exception on the second bill review for on the -- on the alternate CMS-1500 and the UB-04, really, that's not a good one. Our feeling is that the whole -- one of the major points behind the medical billing and payment guide was to establish typewritten, consistent, clear forms being sent to us as a payer so allowing those fields to be populated in a handwritten manner flies in the face of, I believe, what was trying to be accomplished in that guide, Version 1.0, and furthermore, for us as a payer, since we're trying
to expedite payments in an automated fashion, that would require us to stop the bill, look at it manually, blah blah blah, and it would really undermine, I think, part of what we were trying to do with this entire process. So we have much more extensive comments that I'll provide in a written basis, but those are our highlights. Thank you.

MR. PARISOTTO: Thank you. Carl Brakensiek.

CARL BRAKENSIEK


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

First of all, in my opinion, the legislature did a terrible job when they put this IBR language into SB 863. It was not well thought out. And I want to commend you for your yeoman efforts in putting together these regulations and trying to -- to fill in the gaps that the legislature left. The objective, as we understand IBR, was to reduce litigation, was to see that providers are paid in a more timely manner without taking up the time of judges and causing
unnecessary delays. Unfortunately, I think there's more that needs to be done, and we would urge that, as you take another look at these regulations, that perhaps you could expand on them further to provide more guidance to the payer and provider community as to what happens under particular circumstances. For example, in your instructions for requesting Independent Bill Review, you indicate that IBR will not determine a reasonable fee for services that -- for that category of services that are not covered by a fee schedule. The question becomes what about the many procedure codes that we have that are coded by a report. Those services are under the fee schedule, but they're by report. So the question is will the Independent Bill Review Organization determine whether the charge for an IBR by report code was appropriate or is that open. And if it's not covered by IBR, how is that billing to be resolved? What -- What if the dispute, for example, is the amount of time a physician, a treating physician, spent in reviewing medical records? The doctor bills for 45 minutes of bill review, of records review, and the payor says, well, we think you could have reviewed those records in 30 minutes, not 45 minutes. How do you resolve that dispute? Is that covered by Independent Bill
Review or is there some other dispute resolution process for that issue? And if so, I would urge your regulations to clarify which track needs to be taken. What about a situation in which the payer paid the doctor's bill in full, but it was late? So you've got a situation in which there may be penalties and interest to be resolved. If the only issue is the payment of penalties and interest, does that come under Independent Bill Review or does that resolve in some other situation -- some other process? What do you do in a situation in which the payer completely ignores the provider's bill? The provider sends in the bill and nothing happens. There's no EOB or no EOR. They just don't pay the bill. How does that situation get resolved? You also indicate in your instructions that IBR will not determine the appropriate reimbursement -- or just resolve issues of the use of analogous codes. If they don't cover analogous codes, how do you get that issue resolved? What is the process in that case? There's a number of questions that we urge that -- that you address. One of the big areas of concern we have is that your regulations appear to permit the Independent Bill Review Organization to interpret contracts between doctors, and Steve touched on this with the MPN.
contracts, but I have some very grave due process
concerns with Independent Bill Review companies
interpreting contracts. As Steve pointed out, what if
there's a dispute as to whether or not there's a
contract at all? How does that get resolved? But
assuming there is a contract, the term says that the
Independent Bill Review company will, "Apply the terms
of the contract." But what if you disagree as to the
meaning of those terms? What if the payer says, well,
this is what we meant in this contract, and the payer
said, no, when I signed it, I thought this is what you
meant. How does that issue get resolved? What if a
particular issue, a billing dispute, which is
supposedly -- there is a contract in place, but the
contract itself is silent, how do you resolve that
issue when the contract is silent? We don't know.

Over on page -- on Regulation 9792.5.15, I would
like to just suggest for purposes of clarification,
that in subdivision (a), which indicates when there
has been a ruling of the AD, that additional amounts
are payable, that regulation directs the payer to make
those payments. I would urge that you add a clause to
that to say that "and the payer shall reimburse the
provider for any IBR fees paid pursuant to section
9792.5.14(b)." I know you cover that in that
regulation but for clarity purposes, if you could make it clear that the provider is entitled to a reimbursement for the fee, that would be appropriate. On that same page, in 9792.5.15, in subdivision -- it would be (c), sub (1), this is the information which is to be submitted over which -- the process after there's been an overturning of the AD's initial Independent Bill Review decision. It says, they shall submit the dispute to Independent Medical Review by a different IBRO, if available. I would suggest that the word "Medical" in there should be "Bill". It may be a typographical error that you'd like to address. And the question is when -- when you do submit the bill to a second round of IBR, does the payer have to pay the filing fee again or is that all included in the first filing fee that they paid?

In Dr. Ng's testimony a few minutes ago, he requested an amendment to the Medical-Legal Fee Schedule regarding supplemental evaluations. I would also like to request, since you are making changes to the Medical-Legal Fee Schedule, that you also make a very tiny change in the definition of ML-103 complexity code number 5. Right now, you get 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.

There is -- has been an interpretation by the Medical Unit that in order to get those three credits, you must spend some time on all three of those -- those elements. And having been involved in the creation of the Medical-Legal Fee Schedule, that certainly was not the intent that the Industrial Medical Council made in its recommendation to the Administrative Director. It basically, in order to get the three credits, you can have six hours total time in any of those -- those three categories, but you don't have to do all three. Because, for example, you could have a situation where you have one hour of face-to-face time with the patient and five and a half hours of records review. If that's all you have, you would only get two credits, and not three credits, even though the physician spent more than six hours in this case. So what that, in effect, does is to require them to do research. Five minutes of medical research would then give them the third point, and that doesn't make any sense. So we're suggesting that you just delete the word "three" in that particular definition so that any combination of one through three in ML-103 would give them the three credits. That makes it much easier, and it would prevent unnecessary gaming of the system.
Finally, my last point is just to comment on the amount of the IBR fee, the $335. It appears from the language of the statute that IBR is a fairly mechanical process. Did the provider properly bill pursuant to the established fee schedule? And most of the time, that can be done by just matching up the code that was billed and what the fee schedule says. It's a computer process. Most of the time, it can be done entirely by computer. It doesn't even really need human intervention, and we would postulate that, given that, it's a process that can be done in a very short amount of time, that $335 is an extraordinarily high fee to be paid for such a small amount of actual work. And we would urge that you reconsider, particularly since many bills, the total bills, are substantially less than the $335. Thank you very much.

MR. PARISOTTO: Thank you. Mark Gerlach.

MARK GERLACH

MR. GERLACH: Thank you. The name is Mark Gerlach, it's with a "k", G-e-r-l-a-c-h, and I'm representing the California Applicants' Attorneys Association.

We are, I fervently hope, coming to the end of a long series of meetings that the Division has held
with many of us in the audience here today. It's been
a rather extraordinary series of meetings. One of the
things that has stood out the most to me is the number
of providers, be they medical providers, interpreters,
copy services, who have come before you and said they
just don't get paid. They submit their bills, they
submit a bill for $150, they may get $50, they may get
$25, or it may get ignored. The question that I have,
a rhetorical question at this point since you're not
responding, when did it become acceptable for
insurance companies not to pay providers? Look at it
on the other way. Those providers probably have a
workers' compensation insurance policy. Can they tell
the insurance company, oh, you gave me a bill for
$700, maybe in three or four years, I'll pay you 50
percent of that. That's the problem right now. We
have a system in which the insurance companies
essentially cannot pay the bill. They'll wait three
or four years and then outside some judge's chamber
three or four years from now, they'll decide --
they'll get an agreement with the provider to take 50
percent because that's better than nothing for the
provider. That's the system we're operating under
right now. And that's just wrong. It shouldn't be
that way. And I believe that you have a fundamental
responsibility to help change that. I'd like to raise
the same issue that's been raised by a couple other
people, which is 9792.5.12(c)(3). I'll read it.
"Upon a 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." If that is the remedy
for a pattern and practice of underpayment by a claims
administrator, this system is not going to work. We
need to get serious. If there is a pattern and
practice of underpayment of bills, you need to do
something about it. In the hearings last week, I
provided you with copies of what the Department of
Managed Health Care does. One of those letters that I
provided you, again, I get these off the Department of
Managed Health Care web site, they're public letters,
one of the letters I provided to you last week was
indeed a $350,000 fine against a provider for late
payment of provider bills. Incidentally, I had
someone from the audience come up to me afterwards
almost apoplectic about a $350,000 fine. Well, guess
what? That was low. We have here a copy of a letter
of agreement in which the focus of the department's
investigation with the plan's failure to provide the Knox-Keene Act covering claims payment, provider disputes, and unfair payment patterns. The amount of the penalty against the plan was $900,000. The department suspended $400,000 of the penalty contingent upon the financial examination demonstrating that the payer fully complies with claims payment and provisions of Knox-Keene Act. But there was still an agreement to pay $500,000. The second one I'd like to submit to you, DMHC announces nearly five million dollars in health plan fines for improper payment of rider claims. This incidentally was under the last administration, the Schwarzenegger administration, a Republican governor. Our clear and consistent message is that California's hospitals and physicians must be paid fairly and on time. You have a responsibility to make sure that this system works. If it has become standard operating practice, and I contend that the testimony that you've received shows that it has in far too many cases, to simply not pay the bill, that has to be stopped. If there are circumstances in which providers are billing for services that have not been provided, fine, go after the provider. But if the payer is doing something very similar, simply not paying the bill, they need to
be hammered. Thank you.


JONATHAN ROVEN

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

The new IBR regulations are effectively eliminating the doctor's ability to collect from the judicial system. When a party provides services for another party without having to pay for it, that's typically called unjust enrichment. In this type of breach of contract action, the plaintiff is usually able to take a defendant to court to try and get reimbursed for the reasonable value of their services. The lien and Declaration of Readiness to Proceed system helps doctors and medical providers use this quasi judicial system to get paid that reasonable value. The normal statute of limitations for a breach of written contract action in California is four years from the date of the breach. The new IBR regulations are reducing that amount of time to 90 days. Insurance companies are currently recommending zero allowance for thousands of dollars worth of services provided by medical providers. If these providers don't file the requisite documents within the 90-day
period, then to my understanding, the Explanation of Benefits is deemed satisfied. This necessarily gives insurance companies thousands of dollars of services for free. Complying with these extremely limited time statutes 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. The lien system is more beneficial than the proposed IBR system because it allows parties a larger time frame to get the proper documentation together and proof of the reasonable value of their services. This is more consistent with public policy of allowing aggrieved parties to assert claims within a reasonable period of time. I believe that the new IBR system is compromising that public policy. Thank you.

MR. PARISOTTO: Thank you. Amber Ott.

AMBER OTT

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

So I did submit written comments, so I'll try to keep this brief, but I wanted to raise a few points that are especially important to hospitals. So the definition of a provider as it stands in the regulations currently excludes essential parties from
participating in the claims administration process. As you all know, hospitals use vendors and other resources to help bill and appeal and adjudicate claims, and this really limits the ability of a hospital to use any outside sources to assist in that process. We would ask that you expand the definition of a provider to also mean any agent, contractor, or subcontractor that is utilized by that hospital.

The next issue I'd like to touch on has also been addressed by some others in the room, and that's the time frame for the second review on the IBR. So for the second review, hospitals have 90 days, which is just woefully inadequate. Under current law, AB 1455 allows a Knox-Keene license health plan. Hospitals have a minimum of one year to apply to those types of plans, and many hospitals struggle with meeting that deadline. So to reduce that to 90 days really will force hospitals to forfeit most of these payments. Also the two listed options that will trigger the deadline for the second review are not mutually exclusive, so we would ask that you define it as the later of the two. Similarly, for requesting an IBR, the 30 days is really just unreasonable. And there are five trigger deadlines for that which we would also request that you define the latter of the five as
the ultimate trigger deadline. So IBRs are meant to resolve disputes between -- or regarding one date of service and one billing code. I can only assume this was meant for physicians and not for hospitals because as we know, many hospital stays are longer than one day, especially if we're talking about an in-patient stay. So it would be problematic for a hospital to only be able to appeal for the one day of stay. And also for one -- one service code, one billing code, outpatient claims have multiple CPT codes on there, and they're -- they're all required in order to accurately price the claim. So to only be able to appeal one of those codes really wouldn't be appropriate. In addition, in-patient claims will have one DRG assigned to the claim, but in the case of the complex final procedures, you'll also need the code for the Revenue Code 278 to appropriately adjudicate that claim. Similarly, the consolidation request also is limited to one date of service and one billing code. In addition, the dispute must not exceed $4,000. That also is unreasonable in a hospital environment. Most in-patient claims exceed $4,000. So to consolidate any in-patient claims and stay within that limit really is not going to happen. And on the outpatient side, that would also be
unreasonable.

And the final point I'd like to make is on the contract submission requirements. We recognize in some cases, the managed care contracts will be requested to appropriately determine the payment amount. We would just ask that you provide for some specific confidentiality measures and words within that subdivision. Possibly saying, "by no means should the contract, even if heavily redacted, ever become a matter of public record." These contractual agreements are confidential, and hospitals are very sensitive to any of the information being released to the public. Thank you.

MR. PARISOTTO: Thank you. Jeremy Merz.

JEREMY MERZ

MR. MERZ: I'm Jeremy Merz on behalf of the California Chamber of Commerce and today also on behalf of the California Coalition on Workers' Compensation.

Together the two organizations represent tens of thousands of employers, both insured and self-insured, and also insurance companies throughout the state.

I'd like to open my comments by thanking the Division of Workers' Compensation and the Department of Industrial Relations for the hard work that's been
put in through this lengthy process. Specifically, I'd like to commend Director Christine Baker and Acting Director Destie Overpeck for the leadership during this process implementing SB 863, which was a bipartisan labor/employer work comp reform. It was data driven, and it was well vetted, so we appreciate the efforts of getting that into place.

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

The first point is something that wasn't addressed in the regulations, and we think should have been. It's the start of the IBR process, which is the initial payment by the provider to -- or to the provider by the employer. Under Labor Code 4603.2, there's a 45-day deadline to provide this payment. What SB 863 did was not alter this deadline, but it also requires that the EOR be provided with the payment. We would ask the Division to define "with" as meaning as long as both of those are provided within 45 days, that the employers meet the deadline.

Right now it's problematic because EORs and payments are generally sent from two separate locations. So if -- in order to comply, they had to be sent together or
arrive contemporaneously. It just becomes a complex burden and would risk both payment penalties and audit penalties. It seems illogical because you could have a situation where an employer provides payment on day eight and an EOR on day eleven and would not be in compliance with this if they were supposed to be provided together, as we think it states in the Labor Code presently. However, if you provided both of these documents on day 44, which would be providing to the provider a month later, you would be in compliance, so we just think that this should be squared up where as long as both are provided, then the employer is in compliance.

The second point I'll just echo, it's been made a couple of times, is the consolidation. We stated in our emergency regulations, we think this should be stricken. We think this is a judicial function. It is -- It does occur in the work comp system, but it's rare, it's extraordinary, and it's done in front of the Board after multiple hearings and vetting of issues. We don't think that the IBRO is equipped to handle these types of issues and as a result, we think that numerous claims, which have -- which do not have common issues will in fact be decided together. So those are my highlights today, though, again, we are
providing some extensive commentary. I thank you for
the opportunity to speak. I thank you for your
efforts, and I look forward to working with the
Division as this process continues.

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

ADAM FOWLER

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

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

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

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

I appreciate this opportunity to just briefly
note our general support for the intent of the
permanent regulations. We believe the amendments contained therein represent DWC's earnest intent to meet the requirements imposed by SB 863, which included a host of rule-making activities that we know were associated with certain time frames that I'm sure were potentially a pain for the Division to get through, and we appreciate your earnest ability to get to it, and we really appreciate it.

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

Also our submitted written comments, which are more detailed, have several requests for clarifications and suggestions that I won't go into here today to avoid spending too much time. We believe that answers to those questions may assist
PMSI and other stakeholders in properly complying with the permanent regulations once they are adopted. A lot of those questions are based upon our personal experience since January complying with the emergency rules.

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

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

STEVE CATTOLICA

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

I'm presenting these comments separate from our others because it specifically has to do with electronic billing and because it's so integrated into the IBR process, and I know the desire of the Division is for provider participation in electronic billing, I think this is important to understand. As we've commented elsewhere and already, the IBR process is in need of refinement, if it's to be ready to handle the volume and types of disputes contemplated by the
Division. But in the meantime, providers do not need a new, and in many ways, dysfunctional billing and reimbursement system preventing them from getting properly paid in the first place. Based on input from our members, it's apparent to us that as eBilling operates today, the system is a deterrent to participation. As odd as it may seem, providers who contemplate submitting bills electronically must decide to trade the well-known and well-warn problems of the paper billing with the new frontier of electronic billing that is itself replete with its own set of collection problems not contemplated by the Division when it set up this potentially efficient program. The current nature of this new frontier denies reimbursement to providers by methods that cannot be resolved through IBR. In ways we enumerate later in our written comments, which we'll provide, providers are not being reimbursed for services properly submitted, regardless of the amount. For providers submitting electronic bills, it appears impossible to arrive at a point where IBR is even available. We urge the Division to explore the issues that we're going to raise in our written comments and do what may be necessary to bring electronic billing to a level of efficiency that the community
anticipated and deserves. Electronic billing must not be allowed to become the new way of delaying reimbursement or a way of shifting reimbursement disputes from the bill review system to the bill submission system and away from the IBR process. It cannot become a source for systematic -- excuse me, systemic delays and new disputes for which there is no ready avenue for resolution and IBR is not designed to address. Despite the promise of electronic billing technology, physicians or their billing services are being compelled to make hundreds of telephone calls to carriers only to be told that the providers should submit their bills via fax or mail, if they want to get paid. And we have a record of a number of carriers who are not even accepting electronic bills despite the requirement to do so, and we'll provide more of that documentation a little bit later.

I want to double back to a couple of things that have been said with respect to the fee, the $335 fee. I used to be in managed care. Some of the folks in the audience used to be my customers. When we would get a prospect, we'd want to decide or estimate what our revenue was going to be if we landed that prospect. And if it was a bill review customer, we would decide how many bills they were going to provide
to us and what our revenue might be. And granted, this was a decade or so ago, but the revenue was pretty much the number of bills times about eight bucks, eight bucks to do bill review. That was it. I don't know where the Division came up with the number 335, but I believe that there's a requirement that it resemble and somehow reflect either the cost or the benefit, the value of the service being provided to the participants. I don't see the correlation between those two numbers, especially if the provider who settles the dispute prior to having to go through IBR, has to give up the whole of that amount for having done the right thing and settling it away from IBR. The second is consolidation. Consolidation has been amply provided -- or spoken about is an advantage to everybody, and yet the Division -- and, and it's a complicated issue. We applaud your folks even trying to begin to decipher all of this. But consolidation needs to be encouraged, not prescriptively restricted. And we would just urge the Division to do everything it can to allow for consolidation to happen. And I agree with the comment that was made earlier with respect to who gets to decide consolidation. I think that decision needs to lie with the Administrative Director because that's the only place that all the
information is going to reside at one spot at one
time. If it's allowed to be a decision by the IBRO,
then not knowing how many might be necessary, where
the different requests have gone, if it's multiple
codes, that's almost going to be a decision that's
impossible to make. So we would hope that the
Division looks closer at consolidation as an avenue to
make IBR work better and not become more protracted.

Thank you.

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

I'd like to thank everyone today who offered
comments for some very valuable information. I
thought this was incredibly productive. The
opportunity to file written comments will stay open
until 5 o'clock this afternoon. Those comments should
be delivered to the DWC office up on the 17th floor of
this building. As I mentioned earlier, we might be
having problems with our mail box, so if you'd like to
submit comments electronically, you can submit them to
dwcrules@dir.ca.gov. And I would suggest you also
send them to our Regulations Coordinator Maureen Gray
at mgray@dir.ca.gov. I assume that we will go through
all of the sign-up sheets probably later on today, and
if you did manage to attend all four of our public
hearings in the course of the last month, you probably
will be entitled to some award.

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

The hearing is now closed.

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

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REPORTERS' CERTIFICATE

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

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

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

Dated: April 15, 2013