

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.1 CA DWC Electronic Medical Billing & Payment Companion Guide sections 2.4.1 – Submitter/Receiver Trading Partner Identification and 2.4.2 – Claims Administrator Identification	Commenter states that the confusing relationship between claims administrators, the various clearinghouses, bill review companies, and payer IDs is in contradiction to DWC regulations and, in addition, adds unnecessary steps and obstruction to the billing process. Commenter believes that each claims administrator should have a single payer ID, which should be the FEIN number. Commenter recommends that both Sections 2.4.1 and 2.4.2 of California Electronic Medical Billing and Payment Companion Guide be amended so as to delete from each the following language “or other mutually agreed upon number.”	Catherine Montgomery Founder and CEO Daisy Bill October 23, 2013 Written Comment	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p> <p>Nevertheless, the DWC appreciates the commenter’s concerns and in the future will look into possible ways to streamline identification of parties to the billing transactions, including possible adoption of the Other Entity Identification. The International Association of Industrial Accident Boards and Commissions (IAIABC)’s model companion guide (a document relied upon) has the same language allowing “other mutually agreed upon identification number.” The IAIABC model rule discusses the OEID recently adopted for use in HIPAA transactions, and states that it will be considered for workers’ compensation when the US Dept. of Health and Human Services has provided further</p>	None.

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9792.5.1 CA DWC Electronic Medical Billing & Payment Companion Guide – 2.10 – Health Care Provider Agent/ Claims Administrator Agent Roles	<p>Commenter states that many claims administrators charge an extra fee to providers for standard e-billing transaction, and states that these extra fees serve as a disincentive for providers seeking the efficiencies that e-billing can bring. Commenter states that currently the regulations are silent regarding fees for electronic bills. The closest language appears in Section 2.10 of the California Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide, which reads, in part:</p> <p style="padding-left: 40px;">...The rules do not mandate the use of, or regulate the costs of, agents performing electronic billing functions. Providers and claim administrators are not required by rule to establish connectivity with a clearinghouse or to utilize a specific media/method of connectivity....</p> <p>Commenter proposes language to add that would prohibit a party from charging fees in excess of those that would be charged for a paper</p>	Catherine Montgomery Founder and CEO Daisy Bill October 23, 2013 Written Comment	<p>guidance on its use.</p> <p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	None.

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9792.5.1 CA DWC Medical Billing & Payment Guide	<p>transaction.</p> <p>Commenter notes that even though the most recent version of the proposed Medical Billing and Payment Guide contains substantial revisions, it is still referred to a Version 1.1 (which is currently in effect in conjunction with the Emergency Regulations). To avoid confusion, commenter recommends that this modified version be renumbers to 2.0 or at least Version 1.2.</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services October 23, 2013 Written Comment</p>	<p>Agree in part. Agree with Commenter’s suggestion that version 1.1 be retained for the emergency regulations version, and that the next version have a different number. Agree with the suggestion to use version 1.2. However, disagree with the suggestion that the changes are substantial enough to warrant a version 2.0.</p>	<p>Revise the version number to 1.2.</p>
9792.5.1 CA DWC Medical Billing & Payment Guide – 1.0	<p>Commenter recommends the following revised language:</p> <p>1.0 Standardized Billing / Electronic Billing Definitions</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</u></p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period..</p>	<p>None.</p>

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	<p>assignee.</p> <p>Commenter states that Senate Bill 863 added 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. Commenter recommends inclusion of this standard in the definition.</p>			
<p>9792.5.1 CA DWC Medical Billing & Payment Guide, Appendix A – 1.2 Field Table CMS 1500 – for bills submitted on or after April 1, 2014</p>	<p>Commenter opines that the term “OTHER DATE” in Item 15 lacks clarity. Clarification of this term should be added in the Instruction column.</p> <p>Commenter opines that item 17 is also unclear. The item appears to ask for the referring provider but the</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agree in part. The workers’ compensation instructions column is to provide direction specific to workers’ compensation. The proposal is revised to add a note to explain the situational circumstance of “required if applicable” and to direct entry of the applicable qualifier and date. However, disagree to the extent that clarification would duplicate information in the 1500 Instruction Manual.</p> <p>Agree in part. The Table 1.2 and the California Workers’</p>	<p>Revise workers’ compensation instruction column entry for Item 15 in 1.2 Field Table CMS 1500</p> <p>Revise Table 1.2 Field 17 instruction</p>

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	instruction indicates “providers associated with the bill.” Commenter states that there can be many providers “associated” with a bill but they are not the referral source. One example would be co-surgeons. They are associated but neither is the referring provider.		Compensation Instructions column do not provide comprehensive instructions on use of the 1500 Form. The MB&PG specifically states that “Billings must conform to the Reference Instruction Manual and this guide.” The 1500 Instruction Manual provisions on use of Field 17 directs that the provider enter the name and enter the applicable qualifier to identify which provider is being reported. Nevertheless, the Division agrees with the commenter that clarity will be improved by revising the California Workers’ Compensation Instruction column language.	column to reference “Referring Provider, Ordering Provider or Supervising Provider” and direct entry of the applicable qualifier and provider name.
9792.5.1 CA DWC Medical Billing & Payment Guide – 3.0	<p>Commenter recommends the following revised language:</p> <p>3.0 Complete Bills</p> <p>(b) (12) (B) An employer, insurer, pharmacy benefits manager, or third-party claims administrator may request a copy of the prescription.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Disagree. The language commenter seeks to strike is the language of the statute. It conveys the important idea that the request for a copy of the prescription could be made <i>after</i> the prescription is dispensed.</p>	<p>None.</p>

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	<p>during a review of any records of prescription drugs that were dispensed by a pharmacy.</p> <p>Commenter recommends deleting the highlighted text because it lacks clarity. Commenter opines that the only “record” received from a pharmacy is their bill.</p>			
9792.5.1 CA DWC Medical Billing & Payment Guide – 3.0 Complete Bills	<p>Commenter recommends the following revised language:</p> <p>(c) For paper bills, if the required reports and supporting documentation are not submitted in the same mailing envelope as the bill, then a header or attachment cover sheet <u>as defined in Section One – 7.3 for electronic attachments</u> must be submitted <u>that shall contain:-</u></p> <p>(1) <u>Unique Attachment Indicator Number</u></p> <p>(2) <u>Patient’s name</u></p> <p>(3) <u>Claim Number (if assigned)</u></p> <p>(4) <u>Date of Service</u></p>	Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment	Agree in part. It would improve the clarity of the regulation to insert the substance of the paper bill attachment/documentation identification into the regulation rather than cross-reference to the electronic bill attachment provision. However, the electronic bill attachment provision in the Medical Billing and Payment Guide is somewhat duplicative of, and somewhat inconsistent with, the attachment provision in the Electronic Medical Billing and Payment Companion Guide. For clarity, the DWC will retain the Companion Guide provisions regarding identification of bill attachments (section 2.4.7) and	Revise 3.0 Complete Bills subdivision (c) to include the same header or attachment cover identifiers set forth in the Electronic Medical Billing and Payment Companion Guide section 2.4.7 for electronic bill attachments.

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	<p>(5) <u>Date of Injury</u></p> <p>(6) <u>Social Security Number (if available)</u></p> <p>(7) <u>Date of Birth</u></p> <p>Commenter recommends specifying here what a header or cover sheet must include for the convenience of the user and because Section 7.3 has been modified, and the information needed to match documentation with paper bills may differ from what is needed for electronic bills. Commenter opines that a claim number is necessary here, or 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.</p>		<p>will delete the parallel provision from Section 7.3 of the Medical Billing and Payment Guide. The list of identifiers will be added to 3.0 for paper bills. The date of birth is not currently a required identifier for the electronic bill attachments; the DWC is unaware of a need to add that element at this time.</p>	
<p>9792.5.1 CA DWC Medical Billing & Payment Guide – 6.1 and 6.2(b)</p>	<p>Commenter notes that the amendments as modified continue to state that claims administrators are required to issue an EOR “concurrently” with the payment. In relation to this requirement, commenter has the following</p>	<p>Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment</p>	<p>The comments do not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	<p>None.</p>

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	<p>questions for clarification:</p> <ol style="list-style-type: none"> 1. Does this mean the EOR is required to be in the same envelope/ mailing as the payment check, or just that the 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. 2. 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 solution as above. 3. Can an electronic EOR (an 835 file compliant with DWC’s 			
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	<p>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?</p>			
<p>9792.5.1 CA DWC Medical Billing & Payment Guide – 6.4(b)</p>	<p>Regarding the late/untimely payment interest provision noted in this section of the Medical Billing and Payment Guide, and elsewhere in the rules and guides, commenter would appreciate clarification on how it is expected a provider should bill interest if untimely paid:</p> <ul style="list-style-type: none"> • As a request for SBR? • On a separate bill/invoice? <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>Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	<p>None.</p>
<p>9792.5.1 CA DWC Medical Billing &</p>	<p>Commenter recommends the following revised language:</p>	<p>Steven Suchil Assistant Vice</p>		

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<p>Payment Guide – 7.3</p>	<p>7.3 Electronic Bill Attachments</p> <p>(b) All attachments to support an electronically submitted bill shall contain the unique attachment indicator number on the body of the attachment or inscribed on the face of the attachment:</p> <p>Commenter states that it is not clear what “on the body of the attachment” means but he believes “inscribed on the face of the attachment” will be more readily discovered by the reader or processor of the bill.</p> <p>Commenter is concerned that removing all identity items other than the unique attachment indicator could create delays in matching attachments. Commenter recommends having three identifiers in order to ensure correct matching.</p> <p>Commenter states that there is not a similar section for Paper Bill Attachments and he opines that this information should also be specified for paper bills.</p>	<p>President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agree in part. The DWC agrees with the suggestion to retain more than the unique attachment indicator. However, the electronic bill attachment provision in the Medical Billing and Payment Guide is somewhat duplicative of, and somewhat inconsistent with, the attachment provision in the Electronic Medical Billing and Payment Companion Guide. For clarity, the DWC will retain the Companion Guide provisions regarding identification of bill attachments (section 2.4.7) and will delete the parallel provision from Section 7.3 of the Medical Billing and Payment Guide. The list of identifiers will be added to 3.0 for paper bills. The date of birth is not currently a required identifier for the electronic bill attachments; the DWC is unaware of a need to add that element at this time.</p>	<p>Revise the Medical Billing and Payment Guide section 7.3 to cross reference the Electronic Medical Billing and Payment Companion Guide section 2.4.7 for electronic bill attachments, and eliminate the requirements from 7.3. Revise Medical Billing and Payment Guide section 3.0 Complete Bills subdivision (c) to include the same header or attachment cover identifiers set forth in the Electronic Medical Billing and Payment Companion Guide section 2.4.7.</p>

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<p>9792.5.1 CA DWC Medical Billing & Payment Guide – 7.3 Electronic Bill Attachments</p>	<p>Commenter recommends the following revised language:</p> <p>(b) All attachments to support an electronically submitted bill shall contain the following information in the body of the attachment or inscribed on the face of the attachment:</p> <ul style="list-style-type: none"> (1) Patient’s name (2) Claim Number (if available) (3) Unique Attachment Indicator Number (4) <u>Date of Service</u> (5) <u>Date of Injury</u> (6) <u>Social Security Number (if available)</u> (7) <u>Date of Birth</u> <p>Commenter states 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</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>See the Response above to the comment of Steven Suchil Assistant Vice, President/Counsel American Insurance Association dated October 23, 2013, regarding 7.3 which is substantially identical to this comment.</p>	<p>See Action above in relation to the comment of Steven Suchil Assistant Vice, President/Counsel American Insurance Association dated October 23, 2013, regarding 7.3 which is substantially identical to this comment.</p>

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	employee and claim, and the date of service is sometimes needed to identify the correct billing.			
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix A – Field Table 1.2 - Page 25	Commenter states that there is a new 02/12 version of the CMS-1500 claim form. Commenter states that the Divisions current instructions are not in alignment with the NUCC for workers’ compensation bills. Commenter requests the use of field 11b for sole submission of the claim number. Commenter opines that field 11 should be used for the employer’s workers’ compensation policy number.	Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment	Agree.	Revise California instructions in Table 1.2, Field 11 to specify that the field is optional and is to be used for the employer’s workers’ compensation insurance policy number. Delete language requiring the workers’ compensation claim number in Field 11 and move relevant language to Field 11b relating to the workers’ compensation claim number.
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix A – Field Table 1.2 - Page 25	Commenter states that with the publication of the new 02/12 version of the CMS-1500 claim form, NUCC also adjusted their standard instructions for submission of the other provider name in field 17 to also include three qualifiers to denote the specific type of other provider named:	Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment	Agree in part. The Table 1.2 and the California Workers’ Compensation Instructions column do not provide comprehensive instructions on use of the 1500 Form. The MB&PG specifically states that “Billings must conform to	Revise Table 1.2 Field 17 instruction column to reference “Referring Provider, Ordering Provider or Supervising Provider” and direct entry of the

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	referring, ordering or supervising. Each has their own specific definition. Commenter notes that DWC’s proposed instructions for use of this field on the new form, similar to DWC instructions for its use on the old form, only indicate that the field is situationally required —when other providers are associated with the bill, without indication as to use of the appropriate qualifier. To avoid any potential ambiguity concerning the requirements, commenter requests DWC clarify if the appropriate qualifier will also be required in addition to the applicable provider’s name.		the Reference Instruction Manual and this guide.” The 1500 Instruction Manual provisions on use of Field 17 directs that the provider enter the name and enter the applicable qualifier to identify which provider is being reported. Nevertheless, the Division agrees with the commenter that clarity will be improved by revising the California Workers’ Compensation Instruction column language.	applicable qualifier and provider name.
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix A – Section 3.0 – Page 28	Commenter notes that DWC references the use of the NCPDP Manual Claim Forms Reference Implementation Guide Version 1.1 (March 2012) for bills submitted on or after January 1, 2014. Commenter notes that the NCPDP has published two updates since then, the most recent being Version 1.3 (October 2013). Commenter urges the division to either update this reference guide to the current version or modify the language to incorporate the “most current” version published by the	Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment	Agree in part. The Division agrees that the NCPDP Manual Claims Form Reference Implementation Guide version 1.3 should be adopted since it is the most recent version. However, the Division disagrees with the suggestion to “modify the language to incorporate the ‘most current’ version published by NCPDP”. Although a seemingly practical approach, the suggested language would conflict with	Revise Appendix A – Section 3.0 to adopt and incorporate by reference the NCPDP Manual Claim Forms Reference Implementation Guide, Version 1.3, October 2013.

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	NCPDP in order to alleviate any future need for rule-making each time that the guide is updated.		the OAL regulation relating to documents incorporated by reference, codified at Title 1, California Code of Regulations, section 20. For regulations adopted pursuant to the California Administrative Procedure Act, a document incorporated by reference must be identified by document title and date of publication, unless a statute or other applicable law requires the adoption or enforcement of the incorporated provisions as well as any subsequent amendments. No such statute or law exists.	
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix B	<p>Commenter requests that the division take the following actions :</p> <ol style="list-style-type: none"> 1. Adopt the ASC X12N Technical Report Type 2 (TR2) Code Value Usage in ASCX12N/005010X221A1 Health Care Claim Payment/Advice (835). Commenter explains the benefits of adopting this national standard and notes the diligent work of the IAIABC 	<p>Sherry Wilson Executive Vice President Jopari Solutions October 23, 2013 Written Comments</p>	<p>Disagree with the suggestion to adopt the ASC X12N Technical Report Type 2 (TR2) Code Value Usage at this time. The DWC appreciates the comment and intends to explore adopting the TR2 next year. The DWC recognizes the benefits of aligning with national</p>	<p>None.</p>

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	<p>to obtain workers' compensation - specific codes.</p> <p>2. Develop an ongoing CARC RARC Evaluation Code Process in order to evaluate how the process is working.</p> <p>3. Define a state methodology for stakeholders to submit request for new, modified or code deletions.</p>		<p>standards and the IAIABC's model companion guide and appreciates the work of IAIABC and others in obtaining provisions tailored to workers' compensation. However, given the magnitude of the change and the short time for implementation of the revised regulations, it is more appropriate to consider this regulatory approach early in 2014.</p> <p>Agree in part. DWC agrees that it would be useful to convene a stakeholder group periodically to evaluate the CARC RARC Code usage and other billing related issues. Disagree insofar as the commenter may be suggesting codifying stakeholder group meetings into regulation.</p> <p>Agree in part. DWC agrees that it would be useful to establish a method for stakeholders to submit requests for new, modified or code deletions. However, the</p>	<p>None in the regulatory framework. Outside of rulemaking, convene a stakeholder meeting to obtain public input.</p> <p>None.</p>

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	<p>4. Adopt Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rules.</p>		<p>method to obtain stakeholder input should be considered in the context of adopting a new code methodology. At that time the DWC will consider the best method for accepting public input, and whether it should be established in regulation or through a non-regulatory method.</p> <p>Disagree with the suggestion to adopt the Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rules at this time. The DWC appreciates the comment and intends to explore adopting the TR2 next year. The DWC recognizes the benefits of aligning with national standards and the IAIABC's model companion guide. However, given the magnitude of the change and the short time for implementation of the revised regulations, it is more appropriate to consider this regulatory approach early in 2014.</p>	<p>None.</p>

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	Commenter goes into detail regarding her reasoning in her correspondence [available upon request].			
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix B – 1.0 California DWC Bill Adjustment Reason Code/ CARC / RARC Matrix Crosswalk	Commenter opines that the Bill Adjustment Reason Code is, and will be, necessary for services rendered before January 1, 2014, and he notes that many adjustments will be needed to comply with the RBRVS Ground Rules. Commenter states that there is not a lot of time for such adjustments before the effective date for the new physician fee schedule. Commenter recommends that a Bill Adjustment Reason Code be added referring to the CCI edit that pertains.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment	Disagree with the suggestion to add a new Bill Adjustment Reason Code relating to the CCI edits. DWC Bill Adjustment Reason Code G7 addresses the issue: “Provider bills for a service included within the value of another” and sets forth the DWC Explanatory Message: “No separate payment was made because the value of the service is included within the value of another service performed on the same day.” The CA Payer Instructions state: “Requires identification of the specific payment policy or rules applied. For example: CPT coding guideline, CCI Edits, fee schedule ground rules.” Also, the DWC intends to consider adopting the national standard Type 2 Technical Report Code Value Usage in ASCX12N/005010X221A1 Health Care Claim	None.

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	<p>Commenter states that G 53 lacks content in the Issue, DWC Explanatory Message, and CA Payer Instructions columns.</p>		<p>Payment/Advice (835) early next year which will provide a more comprehensive and standard message code set.</p> <p>Agree.</p>	<p>Revise Appendix B – 1.0 California DWC Bill Adjustment Reason Code/CRAC/RARC Matrix Crosswalk to add language for “Issue”, DWC “Explanatory Message”, and CA Payer Instructions for BARC G53.</p>
<p>9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix B – 1.0 California DWC Bill Adjustment Reason Code/ CARC / RARC Matrix Crosswalk</p>	<p>Commenter recommends adding a description of the Issue, DWC Explanatory Message, and Payer Instruction for DWC Bill Adjustment Reason Code G53, as these are missing from the table.</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>Agree.</p>	<p>See response above to same comment submitted by Steven Suchil, AIA, October 23, 2013.</p>
<p>9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix B – Paper Explanation</p>	<p>Commenter notes that the second paragraph under this section states: The 3.0 Table for Paper Explanation of Review specifies use of the DWC</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association</p>	<p>Agree. Commenter is correct in pointing out that 39.1 and 51.1 do not appear in Table 3.0. This is a drafting error.</p>	<p>Revise the second paragraph in Appendix B, Standard Explanation of Review /</p>

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of Review/ Remittance Advice	<p>Bill Adjustment Reason Codes and DWC Explanatory Messages as situational data elements (Data Items 39.1 and 51.1.)</p> <p>Commenter states that data elements 39.1 and 51.1 are not provided in the Table.</p>	October 23, 2013 Written Comment		Remittance Advice, Explanation of Review / Remittance Advice to reference Data Items 39 and 51 rather than 39.1 and 51.1.
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix B – Paper Explanation of Review/ Remittance Advice	<p>Commenter recommends the following revised language:</p> <p>The 3.0 Table for Paper Explanation of Review specifies use of the DWC Bill Adjustment Reason Codes and DWC Explanatory Messages as situational data elements (Data Items 39.1 and 51.1.)</p> <p>Commenter recommends either modifying as indicated or clarifying what is meant by 39.1 and 51.1.</p>	Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment	Agree. Commenter is correct in pointing out that 39.1 and 51.1 do not appear in Table 3.0. This is a drafting error.	Revise the second paragraph in Appendix B, Standard Explanation of Review / Remittance Advice, Explanation of Review / Remittance Advice to reference Data Items 39 and 51 rather than 39.1 and 51.1.
9792.5.1 CA DWC Medical Billing & Payment Guide – General Comment	<p>Commenter supports the division’s incorporation of updated references to both the new CMS-1500 claim form version 02/12 and the pending implementation of the ICD-10 codes. Commenter also supports the inclusion of reference to version 1.1 of the NCPDP WC/PC UCF, recognition of NCPDP reject codes as acceptable in lieu of Remittance Advice Remark</p>	Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment	DWC acknowledges commenter’s support for the referenced regulation revisions.	None.

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	Codes (RARCs), changing of “product strength on the WC/PC UCF to “optional” and the removal of the requirement to include a prescription copy with all pharmacy bills pursuant to Senate Bill 146 (2013).			
9792.5.1 CA DWC Medical Billing & Payment Guide – Pages 18 and 29	Commenter requests that the Division expand the list of types of providers on pages 18 and/or 20 to cover other types of providers, such as Home Health Care agencies, and non-ambulance transportation providers, and require these providers to also conform to standardized billing requirements.	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services October 23, 2013 Written Comment	Disagree that the provider list should be expanded at this time. There is currently no Home Health Agency fee schedule; a study by RAND Corporation of home health agencies and home care providers is currently underway. Adoption of an appropriate standardized billing form and instructions should be considered together with the new fee schedule. Similarly, in regard to non-ambulance transportation providers there is no applicable fee schedule. Although a non-ambulance transportation provider is not prohibited from using the 1500 form, it is premature to mandate use of the form. DWC would prefer to seek stakeholder input, and would need to analyze the applicability of the field	None.

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9792.5.1 CA DWC Medical Billing & Payment Guide – Section 3.0 – Complete Bills – Page 4	<p>Commenter recommends that the Division define the parameters of “correct ICD code” to indicate what, if any, validation is required by the payors to make an initial determination of whether the bill as submitted meets the threshold of a “clean bill”. Modify the language to indicate that a determination of “correct” is not intended to mean a subjective clinical determination, but rather, an objective assessment of whether the code as billed has the appropriate number of characters, <i>etc.</i></p> <p>Commenter notes that Section 3.0 on page 4 of the Medical Billing and Payment Guide adds language in subsection (a)(2) to require the “correct ICD code”, but she states what is meant by “correct” is not specified. Commenter opines that payors may not necessarily routinely cross-validate billed ICD-9 and/or ICD-10 codes against clinical criteria to determine if a bill as coded was “correct” from a medical standpoint, but generally limit the scope of review</p>	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services October 23, 2013 Written Comment	<p>requirements prior to mandating use of the form by non-ambulance providers.</p> <p>Disagree. The “complete bill” definition in Section One Business Rules 1.0(i), which has not been amended, includes the provision that a bill utilizes the “correct uniform billing code sets” and the ICD-9 has been on the list of uniform billing codes since the Guide was first adopted. The new proposed language setting forth requirements for a “complete bill” adds reference to the ICD codes as specified in the Sections 3.1.0-3.2.1, in order to draw attention to the new provision adopting ICD-10, and specifying ICD-9 vs. ICD-10 by date of service. It does not appear that the addition of the specific reference to ICD will cause confusion that a judgment of “clinical” correctness is required at the “complete bill” stage. The ICD-9 has been a required “uniform billing code” since adoption of the</p>	None.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	to a determination of whether a given ICD-9/10 code is a “valid” code <i>from a billing perspective (i.e., does it have the appropriate number of characters, is it a code on the overall list of codes, was the code as billed appropriate to the date of service, etc.)</i>		Guide and the DWC is unaware of questions arising as to the validation of the ICD-9 code as part of the “complete bill” determination.	
9792.5.1 CA DWC Medical Billing & Payment Guide – Appendix B – Standard Explanation of Review – Bill Adjustment Reason Codes and Crosswalk to CARC/RARC – Page 46	<p>Commenter notes that the proposed modifications continue to include DWC-specific bill adjustment reason codes (BARCs) for use in a paper explanation of review (EOR), along with a crosswalk to the analogous standard Claims Adjustment Reason Codes (CARCs) and RARCs. In addition, several proposed changes have been made to the descriptions for the BARCs.</p> <p>Commenter opines that the BARCs and associated crosswalk may be unnecessary and pose a barrier to full compliance for some stakeholders saddled with the need to use state-specific codes for California on paper EORs only, but more standard codes elsewhere. In addition, the CARCs and RARCs are often updated regularly by the national committees who control them. As an example, the most recent updates included the addition of several new</p>	<p>Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment</p>	<p>Disagree with the suggestion to delete the BARCs and adopt the national code sets at this time. See Response above to comment number 1 by Sherry Wilson, Executive Vice President Jopari Solutions October 23, 2013, Written Comments</p>	None.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>property/casualty and workers' compensation codes along with the discontinuation of previously established codes – making DWC's current table potentially obsolete.</p> <p>Commenter opines that the maintenance that would be needed for DWC to constantly update this table to accommodate the national codes for electronic EORs and a crosswalk to them for paper EOR comparison purposes is daunting. Commenter encourages DWC to modify its EOR code language to simply reference the most current national code sets (CARC, RARC and, for pharmacy charges, NCPDP reject codes) for both paper and electronic EORs – which is similar to the IAIABC model billing language. Commenter opines that if the Division is concerned with the need to ensure codes are accommodated for certain adjustment reasons more unique to California workers' compensation, he encourages the DWC to actively coordinate with IAIABC and the other relevant standard-setting organizations to accommodate them in a more standardized fashion.</p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.1 DWC Electronic Medical Billing and Payment Companion Guide	Commenter would like to thank the Division for replacing the term “clean bill” with “complete bill.” Commenter opines that this will prevent confusion, dispute and litigation over the term.	Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment	Agree.	None.
9792.5.1(a)	<p>Commenter recommends the following revised language:</p> <p><i>The California Division of Workers’ Compensation Medical Billing and Payment Guide, version 1.1, 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 XXX (effective date on/after the date the permanent regulation is adopted).</u></i></p> <p>Commenter opines that as written, version 1.1 of the Medical Billing and Payment Guide appears to apply retroactive to October 15, 2011 (“Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011”). To avoid confusion, commenter recommends</p>	Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment	Agree in part. The DWC agrees that the version numbers and effective dates need clarification, but proposes language that is more comprehensive than that proposed by commenter. In addition, the effective dates are based on the bill “submission” not bill “received”.	Revise language in section 9792.5.1 subdivision (a) to clearly set out the versions and effective dates of the Medical Billing and Payment Guide.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	clarifying that version 1.1 of this Guide applies to bills received by the claims administrator on or after the effective date of the permanent regulations and suggests listing here the effective dates for each rendition of the Guide.			
9792.5.1(a) and (b)	<p>Commenter recommends changing the version from 1.1 to 1.2 in both of these subsections.</p> <p>Commenter notes that the Companion Guide submitted for review during this comment period show Version 1.2</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agree that the most recent version of each guide is “1.2”. In addition, will add language clarifying the effective date of each version of the guide.</p>	<p>Revise language in section 9792.5.1 subdivisions (a) and (b) to clearly set out the versions and effective dates.</p>
9792.5.1(b)	<p>Commenter recommends the following revised language:</p> <p>(b) <i>The California Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide, version 1.1, 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 XXX (effective date on/after the date the permanent regulation is adopted).</u></i></p> <p>Commenter states that there appears to</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>Agree in part. The DWC agrees that the version numbers and effective dates need clarification, but proposes language that is more comprehensive than that proposed by commenter. In addition, the effective dates are based on the bill “submission” not bill “received”.</p>	<p>Revise language in section 9792.5.1 subdivision (b) to clearly set out the versions and effective dates of the Medical Billing and Payment Guide.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>be an inadvertent typographical error in the version of the Companion Guide proposed for permanent adoption in this subdivision, which is 1.2, not version 1.1.</p> <p>Commenter opines that as written, the Companion Guide proposed for permanent adoption appears to apply retroactively to October 15, 2011 (“Article 5.5.0 Rules for Medical Treatment Billing and Payment on or after October 15, 2011”). Commenter recommends clarifying that version 1.2 of this Guide will apply to bills received by the claims administrator on or after the effective date of these permanent regulations and suggests listing here the effective dates for each rendition of the Guide.</p>			
9792.5.11	<p>Commenter is supportive of the revised language allows a provider to withdraw their request at any time prior to a final determination being made.</p> <p>Commenter would like to see language that states that a claims administrator is allowed to unilaterally withdraw in a situation where the disputed amount is paid in full prior to a final determination.</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation October 22, 2013 Written Comment</p>	<p>Disagree. Allowing a claims administrator to unilaterally withdraw an IBR request offers no assurance or guarantee that any dispute over the reimbursement of filing fee has been resolved.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter states that § 9792.5.11 (a) provides for the reimbursement of \$270 to the requesting provider. Commenter opines that in a situation where the disputed amount is paid in full prior to a final determination the requesting provider has no incentive to withdraw the IBR request because they would receive an additional \$65 if the process is completed and the claims administrator has to reimburse the IBR fee. Commenter opines that the incentives are aligned in a way that perpetuates disputes that have already been resolved. Commenter opines that allowing a claims administrator to unilaterally withdraw an IBR request under these limited circumstances will help resolve disputes more quickly.</p>			
9792.5.11	<p>Commenter states that it appears that this section is allowing only the provider, not the claims administrator, to withdraw the request for independent bill review prior to the issuance of a final determination on the amount owed. Commenter opines that in a situation where the claims administrator pays the disputed amount in full, prior to the final determination to pay in full,</p>	<p>Peggy Thill Claims Operations Manger State Compensation Insurance Fund October 23, 2013 Written Comment</p>	<p>See response to the above comment by the California Chamber of Commerce regarding this section. The Division agrees that notice of a withdrawal by the provider should be given to the claims administrator.</p>	<p>Amend section 9792.5.11 to require the provider to give concurrent written notice of a withdrawal to the claims administrator.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the provider may not have the incentive of withdrawing the request because, with such final determination, the provider will be reimbursed the whole fee of \$335. The provider will then get \$65 more than the \$270 that the provider would have received if the provider withdrew the request.</p> <p>Commenter recommends allowing either the provider or claims administrator to withdraw the request for independent bill review prior to the issuance of a final determination on the amount of payment owed.</p> <p>Commenter states that this section does not indicate that, if the provider withdraws the request for independent bill review, the claims administrator is notified of the withdrawal. Commenter opines that without such notification, the claims administrator might waste time and effort in unnecessarily working on the matter.</p> <p>Commenter recommends requiring that if a party withdraws the request</p>			

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	for independent bill review, the other party must be notified of the withdrawal.			
9792.5.11	<p>Commenter recommends the following revised language:</p> <p>The provider may withdraw their a request for independent bill review at any time prior to the issuance of a final determination on the amount owed under section 9792.5.14 <u>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 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>Commenter states the first change corrects a minor typographical error.</p> <p>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</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>The typographical error is noted. As to the remaining comment, see response to comment by the California Chamber of Commerce regarding this section.</p>	<p>Revise first paragraph of section 9792.5.11 to correct typographical error.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>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.</p>			
9792.5.11(a)	<p>Commenter appreciates that the DWC modified this subsection to require a partial refund of \$270 to a hospital that chooses to withdraw its request for IBR prior to its assignment to an IBRO. In light of this change, commenter opines that it is important to note that hospitals know how long it will take to assign a request for IBR to an IBRO once the required documentation is submitted. Commenter recommends that the DWC specify an appropriate timeframe in which hospitals may withdraw their request for IBR without foregoing the \$270 refund.</p>	<p>Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment</p>	<p>See section 9792.9.9(f). An IBR request is assigned to the IBRO when the request is found to be eligible. Under Labor Code section 4603.6(d) assignment shall take place within 30 days after the filing of the IBR request.</p>	<p>No action necessary.</p>
9792.5.11(a)	<p>Commenter questions why the entire amount is not refunded if the application is withdrawn before assignment, and he opines that this</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance</p>	<p>The IBR fee accounts for the reasonable estimated cost of the review and the administration of the IBR</p>	<p>No action necessary.</p>

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	<p>incomplete rebate may act as a disincentive for providers to withdraw legitimately settled payable amounts. Commenter states that if the DWC had not allocated this activity to an outside source it would be occurring in-house, without a separate charge.</p>	<p>Association October 23, 2013 Written Comment</p>	<p>program. The current IBRO, Maximus Federal Services, Inc., has determined that the amount not reimbursed, \$65, accounts for processing the request and the share of system costs. It is believed this amount will be reduced as the program matures.</p>	
<p>9792.5.11(a)</p>	<p>Commenter recommends the following revised language:</p> <p>If the request is withdrawn prior to its assignment to an IBRO for an independent bill review under section 9792.5.9(f), the provider shall be reimbursed the amount of \$270.00\$335.00 from the fee provided with the request under section 9792.5.7(d).</p> <p>Commenter opines that the fee should be returned if the request is withdrawn prior to its assignment to an IBRO. Commenter questions whether there is authority for retaining any portion of the fee if the request has not been assigned to the IBRO. Commenter states that reviewing a request for eligibility is the responsibility of the Administrative Director, although she</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>See response to comment by American Insurance Association regarding this section.</p>	<p>No action necessary.</p>

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	<p>may choose to designate another entity to perform the review. No fee is retained for the review when the request is determined ineligible and commenter sees no basis for retaining one when the request is determined eligible.</p> <p>Commenter opines that a \$65.00 fee for withdrawal may also discourage a provider from withdrawing a request, even if the fee has been paid in full or settled, and therefore result in unnecessary independent medical reviews.</p>			
9792.5.11(b)	<p>Commenter recommends the following revised language:</p> <p>If the request is withdrawn subsequent to its assignment to an IBRO for an independent bill review under section 9792.5.9(f), but prior to the issuance of a final determination on the amount owed under section 9792.5.14, the provider shall not be reimbursed the amount of \$270.00 from the fee provided with the request under section 9792.5.7(d).</p> <p>Commenter opines that it is reasonable to return a portion of the fee if the</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>A request to terminate an IBR request can be made at any point up until a decision is issued. If the only action necessary on a request is for the reviewer to issue a determination after completing an analysis, the IBRO will be penalized if the request is withdrawn and \$270 is reimbursed to the provider. To set the line at the assignment of the request ensures that the IBRO will be compensated for their work and acts as an incentive for the parties to</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>request is withdrawn after assignment to an IBRO but prior to a final determination by the IBRO. Commenter states that it is not reasonable to pay an IBRO a full fee when it has not made a determination since it has not completed the contracted task.</p>		<p>resolve their dispute.</p>	
9792.5.12	<p>Commenter notes that throughout this section, the regulations refer to the ability to consolidate reimbursement disputes if the dispute involves the same claims administrator. Commenter opines that while the claims administrator could be responsible for the inappropriate reductions, the reductions could also have been recommended by the payor's agent.</p> <p>Commenter requests that the Division broaden this section to say, claims involving one claims administrator, <u>one payor, or the payor's agent</u> for multiple dates of service could be consolidated. Commenter opines that this would more correctly identify all parties that may be involved in a pattern and practice of inappropriate reductions of the reimbursement.</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association October 10, 2013 Written Comment</p>	<p>Labor Code section 4603.6 does not distinguish between the actions of claims administrators and those of their agents.</p> <p>Allowing consolidation requests by a medical group may result in a more expansive review by the IBRO involving more than one reviewer. The purpose of consolidation was to allow a reviewer to issue a single determination involving closely related IBR requests. That said, if experience shows that bills of a medical group can be efficiently consolidated, the Division may consider including the entity in future rulemaking.</p>	<p>No action necessary.</p>

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	<p>Commenter request that this section should be broadened to state the services rendered by a single provider or <u>medical group</u>.</p>			
9792.5.12	<p>Commenter cannot find any statutory authority for allowing consolidation in the area of IBR. Commenter states that 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 he does not believe an IBRO would be equipped to determine this threshold issue. Commenter strongly recommends that this section be deleted.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Regardless, see response to April 9, 2013 comment by the California Chamber of Commerce regarding this section.</p>	<p>No action necessary.</p>
9792.5.12	<p>Commenter recommends that this entire section be deleted.</p> <p>Commenter opines that adding a process to consolidate requests is an unauthorized expansion of Statute that thwarts its purpose. Commenter is concerned that neither the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>See above response to the comment by the American Insurance Association.</p>	<p>No action necessary.</p>
9792.5.12(b)(2)	<p>Commenter recommends that medical-legal expenses be added to the paragraph to allow for consolidation</p>	<p>Gregory S. Weber Chief Executive Officer</p>	<p>Agreed.</p>	<p>Amend section 9792.5.12 to allow the consolidation of</p>

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	of these types of expenses, in addition to treatment service or items.	Med Legal LLC October 23, 2013 Written Comment		medical-legal disputes.
9792.5.12(b)(3)	<p>Commenter opines that this entire section should be struck. Commenter states that an initial authority issue exists insofar as SB 863 makes no reference to “consolidation” within the context of IBR. Commenter opines that even if authority exists that consolidation should still not be permitted within IBR. Commenter stat that there is a process to consolidate matters at the WCAB level but that it is a rare and extraordinary procedure. The WCAB procedure requires numerous hearings to demonstrate that a common issue exists. Commenter states that an Independent Bill Review Organization (IBRO) is not equipped to determine this type of threshold issue and perform audits. Commenter states 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>Commenter opines that if this consolidation is permitted then the misconduct of both payers and</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation October 22, 2013 Written Comment</p>	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Regardless, see response to April 9, 2013 comment by the California Chamber of Commerce regarding this section.	No action necessary.

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	<p>providers should be captured by these regulations. Commenter states that presently 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 states that this definition be loosened and an additional paragraph should be added to capture misconduct by providers. Commenter recommends the following revised language:</p> <p>(b)(3) “Pattern and practice” means ongoing conduct by a claims administrator <u>and/or a provider</u> that is reasonably distinguishable from an isolated event.</p> <p><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</u></p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<u>other billing irregularities.</u>			
9792.5.12(c)(1) and (3)	Commenter opines that the \$4,000 threshold in these subsections seems to be much too low for truly effective consolidation, particularly for hospitals. Commenter recommends 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," that the \$4,000 threshold be removed.	Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.
9792.5.12(c)(3)	Commenter opines that deleting the requirement of "showing good cause" may loosely allow the IBRO to unfairly find a pattern and practice of underpayment by a claims administrator simply based on the provider's contention which may be inaccurate. Commenter recommends reinstating the requirement of "showing good cause".	Peggy Thill Claims Operations Manger State Compensation Insurance Fund October 23, 2013 Written Comment	An IBRO's consultation with the Administrative Director is sufficient. The purpose of IBR is to allow medical billing experts to resolve disputes over the amount paid on a bill. The IBRO, medical billing experts, can reasonably identify a practice and practice of underpayment without having to provide good cause to the Division.	No action necessary.
9792.5.13(c)	Commenter states that this subsection does not contain sections that apply to a copy service fee schedule. Commenter opines that leaving copy services out of this paragraph means that this Regulation will need to be re-	Gregory S. Weber Chief Executive Officer Med Legal LLC October 23, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. When a copy service fee schedule is adopted, the	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	written once the copy service fee schedule is adopted. Commenter opines that it is better to include the copy service fee schedule in now as the "Labor Code 5307.9 Fee Schedule".		regulation will be amended to include disputes under that schedule.	
9792.5.15	<p>Commenter states that under the emergency version of these regulations, to appeal an IBR determination a party was required to file a "verified petition." Commenter notes that 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 section 4603.6 which requires a "verified appeal" when appealing IBR decision to the WCAB. Commenter requests that the DWC cure this inconsistency so that parties have a clear understanding of the appeals process. Commenter opines that the regulations should also reference Labor Code section 4603.6(f) and its requirements for filing a verified appeal.</p> <p>Commenter notes that the draft regulations remove the requirement that all interested parties be served</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers' Compensation October 22, 2013 Written Comment</p>	Agreed. The statutory reference would be appropriate. 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.	Amend section 9792.5.15(b) to refer to the appeal provision of Labor Code section 4603.6(f).

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	with the petition. Commenter opines that all interested parties should have notice of an appeal as this is a fundamental concept within both California's workers' compensation system and American jurisprudence. Commenter requests that the division reinstate this requirement.			
9792.5.15(b)	<p>Commenter opines that the deletion of the requirement to serve a copy of the petition to appeal on all interested parties including the Administrative Director denies due process notification of the petition to appeal, and, if granted, would unfairly burden the non-appealing parties with short notice to prepare their case</p> <p>Commenter recommends reinstating the requirement to serve a copy of the petition to appeal on all interested parties.</p>	Peggy Thill Claims Operations Manger State Compensation Insurance Fund October 23, 2013 Written Comment	See above response to comment by the California Chamber of Commerce regarding this section.	No action necessary.
9792.5.15(b)	<p>Commenter recommends the following revised language:</p> <p><u>Pursuant to Labor Code section 4603.6(f), the provider or the claims administrator may appeal a determination of the Administrative Director under section 9792.5.14 by</u></p>	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment	See above response to comment by the California Chamber of Commerce regarding this section.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>filing a <u>verified</u> petition with the Workers' Compensation Appeals Board <u>and serving a copy on interested parties within 20 days of serving the determination.</u></p> <p>Commenter opines that since the specifics of Labor Code section 4610.6(f) have been deleted, it would be appropriate and helpful to include in this subdivision a citation to that section as well as the specific timeframe within which a verified petition must be filed.</p>			
9792.5.15(b) and (c)	<p>Commenter strongly recommends that these subsections be reinstated as they were in the previous version. Commenter is aware that the language is also found in Labor Code Section 4603.6 (f), but he believes that in the interests of clarity and efficiency it should be included here as well. Commenter states that parties need to be aware that they must file their appeal within 20 days of the mailing of the determination and the limited grounds for appeal.</p>	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment	See above response to comment by the California Chamber of Commerce regarding this section.	No action necessary.
9792.5.4	Commenter recommends the following language:	Steven Suchil Assistant Vice President/Counsel	The comment does not address the substantive changes made to the proposed regulations	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<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 fee schedules are applied by date of service, however bill review timeframes and rules are triggered throughout this and other healthcare areas by date of bill receipt. Section 84 of SB 863 applies the act to all pending matters that do not specify otherwise. Commenter opines that this regulation should apply to all pending matters. Commenter states that if the 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, and such program changes will be costly and time-consuming. Commenter opines that the new administrative complexity brought by this provision, 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.</p>	<p>American Insurance Association October 23, 2013 Written Comment</p>	<p>during the 1st 15-day comment See response to April 9, 2013 comment by the American Insurance Association regarding this section.</p>	

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter recommends adding the applicable code sections to further clarify what goods and services are included in the regulation.</p>			
9792.5.4	<p>Commenter recommends the following revised language:</p> <p>This section is applicable to billings received on or after January 1, 2013 for medical treatment services and goods rendered under Labor Code section 4600, or medical-legal expenses incurred under Labor Code section 4620 on or after January 1, 2013.</p> <p>Commenter states that Section 84 of Senate Bill 863 mandates that the provisions of the Bill apply to all pending matters unless a specific date is indicated. Senate Bill 863 provisions include new billing and payment requirements that include additional documentation that must be submitted with billings, new payment timeframes, and new content for explanations of review and for explanations of second review (Labor Code section 4603.2 et. al.). Commenter opines that since these new requirements are also</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment See response to April 9, 2013 comment by the American Insurance Association regarding this section.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>prerequisites for subsequent steps in the bill review and bill dispute process, these new requirements apply to billings <u>received</u> on and after January 1, 2013. Commenter opines that applying the regulations only to goods and services <u>rendered</u> on and after that date is overly broad and conflicts with Section 84 of SB 863.</p> <p>Commenter states that fee schedules are applied by <u>date of service</u>, however bill review timeframes and rules are triggered according to <u>date of bill receipt</u>. Commenter opines that if these regulations and their future revisions are applied by date of service, separate sets of rules must be followed, depending on the date of service, and bill review systems must program and maintain different sets of timeframes and rules, creating unnecessary complexity, confusion, dispute and expense. If, on the other hand, the rules for bill review apply according to date of bill receipt, multiple sets of timeframes and rules will not be necessary and billing providers and payers can operate more efficiently under a single set of rules on a going-forward basis.</p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Commenter urges the Administrative Director to apply these regulations by date of bill receipt.</p>			
9792.5.4(a)(1)	<p>Commenter recommends the following revised language:</p> <p>Medical treatment services or goods rendered by a provider in accordance with Labor Code section 4600 that were authorized by Labor Code section 4610, and for which there exists an applicable fee schedule pursuant to statute or adopted by the Administrative Director for those category categories of services, including but not limited to those found at sections 9789.10 to 9789.111, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.</p> <p>Commenter states that this addition is intended to include fee schedules mandated by statute, such as the Medical fee schedule for pharmacy.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 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)	<p>Commenter recommends the following revised language:</p> <p>Medical treatment services or goods rendered by a provider in accordance</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation</p>	<p>Agreed. See response to above comment by the American Insurance Association.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>with Labor Code section 4600 that were authorized by Labor Code section 4610, and for which there exists an applicable fee schedule adopted by Statute or the Administrative Director for those categories of services, including but not limited to those found at sections 9789.10 to 9789.111, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.</p> <p>Commenter recommends including here an applicable fee schedule adopted by Statute as well as one adopted by the Administrative Director. For example, Labor Code section 5307.1(a)(2)(C) adopts a schedule of maximum reasonable fees for physician services and nonphysician practitioner services commencing January 1, 2014, and continuing until the Administrative Director has adopted such a schedule. If the Administrative Director did not adopt an RBRVS-based physician fee schedule that will be effective on January 1, 2014, the statutory fee schedule would have become applicable on that date. The Medi-Cal schedule of fees for pharmacy services</p>	<p>Institute October 23, 2013 Written Comment</p>		

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>and drugs that was promulgated by Labor Code section 5307.1(a) in 2004 is another example.</p> <p>Commenter notes there is a minor typographical error.</p>			
9792.5.4(a)(2)	<p>Commenter notes that this subsection specifically names the medical and interpreters fee schedules, but fails to mention any copy service fee schedule. Commenter opines that this omission could cause copy services to be excluded from IBR.</p> <p>Commenter recommend inserting the following language at the end of the sentence until the new copy service regulation has been adopted:</p> <p>"... and Labor Code 5307.9."</p>	<p>Gregory S. Weber Chief Executive Officer Med Legal LLC October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. When a copy service fee schedule is adopted, the regulation will be amended to include disputes under that schedule.</p>	<p>No action necessary.</p>
9792.5.4(b)	<p>Commenter recommends the following revised language:</p> <p>“Billing Code” means those codes <u>for goods and services provided pursuant to Labor Code section 4600 and 4620 that include but are not limited to those</u> adopted by the Administrative Director for use in the Official Medical Fee Schedule, located at sections 9789.10 to 9789.111, or in the</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. 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</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>Medical-Legal Fee Schedule, located at sections 9795(c) and 9795(d).</p> <p>Commenter notes that SB 863 added the following language in Labor Code section 4603.2(b)(1):</p> <p>“Any provider of services provided pursuant to Section 4600, including, but not limited to, physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services, shall submit its request for payment with an itemization of services provided and the charge for each service...”</p> <p>Commenter opines that the recommended additional language will cover codes for other fee schedule sections promulgated by statute or that may be adopted by the Administrative Director such as the schedule of interpreter fees that is currently in section 9795.3, a vocational expert fee schedule, home health care fee schedule, or copy service fee schedule.</p>		<p>be amended to reflect the applicability of SBR and IBR to disputes under the new schedules.</p>	
9792.5.4(d)	<p>Commenter recommends the following revised language:</p> <p>(d) “Contested liability” means the</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’</p>	<p>Agreed.</p>	<p>Amend section 9792.5.4(d) to correct typographical error.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>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 provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 4620.</p> <p>Commenter notes a typographical omission.</p>	<p>Compensation Institute October 23, 2013 Written Comment</p>		
9792.5.4(i)	<p>Commenter appreciates the expanded definition of a "Provider" to include an entity that has contracted with the provider to process bills for services rendered.</p> <p>Commenter states that many hospitals currently enlist the assistance of vendors to handle any number of claim billing and adjudication functions for workers' compensation bills and the expanded definition will allow them to continue this practice.</p>	<p>Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment</p>	<p>The Division appreciates the comment and agrees.</p>	<p>No action necessary.</p>
9792.5.4(i)	<p>Commenter opines that allowing a billing agent to represent a provider can cause confusion because on many bills submitted by the agent to</p>	<p>Peggy Thill Claims Operations Manger State Compensation</p>	<p>The DWC Form SBR-1, the alternative method of requesting IBR, and DWC Form IBR-1 should</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>the claims administrator, there is no indication which provider the agent is representing.</p> <p>Commenter recommends that the Division require that agents clearly identify in documents the provider that the agent is representing.</p>	<p>Insurance Fund October 23, 2013 Written Comment</p>	<p>sufficiently identify the provider.</p>	
9792.5.4(i)	<p>Commenter recommends the following revised language:</p> <p>A provider may utilize the services of a billing agent, a person or entity that has contracted with the provider to process submit bills under this article for services or goods rendered by the provider, to request a second bill review or independent bill review.</p> <p>Commenter recommends using the word “submit” instead of “process” to remove any potential for the entity representing the provider from receiving the payment.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>The language corresponds with the existing definition of “billing agent” in the California Division of Workers’ Compensation Billing and Payment Guide, version 1.2. To limit a billing agent to simply submitting bills would tax the resources of providers and serve to draw-out the SBR and IBR process.</p>	No action necessary.
9792.5.4(i)	<p>Commenter recommends the following revised language:</p> <p>A provider may utilize the services of a billing agent, a person or entity that has contracted with the provider to process submit bills, a second bill</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013</p>	<p>See above response to comment by the American Insurance Association regarding this subsection.</p>	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>review, or independent bill review under this article on the provider's behalf for services or goods rendered by the provider, to request a second bill review or independent bill review.</p> <p>Commenter opines that while a billing agent may contract with a provider to submit bills, second bill review requests, and requests for independent bill review on the provider's behalf, the billing agent is not entitled to receive payment from the claims administrator for goods or services rendered by a provider. Commenter suggests this modification so that it is clear that an agent may submit on behalf of a provider. Commenter opines that without this recommended modification, the language may result in confusion and litigation over whether the language entitles a bill review agent to payment from the claims administrator.</p>	Written Comment		
9792.5.4(i)	Commenter supports this change that expands the language in the definition of "provider" to explicitly incorporate a "health care facility."	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services October 23, 2013	The Division appreciates the comment.	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.4(i)	<p>Commenter thanks the division for the inclusion of the definition of “billing agent” as a provider. Commenter would like the division to also include assignees to ensure the both third-party types are adequately recognized under the rule and given recourse to bill reconsideration and bill processes.</p>	<p>Written Comment Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment</p>	<p>The Division finds that Labor Code sections 4603.2(e) and 4603.6 require the direct participation of the provider. A billing agent can facilitate the procedures in a manner that an assignee may not. Upon experience, the Division may revisit this issue in future rulemaking.</p>	<p>No action necessary.</p>
9792.5.5	<p>Commenter states that under this section there are two methods for requesting a second bill review on a non-electronic medical treatment bill: (1) submitting the initially reviewed bill on a CMS 1500 or UB04; or (2) submitting a Request for Second Bill Review form (DWC Form SBR-1). Commenter requests that the Division adopt a single method.</p> <p>Commenter opines that the DWC should require the Second Bill Review form (DWC Form SBR-1) to be attached to either the modified CMS 1500 or UB04 forms. Commenter states that this would provide both the necessary billing information and prominently distinguish the request for second bill reviews. Commenter</p>	<p>Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers’ Compensation October 22, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	opines that having one standard process will promote uniformity and efficiency within the IBR process.			
9792.5.5	<p>Commenter’s organization has had the opportunity to review numerous Second Bill Review requests over that last three quarters that have been submitted alternatively via use of the modified CMS-1500/UB-04, as well as through submission of the standardized SBR-1 form.</p> <p>Commenter states that she has found that modification of the standardized billing forms is the most effective means of requesting SBR, and is most readily programmable with a minimal number of errors. Commenter states that while the mapping/data entry of the SBR-1 form itself is not inherently complex, it is a more manually-intensive process to identify those forms, especially if they are submitted amongst a large stack of attachments and/or in situations where the bill and attachments as submitted originally by the provide are re-arranged and/or detached from one another during the unbundled scanning and bill review process.</p> <p>Commenter suggests the following</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers’ Compensation Services October 23, 2013 Written Comment</p>	<p>Agreed as to the second option. Requiring the DWC Form SBR-1 as the first page of the request for SBR may facilitate the process of review.</p>	<p>Amend section 9792.5.5(c)(1)(B) to require that the DWC Form SBR-1 be the first page of the request for second review submitted by the provider, if that form is used.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>two possible solutions:</p> <p>(A) First, in the event that a provider chooses to submit an SBR-1 form, also require that the provider make the requisite modifications to the accompanying standardized billing form (<i>i.e.</i>, Box 10d/22 on the CMS-1500 or Form Locator 18-28 on the UB-04), to help payors recognize that Second Bill Review is being requested.</p> <p>(B) Alternatively, the rules could be modified to require that if an SBR-1 Form is being submitted as the method of requesting Second Bill Review that (a) the SBR-1 Form be placed <i>on top</i> of the stack of submitted papers, followed by (b) the bill itself, and (c) any additional attachments/supporting documentation. Modifying the rules in this manner would be comparable to the proposed language in Section 9792.5.7(d)(2) for requesting Independent Bill Review, which would require that providers submit IBR applications “...indexed and arranged so that each category of documents can be separately identified...” The overall objective in</p>			
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	both instances is to facilitate processing of the documentation on the part of the recipient of the applications (either the claims administrator in the case of SBR, or the Administrative Director in the case of IBR).			
9792.5.5	Commenter notes that the proposed modifications to §9792.5.5 governing SBR remove previously included verbiage noting a penalty and interest amount applicable when any properly documented itemized service is not paid within the timeframes described in Labor Code §4603.2(b)(2) and (3) if the claims administrator untimely communicates the final written determination under the rule section. Commenter is unclear as to the intent of this deletion and requests further clarification from DWC. Commenter would like to know if this means the reference was just deemed duplicative or if this means there is no specific penalty associated with untimely communication or payment of additional amounts due as a result of an SBR.	Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment	The Division does not have statutory authority to impose additional penalties and interest beyond that mandated by Labor Code section 4603.2(b)(1).	Delete section 9792.5.5(f)(2).
9792.5.5(a)	Commenter recommends the following revised language:	Steven Suchil Assistant Vice President/Counsel	The comment does not address the substantive changes made to the proposed regulations	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services rendered that is received on or after January 1, 2013, ” (or if you prefer, the date the permanent regulations become effective) submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred that is received on or after January 1, 2013, ” (or if you prefer, the date the permanent regulations become effective) 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 refers to his remarks regarding Section 9792.4.</p>	<p>American Insurance Association October 23, 2013 Written Comment</p>	<p>during the 1st 15-day comment See response to April 9, 2013 comment by the American Insurance Association regarding this section.</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 services rendered that was received on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment See above response to comment by the American Insurance Association regarding this section.</p>	No action necessary.

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>4603.4, or bill for medical-legal expenses incurred that was received 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 urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013.</p> <p>See comments on section 9792.5.4 regarding the conflict with Section 84 of SB 863 and the additional administrative burdens and expenses caused by the proposed language.</p>			
9792.5.5(b)	<p>Commenter is disappointed that DWC did not incorporate her suggested comments regarding the timeframe for a second review, and urges the DWC to reconsider. 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. Commenter urges the DWC to specify that the latter of the two triggers will be used</p>	<p>Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment</p>	<p>The 90-day requirement for requesting a second bill review is statutory. See Labor Code section 4603.2(e)(2).</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.5(c)	<p>when determining timeliness.</p> <p>Commenter notes that this section allows that the request for second bill review be made on either (1) the initially reviewed bill submitted on a CMS 1500 or UB04, or (2) on the Request for Second Bill Review form (DWC Form SBR-1). Commenter opines that having two methods for that purpose does not promote uniformity and efficiency in the IBR process.</p> <p>Commenter recommends that the request for second bill review should be made only through one method – by using DWC Form SBR-1 while attaching either the modified CMS 1500 or UB04 form. The use of a standardized form, such as the DWC Form SBR-1, would allow automatic recognition and auto routing technologies to expedite the request into the IBR process and would promote uniformity and efficiency.</p>	<p>Peggy Thill Claims Operations Manger State Compensation Insurance Fund October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	<p>No action necessary.</p>
9792.5.5(c)(1)	<p>Commenter recommends the following revised language:</p> <p>(c) (1) For a non-electronic medical <u>goods or service treatment</u> bills, the second review shall be requested on</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
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	<p>either:</p> <p>(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The second review bill shall be marked 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 Dental Claim Form (2006) form or ADA Dental Claim Form (2012), 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>(B) The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6.</p> <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</p>	Written Comment		
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INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>specify only one method, but the best method may be to attach the SBR-1 to the modified standardized billing form.</p> <p>Commenter opines that should this recommendation be accepted, the language regarding the choice must also be removed from the Instruction page of the Request for Second Bill Review form.</p>			
9792.5.5(c)(1) and (c)(1)(B)	<p>Commenter recommends the following revised language:</p> <p>(1) For a non-electronic medical treatment bill, the second review shall be requested on either:</p> <p>(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The second review bill shall be marked 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 Dental Claim Form (2006), or ADA Dental Claim Form (2012), the words “Request for</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	<p>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>(B) 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.</p> <p>Commenter notes 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 supports a single method for paper medical treatment bills: specifically, attaching the Second Bill Review form (DWC Form SBR-1) to the modified standard billing form. Commenter opines that this will provide both the necessary billing information and will prominently identify requests for second bill review for rapid processing so that second review bills are not delayed.</p>			

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
9792.5.5(c)(1) and (d)	<p>Commenter states that in addition to a properly modified bill, the proposed SBR rules as modified continue to list other contents required as part of a complete/compliant request for SBR in §9792.5.5(d). For clarification, commenter would like to know if it is the intention of DWC that those other contents be included on a separate piece of paper (for paper bills) or a separate attachment (for electronic bills)?</p> <p>Commenter cannot fathom 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. Commenter notes that the proposed rules on how to submit a request for SBR in relation to an electronic professional bill only indicate modification of the electronic bill (837format) and not inclusion of an attachment including the additionally required SBR content.</p>	<p>Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. 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 Medical Billing and Payment Companion Guide, version 1.2. No additional clarification is necessary.</p>	<p>No action necessary.</p>

INDEPENDENT BILL REVIEW	RULEMAKING COMMENTS 15 DAY COMMENT PERIOD	NAME OF PERSON/ AFFILIATION	RESPONSE	ACTION
	Commenter requests clarification.			
9792.5.5(f)	Commenter supports the new language. She opines that it prevents a claims administrator from being penalized for violations of reply and payment time constraints when the SBR application submitted is faulty.	Lisa Anne Forsythe Senior Compliance Consultant Coventry Workers' Compensation Services October 23, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.5.5(f)(1)	Commenter thanks the division for clarifying this section by explicitly noting that both the 14-day and 21-day SBR response timeframes may be extended by mutual agreement between a provider and claims administrator.	Kevin C. Tribout Executive Director of Government Affairs PMSI October 18, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.5.5(f)(2)	Commenter is concerned by the removal of this subsection which required a 15 percent penalty plus interest be paid to a provider if a claims administrator communicates the final written determination of the second review in an untimely manner. Commenter opines that without such penalty there is no incentive for the claims administrator to comply with the timeliness in the regulations. Commenter urges the DWC to retain this subsection.	Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment	The Division does not have statutory authority to impose additional penalties and interest beyond that mandated by Labor Code section 4603.2(b)(1).	No action necessary.
9792.5.5(g)	Commenter opines that the provider and claims administrator should be	Amber Ott Vice President,	Agreed.	Amend section 9792.5.5(b) to allow

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	given an opportunity to mutually agree to extend the 90-day time limit for requesting a second review.	Finance California Hospital Association October 22, 2013 Written Comment		the parties to extend the period in which to file a request for SBR.
9792.5.6 – DWC Form SBR-1	Commenter suggests that anywhere the word “goods” was stricken from the DWC Form SBR-1 and Instructions that it be retained for consistency with the definition in §9792.5.4(a)(1).	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers’ Compensation October 22, 2013 Written Comment	There were no instances where the word “goods” was stricken and not replace with the same word in a later part of the sentence.	No action necessary.
9792.5.6 – DWC Form SBR-1 DWC Form IBR-1	Commenter notes that this form requires a signature at the bottom of the form. The signature box is labeled "provider signature;" however, the instructions for completing the form specifically state a "physician signature" is required. Commenter states that hospitals regularly contract with other entities to handle billing and bill review functions. Commenter states that the hospital staffers that perform the billing functions are seldom physicians. Commenter requests that the DWC update the instructions to clarify that a non-physician hospital representative may	Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment	Agreed.	Amend signature line of the DWC Form SBR-1 to read “provider signature.”

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	<p>sign and complete the form, including an entity the hospital has contracted with for bill review services.</p> <p>Commenter notes that similar clarification is also needed for the IBR request form.</p>			
9792.5.6 – DWC Form SBR-1	<p>Commenter recommends replacing the phrase “procedures, services and items” with the phrase “goods and services” in all places on the form and in the instructions. Commenter opines that this provides consistency and will serve to limit confusion. Commenter is especially concerned by the use of the term “procedures” because it has a specific meaning in the Physical Medicine section of the fee schedule.</p> <p>Commenter recommends placing this addition at the end of this section:</p> <p>How to Apply <u>Attach this form to a copy of the standardized bill.</u></p> <p>Commenter recommends that the highlighted sentence referenced below be added in order to clarify that a request for additional information from the provider does not initiate the</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agreed that the phrase “procedures, services and items” should be replaced with the phrase “goods and services” in all places on the form and in the instructions.</p> <p>A request for information, when conveyed in an EOR, would constitute an initial review. See Labor Code section 4603.2(e)(1)(D), which requests the provider to submit “additional information provided in response to a request I the first explanation of review....”</p> <p>Agreed that “please” should be removed from the instructions.</p>	<p>Revise the DWC Form SBR-1 to replace “procedures, services and items” with the phrase “goods and services” in all places on the form and in the instructions. Remove “please” from the Bill Information section.</p>

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	<p>time to request a second review.</p> <p>When to Apply: A request for second bill review must be made within 90 days of service of the explanation of review that reduced or denied the payment you sought in the initial bill. <u>If the initial explanation of review requested additional information, the 90 day time frame would start when the revised explanation of review is served.</u></p> <p>Commenter recommends the following amendment:</p> <p>Bill Information: <u>Please You must</u> complete all fields in this section for each disputed <u>good or service</u>. Attach additional pages if necessary.</p> <p>Commenter opines that the word “please” could be read as volitional. Commenter states that the recommended change is consistent with the mandatory requirement.</p>			
9792.5.6 – DWC Form SBR-1	Commenter submitted revised Request for Second Bill Review forms; one with recommended changes identified by underscore and strikeout, and a clean version without the underscore	Brenda Ramirez Claims and Medical Director California Workers’ Compensation	See response to the comment by the American Insurance Association regarding the DWC Form SBR-1.	Amend DWC Form SBR-1 to remove version numbers from the reference billing guides, make

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	<p>and strikeout [Copies available upon request.]. The reasons for the recommended changes are summarized as follows:</p> <p>“Goods and services” is the standard term used in the industry and is consistent with the language in the regulations. Commenter recommends replacing the terms “Procedure” and “Item.”</p> <p>To conform with the recommendation for section 9792.5.5(c) to attach the form to the second review bill (see comment on section 9792.5.5(c))</p> <p>The version number of the Companion Guide proposed for permanent adoption is 1.2, not version 1.1</p> <p>Minor changes to the instruction for when to apply for clarity and accuracy.</p>	<p>Institute October 23, 2013 Written Comment</p>	<p>The version number of the Billing Guides should be removed to account for the different versions that may be in effect. See section 9792.5.1.</p> <p>The instructions to the DWC Form SBR-1 advise providers to mail or fax the form to the claims administrator. The form does not expressly provide that it shall be the first page of the request, as required by section 9792.5.5(c)(1)(B). Although the effect of this will likely be minimal, this will be inserted in future rulemaking.</p>	<p>minor corrections in language for clarity.</p>
<p>9792.5.7(a)</p>	<p>Commenter recommends the following revised language:</p> <p>If the provider further contests the amount of payment made by the claims administrator on a bill for medical treatment services rendered received on or after January 1, 2013, ”</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment See response to April 9, 2013 comment by the American Insurance Association regarding this section.</p>	<p>No action necessary.</p>

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	<p>(or if you prefer, the date the permanent regulations become effective) submitted pursuant to Labor Code sections 4603.2 or 4603.4, or bill for medical-legal expenses incurred received on or after January 1, 2013, ” (or if you prefer, the date the permanent regulations become effective.) 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. A request for independent bill review shall only resolve:</p> <p>Please note comments provided regarding the date of application under Section 9792.4.</p>			
9792.5.7(a)	<p>Commenter recommends the following revised language:</p> <p>If the provider further contests the amount of payment made by the claims administrator on a bill for medical treatment goods or services submitted pursuant to Labor Code sections 4603.2 or 4603.4 and, for medical treatment services rendered received on or after January 1, 2013</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment</p>	<p>Agreed that “good or services” is more accurate. The remaining comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment</p>	<p>Amend section 9792.5.7 to refer to “services or goods.”</p>

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	<p>(or effective date of these regulations); submitted pursuant to Labor Code sections 4603.2 or 4603.4, or medical-legal bill submitted pursuant to Labor Code section 4622, for medical-legal expenses incurred and received 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. Unless consolidated under section 9792.5.12, a request for independent bill review shall only resolve:</p> <p>Commenter urges the Administrative Director to apply these regulations to bills received on and after January 1, 2013. See comments on section 9792.5.4 regarding the conflict with Section 84 of SB 863 and the additional administrative burdens and expenses caused by the proposed language.</p> <p>Commenter believes that adding a process to consolidate requests is an unauthorized expansion of the scope of the statute that thwarts its purpose. Commenter is concerned that neither</p>			

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	the Division nor the IBRO are equipped to accurately determine whether common issues exist or are factually distinct.			
9792.5.7(a)(1)	Commenter thanks the DWC for accepting the language modification proposed (in his April 9, 2013 letter) to this portion of the proposed regulations. Commenter concern that the term “one billing code” would limit reviews to one billing code and open IBR to abuse and manipulation has been addressed by this change in the language.	Jeremy Merz California Chamber of Commerce Jason Schmelzer California Coalition on Workers’ Compensation October 22, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.5.7(a)(1)	Commenter commends the DWC for specifying that a dispute over the amount of payment for services billed can be for one hospital stay, as opposed to one date of service and one billing code. Commenter opines that the original limitations of "one date of service" and "one billing code" were unnecessarily restrictive and administratively burdensome for all parties involved in the dispute resolution process. Commenter regrets that this section is still limited to “one billing code.”	Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment	The Division appreciates the comment.	No action necessary.
9792.5.7(a)(1)	Commenter recommends the following revised language:	Steven Suchil Assistant Vice President/Counsel	See above response to comment by CWCI regarding this subdivision. The Division	No action necessary.

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	<p>For a bill for medical goods or treatment services, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, and either one date of service, and one billing code, or one hospital stay, 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 date. 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.</p> <p>Commenter states that the first amendment is intended to insure the inclusion of medical “goods” as well as treatment and to be consistent with other terminology in these regulations.</p> <p>Commenter opines that reviewing a single code in isolation would preclude the bill reviewer from considering the totality of fee schedule ground rules where many codes are</p>	<p>American Insurance Association October 23, 2013 Written Comment</p>	<p>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>	

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	interdependent or not allowed at the same date of service. It would encourage unbundling by providers 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 and goods, a dispute over the amount of payment for goods and services billed by a single provider involving one injured employee, one claims administrator, and either one date of service or discharge, and one billing code under in accordance with the applicable fee schedule adopted by Statute or 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>Commenter opines that "goods and services" is the standard term used in the industry and is recommended here and elsewhere in the regulations to maintain consistency.</p>	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment	See response to comment by CWCI regarding this subdivision. Regarding the limitation to one billing code, see response to April 9, 2013 comment by the California Hospital Association regarding this subdivision.	No action necessary.

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	<p>Commenter opines that at a minimum, every independent bill review must encompass all goods and services provided on the same date of service billed by a single provider on a single claim. If not, 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 other codes are billed. Commenter opines that such behavior will negatively impact the injured employee's quality of care and result in higher costs.</p> <p>See comments on section 9792.5.4(c)(1) regarding the addition of "Statute."</p> <p>"Discharge" is added for accuracy and completeness.</p>			
9792.5.7(a)(1) and	Commenter recommends that this	Diane Przepiorski	Allowing a single IBR request	No action necessary.

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(a)(2)	section be changed to allow an IBR to be filed if the services were performed by a single provider <u>or providers within the same medical group</u> on the same date of service.	Executive Director California Orthopaedic Association October 10, 2013 Written Comment	by a medical group may result in a more expansive review by the IBRO involving more than one reviewer and increased costs. That said, if experience shows that bills of a medical group can be efficiently decided through a single IBR application, the Division may consider including the entity in future rulemaking	
9792.5.7(a)(2)	Commenter notes that this subsection explicitly only allows for certain types of medical-legal expenses to go through IBR, and that copy services are not included. Commenter recommends that this subsection be amended to include interpreters and copy service medical-legal expenses - all medical-legal expenses where there is an existing fee schedule. Commenter recommends inserting "Labor Code 5307.9 Fee Schedule."	Gregory S. Weber Chief Executive Officer Med Legal LLC October 23, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. When a copy service fee schedule is adopted, the regulation will be amended to include disputes under that schedule.	No action necessary.
9792.5.7(a)(2)	Commenter recommends the following revised language: For a bill for medical-legal expenses, a dispute over the amount of payment for services <u>and goods</u> billed by a single provider involving one injured	Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 2013	Medical-legal expenses are specifically defined in section 9792.5.4(a)(2), and set forth in section 9794. No further clarification is necessary.	No action necessary.

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	<p>employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation, if any.</p> <p>Commenter opines that “goods and services” is the standard term used in the industry and is recommended here and elsewhere in the regulations to maintain consistency.</p>	Written Comment		
9792.5.7(c)	<p>Commenter opines that the 30-day timeframe established for requesting an IBR is completely unreasonable. Commenter states that in California, AB 1455 established a one-year floor for submitting appeals to Knox Keene licensed plans, and she opines that reducing that timeframe does not allow hospitals adequate time to review the accuracy of payments on the large volume of claims generated each month. At a minimum, commenter urges the DWC to specify that the latter of the five triggers will be used when determining timeliness. Commenter also recommends that the provider and claims administrator be given an opportunity to mutually agree to extend the 30-day time limit for requesting IBR.</p>	<p>Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment</p>	<p>The requirement is statutory. See Labor Code section 4603.6(a).</p>	No action necessary.
9792.5.7(d)(1)(A)	Commenter recommends the	Brenda Ramirez	Agreed in part. DWC should	Revise section

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	<p>following revised language:</p> <p>Completing and electronically submitting the online Request for Independent Bill Review form, which can be accessed on the Internet at the Division of Workers' Compensation's website. The website link for the online form and instructions can be found at https://ibr.dir.ca.gov. Electronic payment of the required fee of \$335.00 shall be made at the time the request is submitted.</p> <p>Commenter states that the Maximus electronic form on the DWC web site differs materially from both the current emergency form and the proposed and modified versions. Commenter recommends 1) replacing it with an electronic version of the adopted form and 2) adding directions to the DWC IBR web pages on how a provider submitting an electronic IBR request shall comply with the statutory and regulatory requirements in Labor Code section 4603.6(b) and CCR section 9792.5.7(f) to concurrently serve a copy of the request upon the claims administrator together with a copy of the supporting documents.</p>	<p>Claims and Medical Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>ensure that the website link in the subdivision is correct and that the online form is the same as the paper form.</p>	<p>9792.5.7(d)(1)(A) to correct the website link for the online form.</p>

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9792.5.7(d)(2)	<p>Commenter opines that the documents will be well organized if the provider is required to separately identify each document and urges the Division to delete the indexing requirement.</p> <p>Commenter understands that the Division has experienced problems sorting through documents that providers have submitted under the IBR process. Commenter agrees that the documents should be arranged so that the documents are separately identified. Commenter opines that it is unreasonable to also require the provider to “index” the documents. Commenter is not sure what is meant by “indexing” the documents. Commenter wonders if the the providers expected to create binders with index tabs of the disputed claims.</p> <p>Commenter would like clarification that the provider would not have to resubmit supporting documents that were previously provided to the claims administrator. Commenter opines that it would be an unnecessary waste of time and effort on the part of the provider, the Division, and the claims administrator to have to process</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association October 10, 2013 Written Comment</p>	<p>The requirement for providers to index and arrange the supporting documents stems from the inordinate amount of time it has taken the Division’s staff to review unlabeled documents submitted by providers in IBR requests made during the time the emergency regulations were in effect. While the regulation is specific as to the categories of documents that need to be submitted, providers have filed additional categories, i.e., proof that a claims administrator has paid more for a code in the past, that are confusing to identify and separate from the required list. To “index” is to list items that give for each item the page number where it may be found. http://www.merriam-webster.com/dictionary/index. The Division believes that providers do not need further instructions or regulations in this regard.</p>	<p>No action necessary.</p>

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9792.5.7(d)(B)(2)	<p>duplicate supporting documents.</p> <p>Commenter recommends the following revised language:</p> <p>The provider shall include with the request form submitted under this subdivision, either by electronic upload or by mail, a copy of the following documents, which shall be indexed and arranged so that each of the following category categories of documents can be separately identified:</p> <p>Commenter states that the proposed addition is meant to clarify that the word “categories” refers to the items that follow.</p>	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment	Agreed.	Amend section 9792.5.7(d)(B)(2) to provide that the required documents shall be indexed and arranged so that the listed category of documents can be separately identified:
9792.5.7(f)	Commenter recommends that this subsection be deleted because there is no statutory authority for consolidation by the AD or IBRO.	Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period. Regardless, see response to April 9, 2013 comment by the California Chamber of Commerce regarding this section.	No action necessary.
9792.5.8 – DWC Form IBR-1	Commenter requests that the entire Consolidation portion of this form be deleted. See his comments on section	Steven Suchil Assistant Vice President/Counsel	The comment does not address the substantive changes made to the proposed regulations	No action necessary.

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	<p>9792.5.12.</p> <p>Commenter recommends removing the Consolidation and Disaggregation sections because he does not believe the Division has statutory authority to create this process or to delegate this process to its vendor, Maximus.</p> <p>Commenter states that the address for Maximus Federal Services provided on this form is different from the one provided on the DWC website. Commenter opines that the addresses on the website and on the Form must be consistent.</p>	<p>American Insurance Association October 23, 2013 Written Comment</p>	<p>during the 1st 15-day comment period. Regardless, see response to April 9, 2013 comment by the California Chamber of Commerce regarding this section.</p> <p>The Division will ensure that the address for Maximus Federal Services on the form will match that on the website.</p>	
<p>9792.5.8 – DWC Form IBR-1 - Instructions</p>	<p>Commenter notes that paragraph 2 states: “IBR can be requested electronically or by submitting this form. The electronic form can be accessed at DWC’s website at https://ibr.dir.ca.gov”</p> <p>Commenter states that it does not appear that an electronic format is set forth on the website.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agreed.</p>	<p>Amend the DWC Form IBR-1 to indicate the correct website.</p>
<p>9792.5.8 DWC Form IBR-1</p>	<p>Commenter states that the Maximus electronic form on the DWC web site differs materially from both the current emergency form and the proposed and modified versions.</p>	<p>Brenda Ramirez Claims and Medical Director California Workers’ Compensation</p>	<p>The Division will ensure that the form and instructions on the DWC web site are materially the same as the DWC Form IBR-1.</p>	<p>Amend DWC Form IBR-1 to: (1) reorder employee information to delete Social Security</p>

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	<p>Commenter recommends:</p> <ol style="list-style-type: none"> 1) replacing it with an electronic version of the adopted form and 2) adding directions on how a provider submitting an electronic IBR request shall comply with the statutory and regulatory requirements in Labor Code section 4603.6(b) and CCR section 9792.5.7(f) to concurrently serve a copy of the request upon the claims administrator with a copy of the supporting documents. <p>Commenter has submitted two Independent Bill Review forms; one with recommended changes identified by underscore and strikeout, and a clean version without the underscore and strikeout. [Copies are available upon request.] The reasons for the recommended changes are summarized as follows:</p> <ul style="list-style-type: none"> • Prompts for addresses, are merged and reordered for clarity and to remain consistent with the Request for Second 	<p>Institute October 23, 2013 Written Comment</p>	<p>Instructions advising the provider to concurrently serve a copy of the request with a copy of the supporting documents will be included.</p> <p>In regards to form suggestions, the Division agrees with the changes absent the deletion of the consolidation and disaggregation sections, and the addition of the word "statute." (The form is sufficiently clear that only services and goods covered by a fee schedule adopted by the Administrative Director are subject to IBR.)</p> <p>The Division will ensure that the information on the form and on the website correspond.</p>	<p>Number and add Claim Number and Employer Name; (2) shorten address prompts; (3) change reference from "procedures/service/it em" 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 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>Review form to the extent feasible</p> <ul style="list-style-type: none"> • Goods and services” is the standard term used in the industry and is consistent with the language in the regulations • The Consolidation section has been deleted because the Institute believes that consolidations are not supported in SB 863 • Instruction to concurrently send a copy of the form and supporting documents to the claims administrator is necessary here so that it is clear that the instruction applies to both a paper and electronic submission • See comments on section 9792.5.4(a)(1) regarding the addition of “Statute.” • The required Folsom mailing address on the form differs from the Sacramento address on the web; the address that is incorrect must be corrected 			
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	<p>because the instructions on both the form and the web site warn that applications not sent to that address will not be considered filed</p> <ul style="list-style-type: none"> The Consolidation and Disaggregation paragraphs have been deleted for the reasons described above and in comments on section 9792.5.12. 			
9792.5.9(a)(4)	<p>Commenter has concerns with the addition of this subsection) as it relates to the eligibility of a request for IBR. Commenter opines that this section can be interpreted to read that, if a claims administrator doesn't complete the second review in a timely manner, the provider's request for IBR may be deemed ineligible. Commenter does not believe that it was the intent of the DWC to punish providers by dismissing their requests for IBR based on an untimely review by the claims administrator, and she requests that the DWC further clarify this section.</p>	<p>Amber Ott Vice President, Finance California Hospital Association October 22, 2013 Written Comment</p>	<p>A second bill review is necessary in order for IBR to occur. Labor Code section 4603.6. The failure of a claims administrator to timely reply to a SBR request, in the absence of mutually-agreed upon extension under section 9792.5.5(g), should allow the provider to pursue its claim through the WCAB. If data indicates that this provision is inhibiting the IBR process, the Division may amend the consideration in future rulemaking.</p>	<p>No action necessary.</p>
9792.5.9(a)(6)	<p>Commenter notes that this subsection references a "required fee for review", but does not specifically state what</p>	<p>Lisa Anne Forsythe Senior Compliance Consultant</p>	<p>Agreed.</p>	<p>Revise section 9792.5.9(a)(6) to specifically reference</p>

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	<p>fees for which specific review. Many bill review service providers are paid fees for their reviews of provider billing statements. Commenter opines that since the apparent intention of Subsection 6 was to reference the \$335 IBR application fee (as opposed to a bill review service provider fee), the wording should be expanded to reflect that intent.</p> <p>Commenter recommend rewording this subsection to read, "...If the required fee for the review pursuant to Section 9792.5.7(d)(1)(A) or (B) was paid..."</p>	<p>Coventry Workers' Compensation Services October 23, 2013 Written Comment</p>		<p>the fee paid pursuant to section 9792.5.7(d)(1)(A) or (B).</p>
9792.5.9(b)	<p>Commenter recommends changing "15" to "5" when referring to the number of days.</p> <p>Commenter states that the timelines to complete other steps in the process are necessarily short since Labor Code section 4603.6(d) requires the request to be assigned to an independent bill reviewer, and provider and employer notified, within 30 days of receipt of the request and fee. Commenter opines that since the notice can be provided when the Administrative Director or his or her designee makes</p>	<p>Brenda Ramirez Claims and Medical Director California Workers' Compensation Institute October 23, 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. Labor Code section 4603.6(d). A 15 day period is reasonable for notifying the parties after a decision is made that a request is eligible for review.</p>	<p>No action necessary.</p>

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	the determination, there is no need to delay notice to the provider and longer than five days.			
9792.5.9(b)(1)	Commenter recommends changing “A” to “An” in order to correct a typographical error.	Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment	Agreed.	Amend section 9792.5.9(b)(1) to correct typographical error.
9792.5.9(b)(3)	<p>Commenter recommends the following revised language:</p> <p>A statement that the claims administrator may dispute both eligibility of the request for independent bill review under subdivision (a) and the provider’s reason for requesting independent bill review 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 <u>the Administrative Director received the request, as</u> designated on the notification, if the notification was provided by mail, or within twelve (12) calendar days of the date</p>	Brenda Ramirez Claims and Medical Director California Workers’ Compensation Institute October 23, 2013 Written Comment	The comment does not address the substantive changes made to the proposed regulations during the 1st 15-day comment period.	No action necessary.

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	<p>designated on the notification if the notification was provided electronically.</p> <p>Commenter states that Labor Code section 4603.6(d) requires the request to be assigned to an independent bill reviewer, and the provider and employer to be notified, within 30 days of receipt of the request and fee. To ensure this timeframe is met, it is necessary to count the fifteen days from the date the Administrative Director designated on the notification that the Request and fee was received.</p>			
9792.5.9(c)	<p>Commenter opines that it is not clear why the term “other party” in the first sentence is changed to “provider” while the term “other party” remains the same in the next sentence.</p> <p>Commenter recommends the use of only one term for clarity and consistency. If the term “provider” will be used, what is the rationale behind specifying the term “provider” instead of the “other party”?</p>	Peggy Thill Claims Operations Manger State Compensation Insurance Fund October 23, 2013 Written Comment	Agreed.	Amend section 9792.5.9(c) to replace “party” with “provider.”
9792.5.9(f)(3)	Commenter recommends the following revised language:	Brenda Ramirez Claims and Medical	Agreed. The IBRO should identify the claim in the notice	Amend section 9792.5.9(f)(3) to

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	<p>Identification of the claim and 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 46222.</p> <p>Commenter opines that the claim number is also needed.</p> <p>A minor typographical error is noted for correction.</p>	<p>Director California Workers' Compensation Institute October 23, 2013 Written Comment</p>	<p>of assignment.</p>	<p>provide that the IBRO identify the claim in the notice of assignment. Correct punctuation error.</p>
9794(i) and (k)	<p>Commenter opines that providers and claims administrators should both be required to maintain records for the same amount of time – which would be useful in the event of disputes. In (k) the Claims Administrator is required to maintain records for 5 years while in (i) a Physician is required to maintain records for only 3 years. Commenter notes that the Initial Statement of Reasons stated that the five year requirement is necessary to make the retention of the bill for medical legal-services identical to the medical-legal retention requirement for QMEs, which appears</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agreed.</p>	<p>Amend section 9794(i) to require that physicians keep and maintain for 5 years copies of all billings for medical-legal expense.</p>

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9794(j)	<p>at section 39.5 of these regulations.</p> <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 or 139.32 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 Senate Bill 863.</p>	<p>Steven Suchil Assistant Vice President/Counsel American Insurance Association October 23, 2013 Written Comment</p>	<p>Agreed.</p>	<p>Amend section 9794(j) to include reference to Labor Code section 139.32.</p>
DWC Form IBR-1	<p>Commenter notes that the form instructions state to mail it to: DWC-IBR c/o Maximus Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. The instructions further state, “Forms that are not sent to this address will be returned by DWC and not considered filed.” However, the IMR section of the DWC website states the IMR App should be mailed to a PO Box address in Sacramento for Maximus. Commenter would like to know if the IMR App is mailed to the PO Box in Sacramento if it will be considered filed. Commenter states that the suite address for Maximus’ physical address on the website is listed as</p>	<p>Jeremy Merz California Chamber of Commerce</p> <p>Jason Schmelzer California Coalition on Workers’ Compensation October 22, 2013 Written Comment</p>	<p>DWC will ensure that the address for Maximus Federal Services on the DWC Form IBR-1 is correct and will correspond to that on the DWC website.</p>	<p>No action taken.</p>

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General Comment	<p>Suite 150, not 100.</p> <p>Commenter urges the Division to clarify that nothing in the regulations is intended to limit the number of times that a provider and the claims administrator could interact in an effort to resolve the reimbursement dispute</p> <p>Commenter states that prior to the implementation of the IBR system, orthopaedic offices worked to resolve their reimbursement disputes with the claims administrator, even if it meant going back and forth several times to resolve the dispute. Now that IBR is in place, claims administrators are less willing to resolve reimbursement issues with providers. They process one appeal under the Physician's Request for Second Opinion, but if the dispute is not resolved, the physician is told to invoke the IBR process. Commenter opines that they know very well that many physicians won't pay the \$335 filing fee to invoke the IBR process to collect smaller disputed amounts.</p> <p>Commenter states that physicians understand that they would receive a</p>	<p>Diane Przepiorski Executive Director California Orthopaedic Association October 10, 2013 Written Comment</p>	<p>The SBR procedure in Labor Code section 4603.2(e) and the IBR procedure in Labor Code section 4603.6 have formalized the manner in which providers and claims administrators resolve disputes over the amount paid on a medical bill. The goal of these procedures is to have medical billing experts expeditiously make the final determination on billing disputes. That said, the statutes and implementing regulations do not prohibit any informal attempt by the parties to resolve their differences.</p>	<p>No action necessary.</p>

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	<p>refund of the filing fee, but it's the staff time and having to front the filing fees that make it difficult for physicians to routinely file IBRs. Commenter opines that many reimbursement disputes could be resolved without invoking the IBR process if the claims administrator was willing to process more than one appeal.</p>			