# UPDATED FINDING OF EMERGENCY
# OF THE
# DEPARTMENT OF INDUSTRIAL RELATIONS
# DIVISION OF WORKERS' COMPENSATION

# REGARDING THE CALIFORNIA LABOR CODE
# CALIFORNIA CODE OF REGULATIONS,
# TITLE 8, ARTICLE 5.5.1
# INDEPENDENT BILL REVIEW

The Acting Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, proposes to readopt Article 5.5.0 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, section 9792.5.1, 9792.5.4, 9792.5.5. 9792.5.6. 9792.5.7, 9792.5.8, 9792.5.9, 9792.5.10, 9792.5.11, 9792.5.12, 9792.5.13, 9792.5.14, and 9792.5.15. Further, the Acting Administrative Director, pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3, proposes to readopt Article 5.6 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9793, 9794, and 9795. These actions are necessary in order to implement, on an emergency basis, the provisions of Labor Code sections 4603.2 through 4603.6, and Labor Code section 4622, as implemented by Senate Bill 863 (Statutes of 2012, Chapter 363).

Pursuant to California Code of Regulations, title 1, section 52(c), DWC is incorporating by reference the rulemaking file, OAL File No. 2012-1219-02E, submitted December 19, 2012, for the initial adoption of the emergency regulations.

## UPDATED FINDING OF EMERGENCY

Pursuant to California Code of Regulations, title 1, section 52(b)(2) there have been no changes in emergency circumstances since the original adoption of the emergency regulations.

The Acting Administrative Director of the Division of Workers' Compensation finds that the readoption of these regulations is necessary for the immediate preservation of the public peace, health and safety, or general welfare, as follows:

### Basis for the Finding of Emergency

- On September 18, 2012, the Governor signed Senate Bill (SB) 863 (Statutes of 2012, Chapter 363), the major provisions of which take effect on January 1, 2013.

- SB 863 has created substantial changes in the manner by which health care providers and those professionals incurring medical-legal expenses, as defined in Labor Code section 4620, are paid for their services. These changes will take effect on January 1, 2013, and will affect all current workers' compensation claims.

- In passing SB 863, the Legislature expressly found in Section 1(h), that the current system of resolving disputes over medical treatment billing and medical-legal billing offers no

avenue for resolution short of litigation. There is no requirement that medical billing and payment experts, those with specialized knowledge regarding the application of complex fee schedules and billing standards, review and resolve disputes, which are now submitted to workers' compensation administrative law judges without the benefit of independent and unbiased findings on these billing issues.

- Billing disputes that seek resolution before the Workers' Compensation Appeal Board (WCAB) – through the filing of liens under Labor Code section 4903 et seq. - now threaten to overwhelm the court system, thereby precluding injured workers from receiving a prompt hearing and an expeditious resolution over such issues as the liability of their employer for an industrial injury, the level and length of temporary disability indemnity benefits, and the level and length of permanent disability indemnity benefits. Independent Bill Review (IBR), as mandated by SB 863, would serve to relive what is now a crushing burden on the administrative court system.

- The length of time in which it now takes to resolve workers' compensation billing disputes through litigation may adversely affect access to quality medical care. Medical providers, interpreters, and other providers may refuse to treat or provide services to injured workers because they will have no way to ensure recovery for their fees, thereby causing harm to the public peace, health and safety, and general welfare.

- The Legislature additionally found in Section 1(h) that IBR is a new state function of such a highly specialized and technical nature that it must be contracted out since the necessary expert knowledge, experience, and ability are not available through the civil service system. See Government Code section 19130(b)(2) and (3).

- Action is necessary in order to implement, on an emergency basis, the provisions of Labor Code sections 4603.2, 4603.3, 4603.4, 4603.6, and 4622, as either amended or enacted by SB 863. Regulations to implement IBR are necessitated by Labor Code section 4603.2(e)(1), which mandates the Administrative Director to prescribe a form for the second bill review process, section 4603.3, which mandates the Administrative Director to prescribe an explanation of review to be provided by the claims administrator following the initial determination of the submitted bill, section 4603.6(b), which mandates the Administrative Director to prescribe a form that initiates the IBR process, and section 4603.5, which requires the Administrative Director to adopt necessary to make effective the requirements of Article 2 of the Labor Code (commending at section 4600).

- The Emergency Regulations are the sole means to implement the Legislature's mandate that IBR be in place by January 1, 2013, and will insure that billing disputes between providers and claims administrators will be resolved in the most efficient, effective manner possible.

**Background**

- The Division of Workers' Compensation (DWC) develops regulations to implement, interpret, and make specific the California Labor Code. (See Labor Code section 5307.3)

- SB 863 was signed into law by Governor Brown on September 18, 2012 to become effective January 1, 2013.

- On October 2, 2012, the DWC held a working group meeting open to the public to obtain input from the stakeholders.

- Draft regulations were posted on the DWC public forum from December 3 through December 7, 2012, to allow for informal public comment.

- A 2011 report prepared by the Commission on Health and Safety and Workers' Compensation indicates approximately 350,000 liens were filed in 2010 and over 450,000 were expected in 2011. Medical treatment liens account for more than 60% of the liens filed and 80% of the dollars in dispute.

- A single lien filing ordinarily includes all the claims by one lien claimant in one injured worker's case. For a medical lien, that means one medical provider files one Notice and Request for Allowance of Lien covering all of the billing disputes connected with the treatment of one worker arising out of one injury or several injuries.

- The typical workers' compensation lien is a direct claim against the defendant for a benefit which is not otherwise payable to the injured worker. The rationale is that the lien claimant has furnished medical treatment or other service that the employer was required to provide, so the lien claimant is entitled to payment from the employer. A medical provider must accept the payment allowed by workers' compensation and must not collect from the patient unless the claim turns out to be non-compensable. A lien is the medical provider's vehicle for contesting the employer's determination of the amount payable for medical goods or services. Unlike conventional liens, these are not obligations of the injured worker.

- The predominant type of liens in workers' compensation proceedings are liens for medical treatment (62% of the liens and 80% of the dollars in dispute). Other types of liens include medical-legal expenses, interpreters, copy services, and attorneys' fees.

**Update**

Emergency Independent Bill Review regulations were approved by the Office of Administrative Law and became effective on January 1, 2013. To date, approximately 115 applications for IBR have been received by DWC's Independent Bill Review Organization, Maximus Federal Services, with volumes expected to substantially increase over the course of the next several months. If the emergency regulations are not readopted, the Acting Administrative Director would not have regulatory authority to continue the IBR program, which would prevent pending and new applications from being processed and approved, and would return medical treatment and medical-legal billing disputes to the inefficient, costly lien process.

The Division of Workers' Compensation has been diligent in proceeding with the Certificate of Compliance. On February 22, 2013, the Notice of Proposed Action for the above-described regulations was published in the California Regulatory Notice Register. DWC correspondingly posted all required rulemaking materials on its website and mailed the notice to the DWC interested parties list. On April 9, 2013, DWC conducted an open, regulatory hearing on the proposed Independent Bill Review, Standardized Paper Billing and Payment, and Electronic Billing and Payment regulations. Since that time, DWC staff has been diligently reviewing extensive comments submitted during the 45-day public comment period, has been working with various stakeholders on the implementation of the IBR program, and has considered potential substantive changes that will likely be incorporated during the regular rulemaking process. The IBR program has been in effect since January 1, 2013 for medical treatment and

medical-legal bill where service was rendered on and after that date; the increased volume of reviews performed by DWC's Independent Bill Review Organization over the last several months has given DWC a unique opportunity as to how the regulations implementing the program can be modified and improved. The Acting Administrative Director has therefore determined that a re-adoption of the emergency regulations is necessary for the immediate preservation of the public peace, health and safety or general welfare.

## AUTHORITY AND REFERENCE

The Acting Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3.

Reference is to Labor Code sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3. 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6,

## INFORMATIVE DIGEST

### Summary of Existing Laws

Labor Code section 4603.6, as enacted in SB 863, establishes an independent bill review (IBR) process, which is new to the California workers' compensation system. Previously, disputes over the appropriate amount of payment for a medical treatment bill or a medical-legal bill were resolved through litigation before the WCAB.

Labor Code section 4603.2 sets forth the procedures and timelines for payment of a medical treatment bill. Bills for medical services rendered under Labor Code section 4600 are required to follow the mandates of this section. SB 863 first added subdivision (b)(1), which states the documents that are required to be submitted by named providers in order for a bill to be properly paid. The documents include an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received.

Labor Code section 4603.2(b)(2) now requires an employer or claims administrator to pay a medical treatment within 45 calendar days after receipt of a complete bill. An objection to the bill must be made within thirty 30 calendar days and must be accompanied by an explanation of review as described in new Labor Code section 4603.3. The explanation of review must contain:

- A statement of the items or procedures billed and the amounts requested by the provider to be paid.
- The amount paid.
- The basis for any adjustment, change or denial of the item or procedure billed.
- The additional information required to make a decision for an incomplete itemization;
- The reason for the denial of payment if it's not a fee dispute; and

Information on whom to contact on behalf of the employer if a dispute arises over the payment

of the billing, including information on how the provider should raise an objection regarding the item paid or disputed and how to obtain an independent review of the medical bill under Labor Code section 4603.6.

Labor Code section 4603.2(b)(4) was expressly added to preclude the duplicate submission of medical treatment bills. Duplicate submissions do not require additional notification or objection by the claims administration.

Subdivision (e) was added to section 4603.2 to establish a second bill review procedure that must be followed before initiating IBR. Under this new process, the provider must generally request a second review within 90 days of receiving the explanation of review that reduced or denied the payment sought in the initial bill. The request, on a form to be prescribed by the Administrative Director, must set for the reason and any additional information that would support the additional payment Under subdivision (e)(3), the claims administrator must respond with a final written determination on each of the disputed items or amounts in dispute within 14 days of a request for second review. The payment of any balance not in dispute must be made within 21 days of receipt of the request for second review. The claims administrator will not be liable to for any additional payments if the second review is not sought by the provider

Labor Code section 4622, the statute that sets forth the procedures and timelines for payment of a medical-legal bill, was amended by SB 863 to require that an explanation of review under Labor Code section 4603.3 be used to object to an initial bill. The bill also makes the second bill review procedure applicable to those bills as well as recourse to IBR under Labor Code section 4603.6 following the second review.

Labor Code section 4603.3 establishes the IBR process. If the only dispute between a provider and a claims administrator is the amount of payment and the second review that did not resolve the dispute, the provider may request IBR within 30 calendar days of service of the claims administrator's second review decision. If IBR is not requested, the bill will be deemed paid. If the dispute involves an issue other than the amount of payment, the time to commence IBR will not begin until that threshold issue is resolved.

IBR will be requested by the provider on a form prescribed by the Administrative Director. The request must include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final written determination of the second review. The Administrative Director may require that the request be made electronically.

Subsection (c) of the new statute requires the provider to pay a fee when seeking review. The fee, which may vary depending on the number of items in the bill, must cover the reasonable estimated cost of IBR and administration of the program. If any additional payment is found owing from the claims administrator to the provider, the claims administrator must reimburse the provider for the fee in addition to the amount found owing.

Upon receipt of a request for IBR and the required fee, the Administrative Director, or the Administrative Director's designee, must assign the request to an independent bill reviewer within 30 days and notify the parties of the assignment. The reviewer may request additional documents from the parties if necessary. Within 60 days of assignment, the reviewer must make a written determination of any additional amounts to be paid to the provider and state the reasons for the determination. The determination, which shall be deemed an order of the

Administrative Director, must be sent to Administrative Director and provided to both the claims administrator and the provider.

Under Labor Code section 4603.6(f), an IBR determination may be appealed to the WCAB within 20 days after service of the determination. The determination is presumed to be correct and can only be overturned on the basis of fraud, conflict of interest, or mistake of fact.

The proposed regulations will provide the public with clear guidelines for the mandated IBR process and set forth the obligations that health care providers and claims administrator must meet in order for the process to work in an efficient and effective manner. The regulations will ensure that billing disputes in the workers' compensation system will be resolved by conflict-free billing and payment experts rather than the lengthy and costly process of litigation.

## TECHNICAL, THEORETICAL, OR EMPIRICAL STUDIES, REPORTS, OR DOCUMENTS RELIED UPON

- WCIRB's Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012.
- The California Commission on Health and Safety and Workers' Compensation Liens Report dated January 5, 2011.
- Negotiated DWC Contract with Maximus Federal Services, Inc. (Agreement No. 41230041) to provide IBR services from January 1, 2013 to December 31, 2015.

## SUMMARY OF PROPOSED REGULATIONS

The Administrative Director adopts and amends administrative regulations regarding independent bill review. These regulations implement, interpret, and make specific sections 4603.2, 4603.3, 4603.4, 4603.6, and 4622 of the Labor Code as follows:

**Item 1 – Section 9792.5.1 Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides.**

- Based on Labor Code sections 4603.2 and 4603.4, subdivision (a) of the regulation is amended to revise the reference to the California Division of Workers' Compensation Medical Billing and Payment Guide to substitute "version 1.1" for "dated 2011."
    - Medical Billing and Payment Guide (which is incorporated by reference) is amended.
        - The cover page is amended to delete the date "2011" and insert "Version 1.1".
        - The introduction page is amended to add Labor Code section 4603.3 as additional authority.
        - Based on Labor Code sections 4603.2 and 4603.4 Section One-Business Rules, 1.0 Standardized Billing/Electronic Billing Definitions, subdivision (b) "Authorized medical treatment," is amended to refer to treatment that has been "provided or prescribed by the treating physician" instead of "provided or authorized by the treating physician."

- Based on Labor Code sections 4603.3 and 4603.4 Section One-Business Rules, 1.0 Standardized Billing/Electronic Billing Definitions, subdivision (m) is amended revise the definition of "explanation of review." Subdivision (p) is amended revise the definition of "itemization" of services. Subdivision (w) is amended to revise the definition of "supporting documentation."

- Based on Labor Code section 4603.2 Section One-Business Rules, 2.0 Standardized Medical Treatment Billing Format, subdivision (a) is amended to allow a handwritten entry indicating a Request for Second Review. Subdivision (a)(4) is amended to make a technical correction in the reference to the National Council on Prescription Drug Programs paper WC/PC Universal Claim Form by deleting version "1.0 05/2008" (a prototype never put in production) and inserting version "1.1 -05/2009."

- Based on Labor Code section 4603.2 subdivision (b)(1), Section One-Business Rules, 3.0 Complete Bills, subdivision (b)(11) is amended to expand the requirement to provide any evidence of authorization for services that may have been received so that the requirement applies to both paper and electronic, and applies to all providers, not just physicians.

- Based on Labor Code section 4603.2 subdivision (b)(4), Section One-Business Rules, 5.0 Duplicate Bills, subdivision (a) is amended to prohibit the submission of a duplicate bill after an explanation of review has been provided. A cross reference to 6.0(b) is revised to reference sections 6.1 and 6.2 to conform to changes in Chapter 6. Also, a grammatical change is made.

- Based on Labor Code sections 4603.2 and 4603.3, Section One-Business Rules, 6.0 Medical Treatment Billing and Payment Requirements for Non-electronically Submitted Bills is amended to add introductory language and provide that a claims administrator is not required to respond to a duplicate bill if an explanation of review has already been issued on the original bill. Also, the title of 6.0 is changed to more accurately reflect the contents of the section. Sections 6.1 and 6.2 are added to carry out the provisions regarding timeliness of payment on original bills. Section 6.3 is amended to delete language that is no longer accurate or that is duplicative (lien information and the statement that contested charges can be challenged before the Workers' Compensation Appeals Board.) Section 6.3 is amended to carry out the statutory provisions regarding the explanation of review on original bills that are contested, denied or considered incomplete. Section 6.4 is added to specify the penalties for failure to pay or dispute treatment bills. Section 6.5 is added to specify the timeframes responding to a Request for Second Review and for issuance of payment of any balance not in dispute after the second review.

- Based on Labor Code sections 4603.2, 4603.3 and 4603.4, Section One-Business Rules, 7.0 Medical Treatment Billing and Payments Requirements for Electronically submitted Bills is amended. Section 7.1

Timeframes (b)(1) is amended change the language from “treatment provided or authorized by the treating physician” to “treatment provided or prescribed by the treating physician.” Section 7.2 Penalty is amended to specify “30 days” rather than “30 working days” to conform to the statutory change. Section 7.4 is added to provide timeframes for issuing an explanation of review and payment in response to a Request for Second Review.

- Based on Labor Code section 4603.2, Appendix A, Standard Paper Forms, 1.1 Field Table CMS 1500, Field 10d, California Workers’ Compensation Instruction is amended to specify that the W3 – Level 1 Appeal is a Request for Second Review. 2.1 Field Table UB-04, Form Locator 18-28, the California Workers’ Compensation Instruction is amended to specify that the W3 – Level 1 Appeal is a Request for Second Review. Section 3.0 National Council for Prescription Drug Programs is amended to make a technical correction in the reference to the National Council on Prescription Drug Programs paper WC/PC Universal Claim Form by deleting version “1.0 05/2008” (a prototype never put in production) and inserting version “1.1 -05/2009.” 4.1 Field Table ADA 2006 is amended to specify that a Request for Second Review will be identified by entering the words “Request for Second Review” in Field 1.

- Based on Labor Code sections 4603.2, 4603.3 and 4603.4, Appendix B, Standard Explanation of Review is amended to specify that an explanation of review must be issued after review of an original bill and after conducting a second review. The language regarding Paper Explanation of Review is amended to clarify that the claims administrator must include relevant situational data elements. The section is also amended to specify that the claims administrator shall utilize additional narrative explanatory language where necessary to fully explain why the bill is adjusted, denied or considered incomplete.

- Based on Labor Code section 4603.2 Appendix B, Table 1.0 California DWC Bill Adjustment Reason Code/CARC/RARC Matrix Crosswalk, Code M2 is amended to add “Request for Second Review” to the explanatory message as it currently refers to “Appeal/Reconsideration” which is equivalent to the Request for Second Review under the statutory amendments. “Request for Second Review” is added to message codes M5 and M6.

- Based on Labor Code sections 4603.2 and 4603.3, Appendix B, Table 3.0 Data Item No. 8 and No. 9 are amended to conform the language regarding whom to contact regarding billing disputes. The Table 3.0 is amended to add a new required Data Item No.54 to give information regarding provider remedies, including time limit and method to dispute payment and request second review, and time limit and method to request independent bill review.

- Based on Labor Code sections 4603.2 and 4603.4, subdivision (b) of the regulation is amended to revise the reference to the California Division of Workers’ Compensation

Electronic Medical Billing and Payment Companion Guide to substitute “version 1.1” for “dated 2012.”

- Electronic Medical Billing and Payment Companion Guide (which is incorporated by reference) is amended.

  - The cover page is amended to delete the date “2012” and insert “Version 1.1”.

  - Based on Labor Code section 4603.2, the heading of Chapter 2, Section 2.11 is amended to include the “Request for Second Review.”

  - Based on Labor Code section 4603.2, Chapter 2, Section 2.11.1 Claim Resubmission Code the words “second review” are added to modify “request for reconsideration.” Section 2.11.4 is amended to insert the phrase “Request for Second Review” in the heading and in the description of the W3 – 1st Level Appeal. The phrase “Second Review” is added in several places so that the regulation uses the term “Reconsideration/Second Review.” The section is amended to delete language related to “subsequent reconsideration bill transactions.”

  - Based on Labor Code sections 4603.2 and 4603.4, Chapter 2, Section 2.11.2 is amended to specify the manner of indicating a duplicate bill in the electronic 005010X224 dental transmission. The duplicate bill transaction examples are corrected and the “Original Reference Number” is changed to “Payer Claim control Number.” The section is amended to add language stating that the claims administrator is not required to respond to a duplicate bill if the 0050X221 has already issued on the original bill.

  - Based on Labor Code section 4603.2, Chapter 3, the table in Section 3.3.1 ASC X12N/005010X222 Health Care Claim: Professional (837) is amended for Loop 2300, the HI segment Condition Information by adding the “request for second review” to the California Workers’ Compensation Instructions.

  - Based on Labor Code section 4603.2, Chapter 4, the table in Section 4.3.1 ASC X12N/005010X223 Health Care Claim: Institutional (837) is amended for Loop 2300, the HI segment Condition Information by adding the “request for second review” to the California Workers’ Compensation Instructions.

  - Based on Labor Code section 4603.2, Chapter 6, Section 6.11 is added to specify that the trading partner agreement may include business rules to establish a method for identifying pharmacy second review transmissions, or may use the DWC Form SBR-1.

  - Based on Labor Code sections 4603.2, 4603.3 and 4603.6, Chapter 7, Section 7.6 Claim Level California Jurisdictional EOR Statement ID Qualifier is amended to delete language referring to seeking review of

contested charges by filing a lien at the Workers' Compensation Appeals Board and to insert language referring to the process and timelines for making a request for second review or a request for independent bill review.

- Based on Labor Code sections 4603.2, 4603.3 and 4603.6, Chapter 9, Section 9.4.4 ASC X12N/005010X221 Health Care Claim Payment/Advice (835) is amended to identify the 835 as the explanation of review. Chapter 9, sections 9.2, 9.2.1, 9.3.1 are amended to change code qualifier "U" to "WQ" correct an error, as "U" indicates a rejection and "WQ" indicates acceptance for further bill processing.

- Based on Labor Code sections 4603.2 and 4603.3, Appendix A Glossary of Terms is amended to modify the definition of "EOR" to include both paper and electronic forms of explanation of review.

- Based on Labor Code section 4603.2, Subdivision (h) is amended to make a technical correction in the reference to the National Council on Prescription Drug Programs paper WC/PC Universal Claim Form by deleting version "1.0 05/2008" (a prototype never put into production) and inserting version "1.1 -05/2009."

**Item 2 – Section 9792.5.3 Medical Treatment Bill Payment Rules.**

- Based on Labor Code section 4603.3 which mandates the adoption of rules to require the issuance of an explanation of review upon payment, adjustment, or denial of a complete or incomplete medical bill, reference to Labor Code section 4603.3 is added to this section which governs payment and communication by a claims administrator.

**Item 3 – Section 9792.5.4. Second Review and Independent Bill Review – Definitions.**

- Based on the amendments to Labor Code sections 4603.2 and 4622, and the enactment of sections 4603.3 and 4603.6, this section provides definitions for key terms regarding the second bill review process and IBR. .

- The definitions are added to ensure that the terms meaning, as used in the regulations, will be clear to the regulated public.

**Item 4 - Section 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill.**

- This section sets for the procedures and timelines for the second bill review process, as it relates to medical treatment bills and medical legal bills. Subdivision (b) provides the timeline for filing the request, which is based on 90 days from the date of service of the explanation of review or 90 days of the date of service of an order of the Workers' Compensation Appeal Board resolving any threshold issues that would preclude a provider's right to receive compensation for the submitted bill.

- Subdivision (c) addresses the manner in which a second bill review request can be made, which encompasses medical treatment billing on standardized forms, medical-legal billing, and electronic billing. The provider can use either the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6, or the standardized or electronic bill as modified. For electronic pharmacy bills, the method to identify a request for second review may be addressed in the trading partner agreement. Subdivision (d)

indicates the required contents of the second bill review request.

- Subdivision (f) provides the timeframe for the claims administrator to respond the second bill review request with a final written determination and the consequences – a 15% increase – for a failure to pay any undisputed amounts.

- Subdivision (g) expressly provides that if a provider still contests the amount of payment following the second review, IBR may be sought to resolve the dispute.

**Item 5 - Section 9792.5.6. Request for Second Review of Bill – Form.**

- This section contains the form for requesting a second review of a medical treatment bill or a medical-legal bill. The form contains identifying information and those elements required by Labor Code section 4603.2(e).

**Item 6 - Section 9792.5.7. Requesting Independent Bill Review.**

- This section contains the procedure and timeframes for the IBR process. Subdivision (a) sets forth the scope of the billing dispute that can be determined by IBR. For a bill for medical treatment services, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, one date of service, and one billing code under the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates. For a bill for medical-legal expenses, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation.

- Subdivision (b) provides that a dispute subject to IBR is limited to the amount of payment owed to the provider under a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11. IBR shall not include a determination of reasonableness of a fee or the selection of an analogous billing code, unless allowed by an existing fee schedule.

- Subdivision (c) sets forth the timeline for a provider to request IBR. The deadline is generally 30 days from the date of service of the final written determination of the second bill review or the date of resolution of any threshold issue that would preclude a provider's right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 9720.

- Subdivision (d) sets forth the manner in which to request IBR, which can be either online through the Division's website, or by utilizing the Request for Independent Bill Review form, DWC Form IBR-1, located in section 9792.5.8. In addition to the form, the subdivision states that the fee of $335.00 must accompany the request.

- Subdivision (d) further lists the documents, mandated by Labor Code section 4603.6(b) that the provider must submit in order to conduct IBR. The provider may ask for the consolidation of two or more disputes that would constitute separate requests for IBR.

- Subdivision (f) provides that the provider shall serve all documents on the claims

administrator. Any document that was previously provided to the claims administrator or originated from the claims administrator need not be served by the provider if a written description of the document and its date is served.

**Item 7 - Section 9792.5.8. Request for Independent Bill Review, DWC Form IBR-1.**

- This section contains the form for requesting IBR. The form contains identifying information regarding the parties and identifying information regarding the billing dispute.

**Item 8 - Section 9792.5.9. Initial Review and Assignment of Request for Independent Bill Review to IBRO.**

- This section contains the procedure for identifying those IBR requests that are ineligible for review and assignment of those for which a determination shall issue.

- Subdivision (a) allows the Administrative Director to determine ineligible IBR requests based on the information contained in the request form. The Administrative Director shall consider timeliness, whether the fee was paid, or whether the treatment for which payment is sought was authorized, or whether the dispute is covered under an existing fee schedule.

- Should a request appear eligible, subdivision (b) requires the Administrative Director to notify the parties of the filing and allow the claims administrator to submit any documentation indicating that the provider's request is ineligible for IBR.

- Upon receipt of documents from the claims administrator, the Administrative Director shall issue a determination finding the request for IBR to be ineligible or else assign the request to an independent bill review organization (IBRO) for review. If the request is found ineligible, the provider will be reimbursed the amount of $270.00. The IBRO shall notify the parties of the assignment and assign the case to conflict-free bill reviewer. If the bill reviewer is found to have prohibiting interest as set forth in Labor Code section 139.5(c), the dispute shall be reassigned to another bill reviewer.

**Item 9 - Section 9792.5.10. Independent Bill Review - Document Filing.**

- This section contains the procedure for the reviewer assigned by the IBRO to review the dispute to request additional documents from the parties. Subdivision (b) sets forth the timeframe in which the parties must provide and serve the requested documents (within 35 days of the request, if the request is made by mail, or 32 days of the request, if the request is made electronically).

**Item 10 - Section 9792.5.11. Withdrawal of Independent Bill Review.**

- This section contains the procedure for the provider to withdraw the request for IBR if, before a determination on the amount of payment owed, the provider and claims administrator settle their dispute regarding the amount of payment of the bill. If the provider and claims administrator settle their dispute, they shall make a written joint request for withdrawal and serve it on the independent bill reviewer.

- If a request for IBR is withdrawn, the provider shall not be reimbursed the fee provided with the initial request.

**Item 11 - Section 9792.5.12. Independent Bill Review - Consolidation or Separation of Requests.**

- An IBR request can either be consolidated with other requests for a single determination or separated – disaggregated – into multiple requests. This section contains the procedures for consolidation or disaggregation.

- Subdivision (b) provides definitions for key terms regarding IBR consolidation and disaggregation. The definitions are added to ensure that the terms meaning, as used in this section, will be clear to the regulated public.

- (c) Two or more requests for independent bill review by a single provider may be aggregated if the Administrative Director or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services.

- Under subdivision (c)(1) IBR requests by a single provider involving multiple dates of medical treatment services may be consolidated and treated as one single IBR request if the requests involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, and the total amount in dispute does not exceed $4,000.00.

- Under subdivision (c)(2), an IBR request by a single provider involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service.

- Under subdivision (c)(3), upon a showing of good cause and after consultation with the Administrative Director, the IBRO may allow the consolidation of IBR requests by a single provider that show a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Such consolidation requests must involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service, and aggregated amounts in dispute up to $4,000.00 or individual amounts in dispute less than $50.00 each.

- If a request for IBR also requests consolidation, the provider, in addition to providing the filing fee, must specify all of the IBR requests sought to be consolidated with a description of how the requests involve common issues of law and fact or delivery of similar or related services.

- The decision to grant or deny consolidation shall be immediately communicated in writing by the IBRO.

- Conversely, under subdivision (f)(1) the IBRO may disaggregate into separate independent bill review requests a single request that does not meet the consolidation standards set forth in subdivision (c). For any IBR request subject to disaggregated, the same fee shall be charged for each additional IBR request as charged for one IBR request.

- Under subdivision (f)(2), if an IBR request is separated by the IBRO, the IBRO must immediately provide notice in writing to the provider and claims administrator stating the reasons for separation, and shall inform the Provider of the additional fee or fees required to perform the independent bill review. The failure to provide the additional fee or fees shall subject the request to a determination of ineligibility.

**Item 12 - Section 9792.5.13. Independent Bill Review – Review.**

- This section provides the standards under which IBR is conducted to determine the additional amounts, if any that are to be paid to the provider. The bill reviewer must apply, as applicable, the Official Medical Fee Schedule (OMFS), found at California Code of Regulations, title 8, sections 9789.10 to 9792.5.3, the Medical-Legal Fee Schedule (M/L Fee Schedule), found at sections 9793-9795 and 9795.1 to 9795.4, or a contract for reimbursement rates under Labor Code section 5307.11.

- The bill reviewer must apply the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, as if the bill is being reviewed for the first time.

**Item 13 - Section 9792.5.14. Independent Bill Review – Determination.**

- This section implements Labor Code section 4603.6(e) and (f) by setting forth the manner in which an IBR decision is made. Under subdivision (a), the bill reviewer must, within 60 days of the assignment, issue a written determination, in plain language, if any additional amount of money is owed the provider under the IBR request. The determination shall state the reasons for the determination and the information received and relied upon in reaching the determination.

- Under subdivision (b), if any additional amount of money is found owed to the provider, the determination must order the claims administrator to reimburse the provider the amount of the filing fee in addition to any additional payments for services found owing.

- The determination, which is deemed to be the determination of the Administrative Director and be binding on all parties, must be served on the provider, the claims administrator and the Administrative Director.

**Item 14 - Section 9792.5.15. Independent Bill Review – Implementation of Determination and Appeal.**

- Subdivision (a) applies Labor Code section 4603.6(h)'s mandate as to how and when final IBR determinations are implemented; the claims administrator must pay additional amounts determined owed per the timely payment requirements set forth in Labor Code sections 4603.2 and 4603.4.

- Subdivision (b) and (c) provide and clarify the time and manner by which a claims administrator can appeal a final IBR determination to the Workers' Compensation Appeals Board (WCAB), as allowed by Labor Code section 4603.6(f).

- Subdivision (e) implements Labor Code section 4603.6(g) by providing the procedure for reassigning an IBR review should the WCAB reverse and remand the final IBR determination.

**Item 15 - Section 9793. Definitions.**

- This section of the Medical-Legal Expense regulations (commending at section 9790) is amended to provide definitions for key terms regarding comprehensive medical evaluations, the Independent Medical Review (IMR) process, the second bill review process, and IBR.

- Subdivision (e) is amended to conform to Labor Code section 4061 and 4062's mandate that disputes over the necessity of medical treatment will be decided by IMR under Labor Code sections 4610.5 and 4610.6. The dates reflected indicate the effective dates of IMR.

- Subdivision (f) is added to include the definition of "explanation of review" as described in Labor Code section 4603.3.

- Re-lettered subdivision (m) is amended to allow for the factual correction procedure set forth in Labor Code section 4061(d).

**Item 16 - Section 9794. Reimbursement of Medical-Legal Expenses.**

- This section is amended to reflect the addition of the second bill review process for disputes regarding the amount of payment on a medical-legal bill.

- Subdivision (d) sets forth the second bill review process. With the explanation of review the claims administrator must advise the provider that they may seek a second review by the claims administrator of the reduction of billing of the medical-legal expense. The statement shall also state the second review process is a prerequisite to seeking independent bill review provided in Labor Code section 4603.6. The failure of a physician to seek request a second review shall deem a bill satisfied and neither the employer nor the employee shall be liable for any additional payment.

- Under subdivision (d)(5), if after completion of the second review process the physician still contests the amount paid for the medical-legal expense, the physician must request IBR.

- Under subdivision (d), if a claims administrator denies liability for the medical-legal expense for any reasons other than the amount to be paid pursuant to the Medical-Legal fee schedule, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which must also advise the physician of their right to file a written objection with the claims administrator. If the physician does not submit a written objection, then neither the employer nor the employee shall be liable for the amount of the expense was denied.

- Under subdivision (e), if the claims administrator receives a written objection to the denial of the medical-legal expense, the claims administrator shall file a petition to review of the denial of medical–legal expense and a declaration of readiness to proceed with the WCAB.

**Item 17 - Section 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.**

- This section, which sets forth the billing codes for the Medical-Legal Fee Schedule, is amended to reflect Labor Code section 4061 and 4062's mandate that disputes over the necessity of medical treatment will be decided by IMR under Labor Code sections 4610.5 and 4610.6. The dates in Code ML103 (found in subdivision (c)) indicate the effective dates of IMR and when those services under that code will not be payable.

**Small Business Effect**

The Department of Industrial Relations, Division of Workers' Compensation has determined that the proposed regulatory action will have no significant statewide adverse economic impact directly affecting business. The Division relies upon the costs savings estimates set forth in the WCIRB's Evaluation of the Cost Impact of SB 863 as updated on October 12, 2012.

**Policy Statement Overview**

The objective of the proposed emergency regulations is to establish an independent bill review program, a system where disputes over the amount of payment made on a medical treatment bill or a bill for medical-legal expenses are ultimately made by conflict-free payment and billing experts applying fee schedules adopted by the Administrative Director of DWC.

## MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

NONE

## MANDATE ON LOCAL AGENCIES OR SCHOOL DISTRICTS

The Department of Industrial Relations, Division of Workers' Compensation has determined that this proposed regulatory action would not impose a mandate on local agencies or school districts.

## FISCAL IMPACT STATEMENT

A. Cost or Savings to any state agency: **NONE**

B. Cost to any local agency required to be reimbursed under Part 7(commencing with Section 17500) of Division 4: **NONE**

C. Cost to any school district required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4: **NONE**

D. Other nondiscretionary cost or savings imposed on local agencies: **NONE**

E. Cost or savings in federal funding to the state: **NONE**

**STATEMENT OF CONFIRMATION OF**
**MAILING OF FIVE-DAY EMERGENCY NOTICE**
(Title 1, CCR section 50(a)(5)(A))

The Division of Workers' Compensation sent notice of the proposed emergency action to every person who has filed a request for notice of regulatory action at least five working days before submitting the emergency regulations to the Office of Administrative Law for readoption in accordance with the requirements of Government Code section 11346.1(a)(2).

## SUPPLEMENT TO INFORMATIVE DIGEST

The Division of Workers' Compensation includes the following information as a supplement to the Informative Digest set forth above.

### 1. CONSISTENCY AND COMPATIBILITY WITH EXISTING STATE REGULATIONS

The Division has reviewed and evaluated this regulatory proposal against current and operative regulations and has determined it is neither inconsistent nor incompatible with existing state regulations.

### 2. DUPLICATION OF LABOR CODE PROVISIONS.

The proposed regulations repeat or rephrase various provisions of Labor Code sections 4603.2, 4603.6, and 4622, as amended or added by Senate Bill 863. Duplication is necessary for the purpose of clarity in that statutes establish comprehensive and detailed procedures for the second bill review and independent bill review programs. Rather than simply delegating to the Division authority to establish such programs, the Labor Code provisions specify the documents that must be filed or submitted by the parties, the timelines for filing, the nature of the review that will be conducted, and the required elements in a decision. Since these programs are entirely new to workers' compensation in this state, duplication is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of documents.

### 3. SUMMARY OF PROPOSED REGULATIONS.

**Item 6 - Section 9792.5.7. Requesting Independent Bill Review.**

An error in the lettering of the subdivisions in section 9792.5.9 prompted the Division to review the cross-references to section 9792.5.9 contained in other regulation sections. During this review, it was found that the last sentence of section 9792.5.7(d)(1)(A), as submitted to the Office of Administrative Law on December 19, 2012, was not consistent with the requirements the subsequent subdivision (d)(2). The sentence was deleted.

**Item 8 - Section 9792.5.9. Initial Review and Assignment of Request for Independent Bill Review to IBRO.**

Section 9792.5.9(a) sets forth various circumstances the Administrative Director must consider when determining whether a medical billing dispute is eligible for independent bill review. (For example, whether the request for bill review was timely, whether a second review was conducted, whether the application fee was paid, etc.) Subdivision (a)(7) is a seemingly wide-ranging provision: "Other reasons, if any, that the application may be ineligible for independent bill review."

It is believed that the reasons set forth in section 9792.5.9(a)(1)-(6) for determining whether a request for independent bill review is eligible for that procedure encompasses all possible considerations. However, the independent bill review program is new to the California workers' compensation system; previous disputes over medical billing were taken directly to a judge for resolution. The Division is unaware of any other considerations that may affect eligibility, but, given the unique nature of the program, it may be that the Division does not have enough

experience with independent bill review to ascertain other relevant considerations. The "catch-all" provision in subdivision (a)(7) allows the Division the opportunity to gain experience and determine if any other considerations exists which may affect eligibility for independent bill review.

**Item 9 - Section 9792.5.10. Independent Bill Review - Document Filing.**

Section 9792.5.10(b) provides that if additional documents are requested by the independent reviewer, the parties shall file the requested documents with the reviewer "within 35 days of the request" if by mail, or "32 days of the request" if the request was made electronically. This language appears inconsistent with Labor Code section 4603.6(e), which provides "If additional documents are requested, the parties shall respond with the documents requested within 30 days and shall provide the other party with copies of any documents submitted to the independent reviewer."

The timeframes set forth in the proposed regulation takes into consideration Code of Civil Procedure sections 1010.6 and 1013(a), which extend certain deadlines to act or respond to documents that are served by mail (5 additional days) or by an electronic method (2 additional days). The Division feels this extension is necessary to obviate any prejudice resulting from a delay in the receipt of a request for additional documents.

## 3. SUPPLEMENTAL RESPONSE TO COMMENTS

The Division of Workers' Compensation has received many comments submitted to the Office of Administrative Law (OAL) from pharmaceutical providers and entities in the pharmaceutical industry. The following is in response to the two concerns raised by the commenters.

### (1) The requirement for the attachment of a prescription complies with the intent of the statute and rules of statutory construction.

Senate Bill (SB) 863 amended Labor Code section 4603.2 to create a second medical bill review process and, as expressly shown in the new-added section 4603.6, an independent bill review procedure. In this regard, subdivision (b)(1) was added to section 4603.2 to specify how the medical billing process should be initiated in the workers' compensation arena (emphasis added):

> 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, a copy of all reports showing the services performed**, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician**, and any evidence of authorization for the services that may have been received. Nothing in this section shall prohibit an employer, insurer, or third-party claims administrator from establishing, through written agreement, an alternative manual or electronic request for payment with providers for services provided pursuant to Section 4600.

Based on this statutory provision, the Division, through emergency regulations, has amended its California Division of Workers' Compensation Medical Billing and Payment Guide, incorporated

by reference in California Code of Regulations, title 8, section 9792.5.1(a), to change the definition of "complete bill." (See Section 1 – Business Rules; 3.0 Complete Bills.) In addition to other listed requirements (i.e., medical reports, an invoice), a complete bill for medical treatment must include "(12) The prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician.

The commenters have found this amendment to be unworkable in regards to the rendering of pharmaceuticals. The commenters assert that the Division has not clarified how a provider would include a prescription in the current required billing format, especially since the electronic billing standard adopted by the Division for pharmacy bills (NCPDP Telecommunications Standard Version D.0) does not currently support the inclusion of attachments. As stated by the California Retailers Association in their comments of December 21: "Pharmacies are not currently required to attach full prescription records to claims and requiring them to do so would inhibit their ability to adjudicate claims in real-time, delaying care for injured workers."

The Division appreciates the concerns of the pharmaceutical industry. However, Labor Code section 4603.2(b)(1) is very clear: a medical bill must include the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician. The Division's proposed regulation mirrors this statutory mandate. While it is understood that this requirement maybe contrary to industry practice, the Division simply cannot craft a plausible interpretation of that provision that would both exempt the pharmaceutical industry from the prescription requirement and comply with the plain language of statute.

It is noted that section 4603.2(b)(1) allows claims administrator and providers to agree upon an alternative manual or electronic method for medical bill submission. Until a statutory change is affected that addresses the commenters' concerns, it is hoped that the parties will agree upon a bill submission method – possibly the one currently in place – that is workable for all concerned.

**(2) The Division will clarify use of the NCPDP Form.**

The emergency regulations adopt the updated paper billing form for pharmacy billing in the Medical Billing and Payment Guide, by changing the designation of the form to NCPDP Workers' Compensation /Property & Casualty Universal Claim Form (WC/PC UCF) version 1.1 – 05/2009. The new version 1.1 – 05/2009 replaces the codified reference to version 1.0, 05/2008. The Division was informed by the National Council on Prescription Drug Programs that version 1.0 – 05/2008 of the form was a draft that was never put into production. The public has therefore been utilizing version 1.1 – 05/2009 since the regulation became effective on October 15, 2011. The version 1.1 adds only one new field that was not on the version 1.0: Field 68 Prescription Origin Code. The Division agrees with the public comments indicating that the form usage table should be updated. The Division is resubmitting the Medical Billing and Payment Guide to the Office of Administrative Law to correct the 3.1 Field Table to accomplish the following in the emergency adoption: Revise the table heading on column two to eliminate reference to the 2008 form; add Field 68 Prescription Origin Code and designate it as an optional data element; renumber the fields following number 68; and make non-substantive corrections to field description names and cross references to the NCPDP D.0 electronic transaction standard.

The Division of Workers' Compensation appreciates the comments made and welcomes the participation of the commenters in the rulemaking to adopt the permanent regulations. It is imperative that the emergency regulations go forward in order to implement the mandates of SB 863 at the earliest possible time.