

Request for Authorization Independent Medical Review Second Bill Review Independent Bill Review

COA 2014 Annual Meeting



California
Orthopaedic
Association



SB 863 Changed Workers' Compensation

MAJOR changes impacting every Provider's revenue

The screenshot shows the website for the State of California Department of Industrial Relations. The header includes the CA.GOV logo, the department name, and navigation links for Home, Labor Law, Cal/OSHA - Safety & Health, Workers' Comp, Self Insurance, Apprenticeship, Director's Office, and Boards. A search bar is also present. The main content area is titled 'Division of Workers' Compensation (DWC)' and features a prominent section for 'Senate Bill 863'. Below this, there is a paragraph explaining the bill's passage and its impact on the workers' compensation system. A list of tools provided by the DWC to assist with analyzing SB 863 is shown, including links to read the text, overview, rulemaking timeline, and index by Labor Code section. Three main review categories are highlighted with dark blue headers: 'Independent bill review (IBR)', 'Independent medical review (IMR)', and 'Lien filing fees'. Each category has a list of related links. On the right side, there is a sidebar with 'Quick Links' and 'About DWC' sections, both containing several links for user assistance.

State of California
Department of Industrial Relations

CA.gov | Contact DIR | Press Room

Search

This Site • California

Home Labor Law Cal/OSHA - Safety & Health Workers' Comp Self Insurance Apprenticeship Director's Office Boards

Division of Workers' Compensation (DWC)

Senate Bill 863

Senate Bill 863 was passed on Aug. 31, 2012 and was signed into law by Governor Brown on Sept. 18, 2012. The bill makes wide-ranging changes to California's workers' compensation system, including increased benefits to injured workers and cost-saving efficiencies. The bill takes effect on Jan. 1, 2013, although not all of its provisions will be effective immediately.

The Division of Workers' Compensation offers the following tools to assist you in analyzing SB 863:

- Read the text of Senate Bill 863
- Overview of Senate Bill 863
- Rulemaking timeline
- Index by Labor Code section

Independent bill review (IBR)

- Independent Bill Review (IBR)
- Frequently asked questions about independent bill review

Independent medical review (IMR)

- Independent Medical Review (IMR)
- Frequently asked questions about independent medical review

Lien filing fees

Division of Workers' Compensation (DWC)

Quick Links

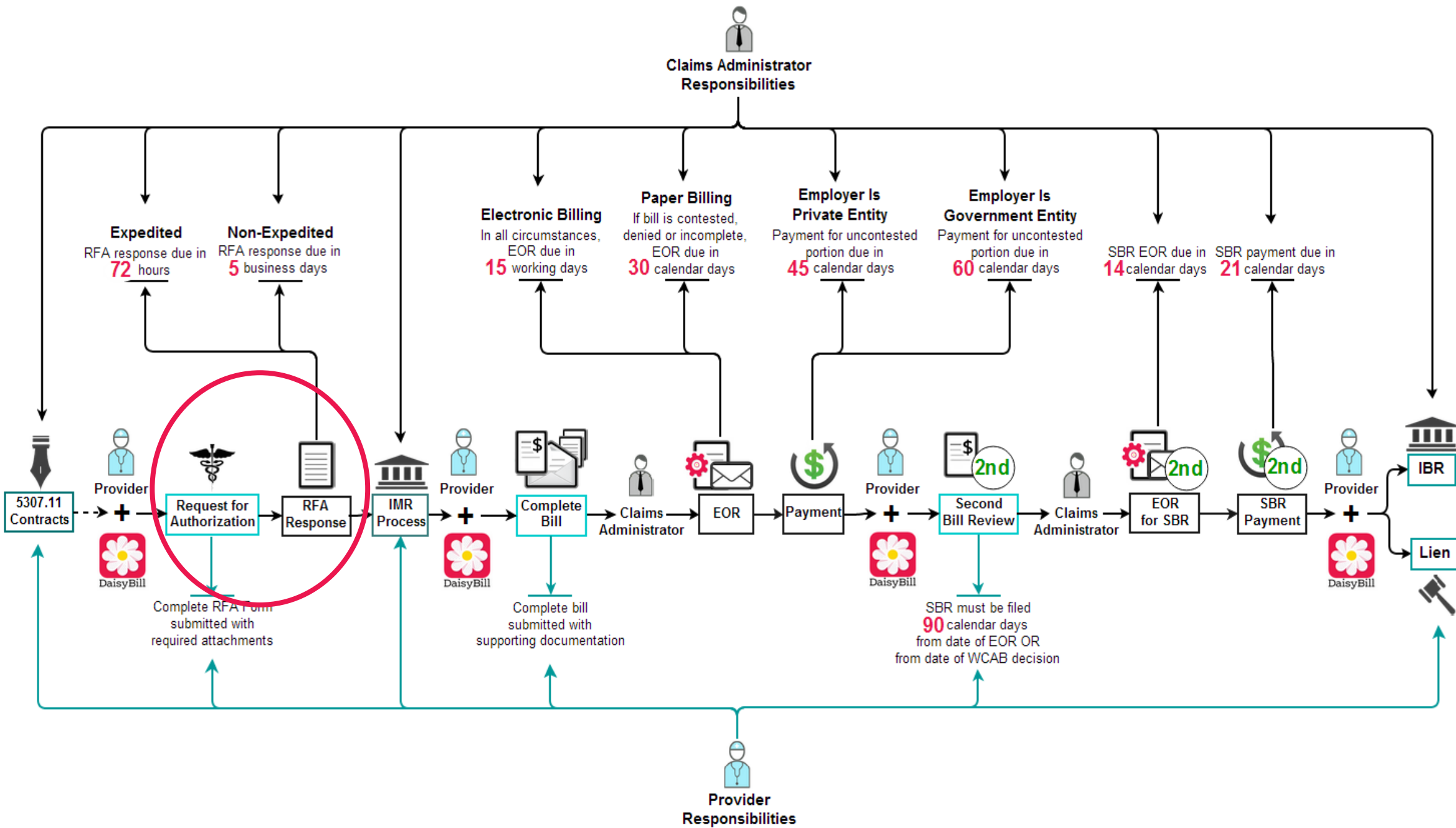
- Search for a workers' comp case
- Know my rights
- What to do if you get hurt on the job
- Find a fact sheet or I&A guide
- Forms
- Publications
- Reports
- File a complaint
- Pay my bill online

About DWC

- Contact
- Locations

DWC Home

Request For Authorization (RFA) Form



Request For Authorization (RFA) Form

a written request for authorization of **medical treatment for a specific course of proposed medical treatment,**

or

a written confirmation of an **oral request for a specific course of proposed medical treatment,**

must be set forth on the

“Request for Authorization of Medical Treatment,” DWC Form RFA, contained in section 9785.5.

Request for Authorization Form - MANDATED

“Request for Authorization of Medical Treatment,” DWC Form RFA, contained in section 9785.5

[PRINT CLE](#)

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

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

New Request Resubmission – Change in Material Facts
 Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
 Check box if request is a written confirmation of a prior oral request.

Employee Information				
Name (Last, First, Middle):				
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):		
Claim Number:		Employer:		
Requesting Physician Information				
Name:				
Practice Name:		Contact Name:		
Address:		City:	State:	
Zip Code:	Phone:	Fax Number:		
Specialty:		NPI Number:		
E-mail Address:				
Claims Administrator Information				
Company Name:		Contact Name:		
Address:		City:	State:	
Zip Code:	Phone:	Fax Number:		
E-mail Address:				
Requested Treatment (see instructions for guidance; attached additional pages if necessary)				
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.				
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (Required)	Other Information: (Frequency, Duration)

WCAB Decision: Stricter RFA Standards

In the Torres-Ramos v. Marquez decision, WCAB Commissioners said that all requests for treatment authorization made after this Feb. 12 need to be made on the official Division of Workers' Compensation Form RFA. "A treatment request that is not on the form or not compliant with the requirements for an alternate is not a valid request." And, pursuant to the WCAB's April 28 ruling, an invalid request will not trigger a carrier's obligation to initiate the utilization review process.

RFA: Alternate to DWC Form RFA

However, a claims administrator may accept a request for authorization for medical treatment that was not made on the DWC form if the request is made in writing, and it clearly says "Request for Authorization" at the top of the first page of the document.

The first page must also list all the requested medical services, goods or items and the request must be accompanied by documentation substantiating the medical necessity for the requested treatment, Melton added.

Required: Treating Physician Initiates RFA

Carefully follow the DWC's instructions on filing a complete RFA.

Instructions for Request for Authorization Form

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached. The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq.

Required: RFA Attachments

- Doctor's First Report (Form DLSR 5021),
- Treating Physician's Progress Report (DWC Form PR-2), or
- Equivalent narrative report substantiating request for treatment

Instructions for Request for Authorization Form

Warning: Private healthcare information is contained in the Request for Authorization for Medical Treatment, DWC Form RFA. The form can only go to other treating providers and to the claims administrator.

Overview: The Request for Authorization for Medical Treatment (DWC Form RFA) is required for the employee's treating physician to initiate the utilization review process required by Labor Code section 4610. **A Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment must be attached.** The DWC Form RFA is not a separately reimbursable report under the Official Medical Fee Schedule, found at California Code of Regulations, title 8, section 9789.10 et seq.

Form: New Treatment vs Resubmission

PRINT CLEAR

Step #1

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

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input type="checkbox"/> New Request	<input type="checkbox"/> Resubmission – Change in Material Facts
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health	
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.	

Instructions for Request for Authorization Form

Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a **new treatment request** for the employee or **the resubmission of a previously denied request based on a change in material facts regarding the employee's condition**. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.

Form: Expedited Review

PRINT CLEAR

Step #2



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

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input type="checkbox"/> New Request	<input type="checkbox"/> Resubmission – Change in Material Facts
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health	
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.	

Instructions for Request for Authorization Form

Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- **Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.**

§9792.6. (h) "Expedited review" means utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

Form: Oral Request for Authorization

PRINT CLEAR

Step #3

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

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

- | | |
|--|--|
| <input type="checkbox"/> New Request | <input type="checkbox"/> Resubmission – Change in Material Facts |
| <input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health | |
| <input type="checkbox"/> Check box if request is a written confirmation of a prior oral request. | |

Instructions for Request for Authorization Form

Checkboxes: Check the appropriate box at the top of the form. Indicate whether:

- This is a new treatment request for the employee or the resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.
- Review should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.
- **The request is a written confirmation of an earlier oral request.**

§9792.6. An oral request for authorization must be followed by a written confirmation of the request within seventy-two (72) hours.

Form: Complete All Underlying Information

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION

Step #4 RFA Form must be complete **DWC Form RFA**

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

<input type="checkbox"/> New Request	<input type="checkbox"/> Resubmission – Change in Material Facts
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health	
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.	

Employee Information			
Name (Last, First, Middle):			
Date of Injury (MM/DD/YYYY):		Date of Birth (MM/DD/YYYY):	
Claim Number:		Employer:	
Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			
Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Instructions for Request for Authorization Form

Routing Information: This form can be mailed, faxed, or e-mailed to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information regarding the employee, the claims administrator, and the physician.

Required: Diagnosis, ICD-Code & Service/Goods Requested

- Step #5 Requested Treatment Details


Requested Treatment (see instructions for guidance; attached additional pages if necessary)				
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.				
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Requesting Physician Signature:			Date:	

Instructions for Request for Authorization Form

Requested Treatment: The DWC Form RFA must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included.
- For requested treatment that is: (a) inconsistent with the Medical Treatment Utilization Schedule (MTUS) found at California Code of Regulations, title 8, section 9792.20, et seq.; or (b) for a condition or injury not addressed by the MTUS, you may include scientifically based evidence published in peer-reviewed, nationally recognized journals that recommend the specific medical treatment or diagnostic services to justify your request.

Required: Requesting Physician Signature

Requested Treatment (see instructions for guidance; attached additional pages if necessary)				
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.				
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Step #6 				
Requesting Physician Signature:			Date:	

Instructions for Request for Authorization Form

Requesting Physician Signature: Signature/Date line is located under the requested treatment box. A signature by the treating physician is mandatory.

Information Resource: DWC's Frequently Asked Questions

www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm



CA.GOV State of California Department of Industrial Relations

Home Labor Law Cal/OSHA - Safety & Health Workers' Comp Self Insurance A

Division of Workers' Compensation (DWC)

▶ **Answers to frequently asked questions about utilization review (UR) for claims administrators**

In addition to the FAQs below, claims administrators may call 1-800-736-7401 to hear recorded information on a variety of workers' compensation topics 24 hours a day.

Claims administrators may also call a [local office of the state Division of Workers' Compensation \(DWC\)](#) and speak to the Information and Assistance (I&A) Unit for help during regular business hours.

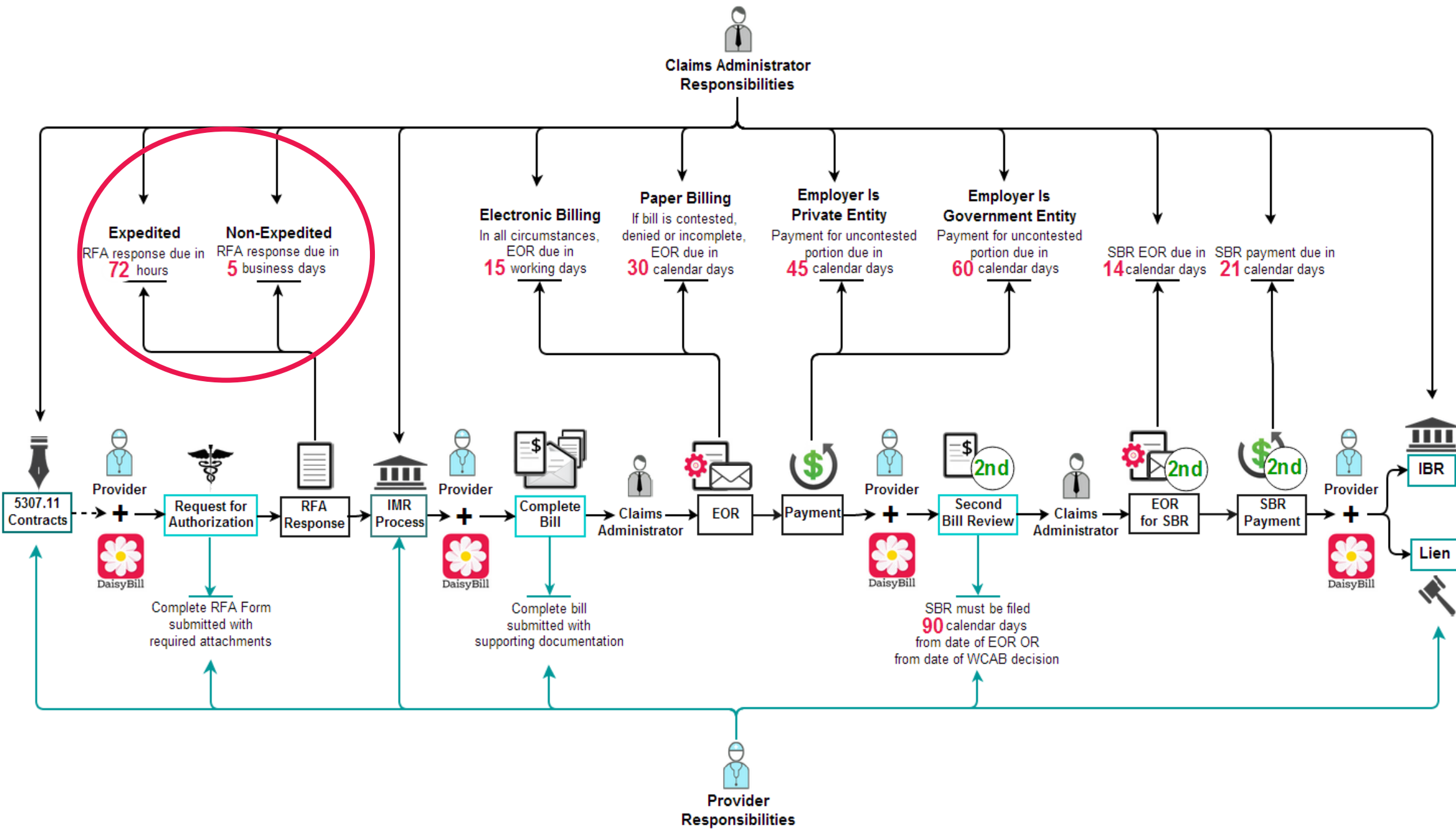
Claims administrators may find the DWC's fact sheets and guides for injured workers useful and can access them on the [I&A Unit's Web page](#).

Throughout this FAQ, when citations to Title 8 of the California Code of Regulations are made, they will appear in this format: (CCR, Title 8 §number.) Citations to California's Labor Code appear as: (LC number).

Topics covered in this FAQ include:

- Utilization review
- Requests for authorization
- Different types of UR
- Who can make UR decisions?
- UR program requirements
- Timelines and timing
- UR replies
- Prior authorization
- UR penalty regulations
- UR and AME/QME reports
- Maintaining and modifying a UR plan
- UR and medical provider networks (MPNs)

Request For Authorization Response



5 Business Days Non-Expedited RFA Response Timeframes

Claims Administrator/URO Response: Upon receipt of the DWC Form RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of Regulations, title 8, section 9792.9.1. To communicate its approval on requested treatment, the claims administrator may complete the lower portion of the DWC Form RFA and fax it back to the requesting provider. (Use of the DWC Form RFA is optional when communicating approvals of treatment; a claims administrator may utilize other means of written notification.) If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.

Q. Prospective or concurrent reviews of RFAs require a five business day turnaround of the decision. When do the five days begin?

A. Prospective or concurrent decisions must be made within five business days from the date the written RFA was first received, whether by the employer, the claims adjuster or the URO.

According to the California Civil Code: "The time in which any act provided by law is to be done is computed by excluding the first day and including the last, unless the last day is a holiday, and then it is also excluded." In other words, except for expedited reviews (see below), if you receive an authorization request sometime before 5:30 p.m. on a Tuesday (non-holiday) the next day, Wednesday, is counted as day one. The reviewer must make the decision no later than the following Tuesday (the 5th business day). The decision must be communicated by phone or fax within 24 hours of making the decision. Saturday and Sunday are not counted as business days, and therefore receipt of requests on a weekend or a holiday does not count as a receipt, until the next business day. Holidays do not count as business days.

For all reviews excluding expedited reviews, count the date of first receipt as "zero" so the next day is counted as "one." When counting business days, the Saturday, Sunday or holiday is not counted as a business day, so continue the count on the next business day. Whenever the last day in counting a calendar day deadline falls on a Saturday, Sunday or holiday, the count moves to the next day.

For expedited reviews the time for making the decision is counted in hours, regardless of whether the day is a calendar or business day.

72 Hours Expedited RFA Response Requirement

Q. What is an expedited review?

A. An expedited review is UR conducted when the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function. Expedited review also applies when the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health, or could jeopardize the injured worker's permanent ability to regain maximum function. **Expedited reviews must be completed within 72 hours or less if the injured worker's condition warrants a shorter timeframe.** When an expedited review is needed, the requesting physician must alert the reviewer, by checking the "Expedited Review" box at the top of the RFA.

Q. If a request for an expedited review, with all necessary information, is received at 9 a.m. on a Friday morning, when is the decision due?

A. Requests for expedited review must be decided within 72 hours or less, depending on the injured worker's condition. In this example, the decision would be due no later than 9 a.m. the following Monday. **With expedited reviews, the time is counted in hours, not days.**

Q. What is required of the requesting physician for an expedited review?

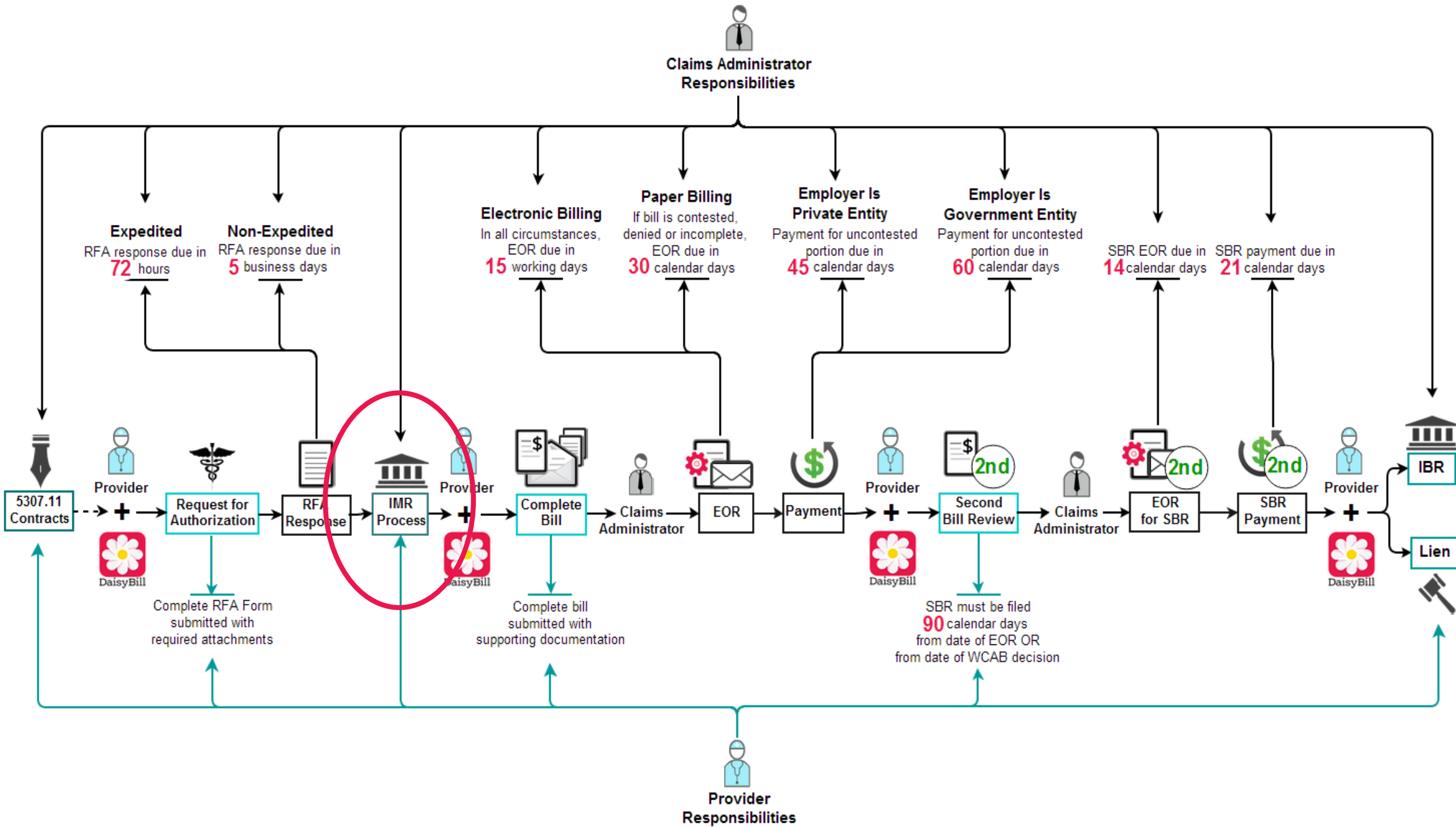
A. **The requesting physician must indicate the need for an expedited review upon submission of the request.** The requester should provide all necessary information in writing so that the claims administrator can make a decision quickly.

WCAB Decision: Timely & Valid UR

In the Dubon vs World Restoration case, the commissioners decided that an applicant MAY challenge a UR or IMR determination because of procedural flaws such as "timeliness and compliance with statutes and regulations." The Appeals Board specifically held as follows:

1. IMR solely resolves disputes over the medical necessity of treatment requests. Issues of timeliness and compliance with statutes and regulations governing UR are legal disputes within the jurisdiction of the WCAB.
2. A UR decision is invalid if it is untimely or suffers from material procedural defects that undermine the integrity of the UR decision. Minor technical or immaterial defects are insufficient to invalidate a defendant's UR determination.
3. If a defendant's UR is found invalid, the issue of medical necessity is not subject to IMR but is to be determined by the WCAB based upon substantial medical evidence, with the employee having the burden of proving the treatment is reasonably required.
4. If there is a timely and valid UR, the issue of medical necessity shall be resolved through the IMR process if requested by the employee.

Independent Medical Review (IMR)



IMR: Required for Denied or Modified Requests for Authorization

Disputes over an IMR decision are resolved via Independent Medical Review (IMR)



The screenshot shows the website for the State of California Department of Industrial Relations, specifically the Division of Workers' Compensation (DWC). The page is titled "Independent Medical Review (IMR)" and includes a "What is IMR" section. The text explains that California's worker's compensation system uses IMR to resolve disputes about medical treatment. It also mentions that a request for medical treatment must go through a "utilization review" process. The costs of IMR are paid by employers, and the costs are based on the nature of the medical treatment dispute. A "NOTE" section at the bottom states that IMR and IBR prices have been reduced retroactive to April 1, 2014.

CA.gov | Contact DIR | Press Room

State of California
Department of Industrial Relations

CA.GOV

Home | Labor Law | Cal/OSHA - Safety & Health | Workers' Comp | Self Insurance | Apprenticeship | Director's Office | Boards

Division of Workers' Compensation (DWC)

▶ Independent Medical Review (IMR)

What is IMR

California's worker's compensation system will use a process called independent medical review (IMR) to resolve disputes about the medical treatment of injured employees. As of July 1, 2013, medical treatment disputes for all dates of injury will be resolved by physicians through an efficient process known as IMR, rather than through the often cumbersome and costly court system.

A request for medical treatment in the workers' compensations system must go through a "utilization review" process to confirm that it is medically necessary before it is approved. If utilization review denies, delays or modifies a treating physician's request for medical treatment because the treatment is not medically necessary, the injured employee can ask for a review of that decision through IMR.

The costs of IMR are paid by employers who are required by law to provide injured employees with all medical treatment that is reasonable and necessary to cure or relieve the effects of a work-related injury. The DWC is required to contract with one or more independent medical review organizations (IMROs), to conduct IMR on its behalf.

The costs of IMR are based upon the nature of the medical treatment dispute and the number of medical professionals needed to resolve the dispute. The 2013 costs for IMR were based upon the DWC data regarding the estimated number of medical necessity disputes and the expertise of the IMRO. The costs of resolving a medical treatment dispute through IMR are expected to be significantly less than the cost to litigate a treatment dispute.

NOTE:

The IMR and IBR prices have been reduced retroactive to April 1, 2014. Please see the May 19, 2014 [newsline](#) for the new price list.

Division of Workers' Compensation (DWC)

Quick Links

- Search for a workers' comp case
- Know my rights
- What to do if you get hurt on the job
- Find a fact sheet or I&A guide
- Forms
- Publications
- Reports
- File a complaint
- Pay my bill online

About DWC

- Contact
- Locations

DWC Home

When is IMR Appropriate?

- Request for Authorization Submitted
- After Utilization Review:
 - Request Denied
 - Request Delayed
 - Request Modified
- Employee disputes UR decision.

There is No internal UR Appeals Process.

IMR: Initiated by the Injured Worker

Independent Medical Review (IMR) is initiated by the injured worker to contest denied or modified RFAs.

Providers may join or assist employee with IMR.

IMR: Initiated by the Physician

Exception: Emergency treatment provided to the injured workers that is subsequently denied can be put through the IMR process by the physician.

§9792.6. (g) “Emergency health care services” means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

IMR: Submission Timeframe

Submit by Mail:

within 30 Days of:

Receipt of UR Decision

or

Within Service of Notice of Dispute Resolution at WCAB

IMR Response Timeframes

For regular review:

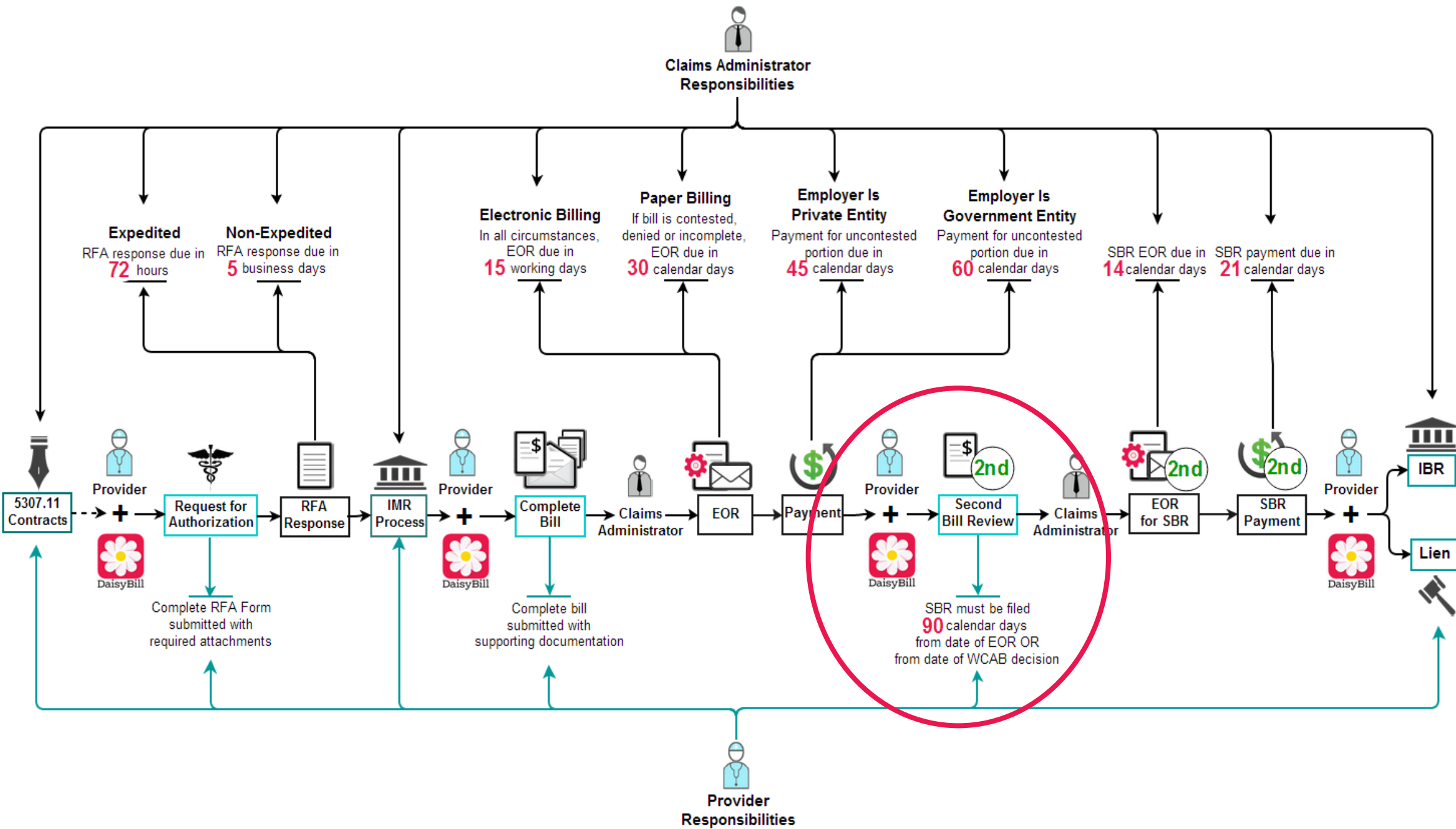
Within 20 days of receipt of DWC form & supporting documentation

For expedited review:

Treatment has not been provided: within 3 days of request & supporting documentation

Treatment has been provided: within 30 days of receipt of request & supporting documentation

Second Bill Review



With SB 863, Second Bill Reviews Are Mandated

§ 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services or goods rendered on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred 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.

(b) The second review must be requested within 90 days of:

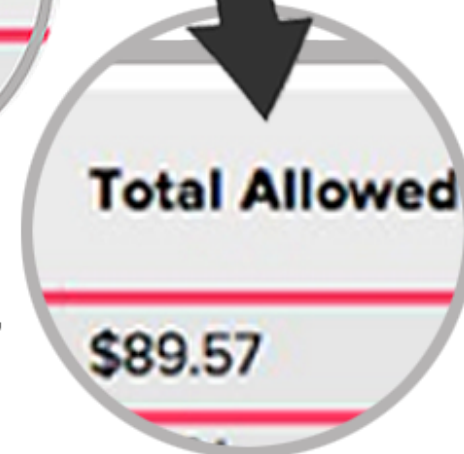
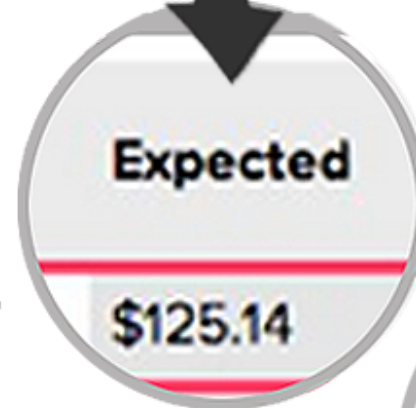
(1) The date of service of the explanation of review provided by a claims administrator in conjunction with the payment, adjustment, or denial of the initially submitted bill, if a proof of service accompanies the explanation of review.

With RBRVS, Second Bill Reviews Are Critical

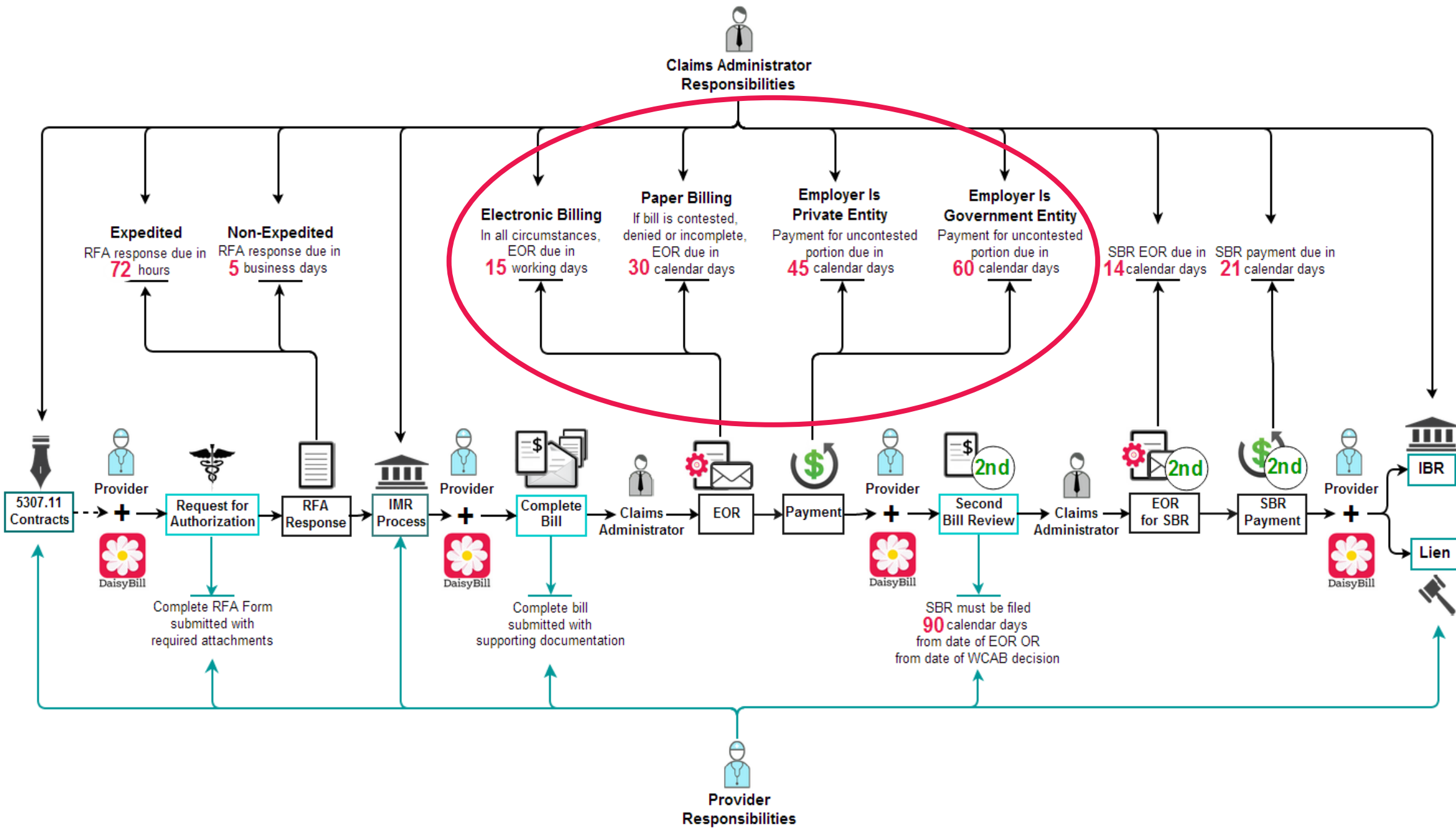
Procedure Code	Units	Charge	Allowed	Expected	Total Allowed	Total Percent Allowed	Write Off	Balance
99214:25	1	\$250.28	\$89.57	\$125.14	\$89.57	72%	\$35.57	\$0.00
WC002	1	\$23.82	\$11.91	\$11.91	\$11.91	100%	\$0.00	\$0.00
L3908	1	\$165.42	\$81.90	\$82.71	\$81.90	99%	\$0.81	\$0.00
Total		\$439.52	\$183.38	\$219.76	\$183.38	83%	\$36.38	\$0.00

Correct 2014 RBRVS reimbursement is \$125.14

Claims Admin incorrectly used 2013 OMFS rate for reimbursement of \$89.57



Mandated Life Cycle of a Complete Bill



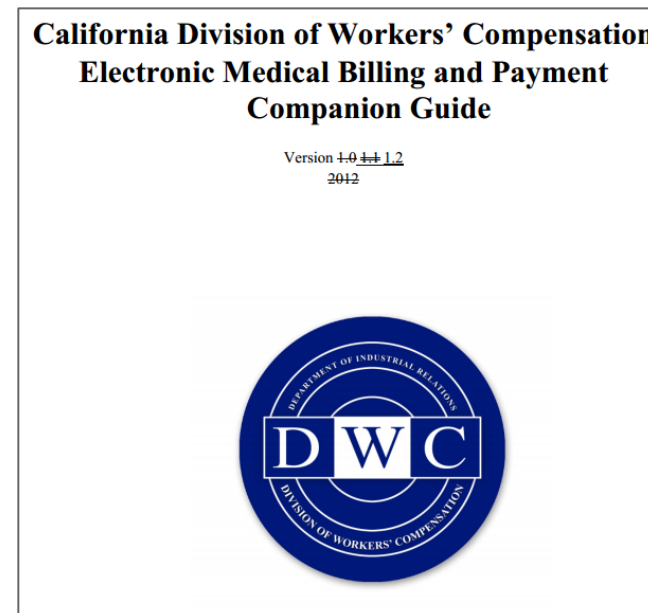
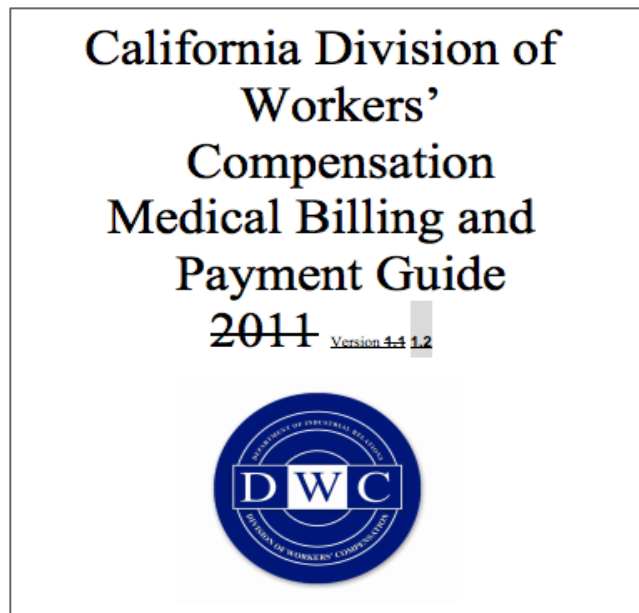
As of 1/1/2013: Mandated Life Cycle of a Work Comp Bill

1. Provider submits a complete bill to Claims Administrator
2. Claims Administrator responds to bill with a compliant (timely and complete) Explanation of Review (EOR)
3. If Provider disputes Claims Administrator's adjudication / payment of the bill, Provider submits a compliant (timely and complete) Second Bill Review (SBR) to Claims Administrator
4. Claims Administrator responds to SBR with a compliant (timely and complete) final Explanation of Review (EOR)
5. If Provider disputes Claims Administrator's adjudication / payment of the SBR, Provider submits either an IBR to the Administrative Director or files a lien with the WCAB.

1. Provider Submits Complete Bill to Claims Administrator

3.0 Complete Bills

- (a) To be complete a submission must consist of the following:
- (1) The correct uniform billing form/format for the type of health care provider.
 - (2) The correct uniform billing codes for the applicable portion of the OMFS under which the services are being billed, **including the correct ICD code as specified in Section 3.1.0 – 3.2.1.**
 - (3) The uniform billing form/format must be filled out according to the requirements specified for each format in Appendix A and/or the Companion Guide. Nothing in this paragraph precludes the claims administrator from populating missing information fields if the claims administrator has previously received the missing information.
 - (4) A complete bill includes required reports and supporting documentation specified in subdivision (b).



2. Claims Administrator Responds to Bill with a Compliant Explanation of Review (EOR)

Labor Code and Administrative Director's Guide require Claims Administrators to issue timely and complete EORs.

California Division of
Workers'
Compensation
Medical Billing and
Payment Guide
2011 Version 4.4 1.2



California Labor Code Section 4603.3

[Legal Research Home](#) > [California Laws](#) > [Labor Code](#) > California Labor Code Section 4603.3

4603.3. (a) Upon payment, adjustment, or denial of a complete or incomplete itemization of medical services, **an employer shall provide an explanation of review in the manner prescribed by the administrative director** that shall include all of the following:

- (1) A statement of the items or procedures billed and the amounts requested by the provider to be paid.
- (2) The amount paid.
- (3) The basis for any adjustment, change, or denial of the item or procedure billed.
- (4) The additional information required to make a decision for an incomplete itemization.
- (5) If a denial of payment is for some reason other than a fee dispute, the reason for the denial.
- (6) Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.

(b) The administrative director may adopt regulations requiring the use of electronic explanations of review.

EOR: Non-Electronic and Electronic Bills

Non-electronic and electronic EORs: Different timeframes for different types of bill submission, but identical information requirements.

6.0 ~~Medical Treatment Billing and~~ Processing and Payment Requirements for Non-Electronically Submitted Medical Treatment Bills.

Upon receipt of a medical bill submitted by a health care provider, health care facility or billing agent/assignee, the claims administrator shall promptly evaluate and take appropriate action on the bill. The claims administrator is not required to respond or issue any notice in relation to a duplicate bill if the claims administrator has issued an explanation of review on the original bill.

7.0 ~~Medical Treatment Billing and~~ Bill Processing and Payment Requirements for Electronically Submitted Medical Treatment Bills

7.1 Timeframes

When a medical treatment bill has been submitted electronically, the claims administrator must transmit the Acknowledgments and Payment/Advice as set forth below using the specified transaction sets. These transactions are used to notify the provider regarding the entire bill or portions of the bill including: acknowledgment, payment, adjustments to the bill, requests for additional information, rejection of the bill, objection to the bill, or denial of the bill.

Timely EOR Requirements - Uncontested Bill

Uncontested bills sent non-electronically: EOR must be sent with payment within 45 or 60 days of Claims Administrator's receipt of bill, depending on whether employer is a governmental entity.

6.1 Timeframes: Original Treatment Bills That Are Uncontested.

Any complete bill submitted in other than electronic form or format for uncontested medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer shall be paid by the claims administrator within 45 days of receipt, or within 60 days if the employer is a governmental entity. The claims administrator shall issue an explanation of review concurrently with the payment.

Uncontested bills sent electronically: electronic EOR must be sent within 15 working days of Claims Administrator's receipt of e-bill.

(1) Complete Bill - Payment for Uncontested Medical Treatment.

ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835) – If the electronically submitted bill has been determined to be complete, payment for uncontested medical treatment provided or ~~authorized~~ prescribed by the treating physician selected by the employee or designated by the employer shall be made by the claims administrator within 15 working days after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Labor Code §5307.1. Nothing prevents the parties from agreeing to submit bills electronically that are being paid per contract rates under Labor Code § 5307.11. Remittance advice shall be sent using the 005010X221A1 payment transaction set as defined in Companion Guide Chapter 9. Explanations of Review are embedded in the 005010X221A1 and shall use the Claims Adjustment Reason Codes and Remittance Advice Remarks listed in Appendix B – 1.0.

Timely EOR Requirements - Contested, Denied, or Incomplete Bill

Contested, Denied or Incomplete Bills sent non-electronically: EOR must be sent within 30 days of Claims Administrator's receipt of bill.

6.2 Timeframes: Original Treatment Bills That Are Contested, Denied, Or Considered Incomplete.

- (a) If the non-electronic bill or a portion of the bill is contested, denied, or considered incomplete, the claims administrator shall so notify the health care provider, health care facility or billing agent/assignee in the explanation of review. The explanation of review must be issued within 30 days of receipt of the bill and must provide notification of the items being contested, the reason for contesting those items and the remedies open to the health care provider, health care facility or billing agent/assignee. The explanation of review will be deemed timely if sent by first class mail and postmarked on or before the thirtieth day after receipt, or if personally delivered or sent by electronic facsimile on or before the thirtieth day after receipt.
- (b) If a portion of the non-electronic bill is uncontested, payment of the uncontested amount shall be issued within 45 days of receipt of the bill, or within 60 days of receipt of the bill if the employer is a governmental entity. The claims administrator shall issue an EOR concurrently with the payment.

Contested, Denied or Incomplete Bills sent electronically: electronic EOR must be sent within 15 working days of Claims Administrator's receipt of e-bill.

(2) Objection to Bill / Denial of Payment.

The ASC X12N/005010X221A1 Health Care Claim Payment/Advice (835) is utilized to object to a bill, to deny a bill, and to notify the provider of the adjustment of charges, if the bill has not been rejected at the Acknowledgment stage. A claims administrator who objects to all or any part of an electronically submitted bill for medical treatment shall notify the health care provider, health care facility or assignee of the objection within 15 working days after receipt of the complete bill and shall pay any uncontested amount within 15 working days after receipt of the complete bill. If the claims administrator receives a bill and believes that the report and/or supporting documentation is/are not sufficient to support the bill, the claims administrator shall so inform the health care provider within 15 working days of receipt of the bill utilizing the 005010X221A1. If the bill was placed in pending status during the Acknowledgment stage, the 15 working day time frame is extended by the number of days the bill was held in pending status under 7.1(a)(3)(A). Any contested portion of the billing shall be paid in accordance with Labor Code section 4603.2.

Penalty & Interest: Electronic & Non-Electronic Bills

Penalty and interest are due if Provider is not paid for the uncontested portion of bill within 45 (60 days for government employers) of the Claim Administrator's receipt of the bill.

6.4 Penalty

- (a) Any non-electronically submitted bill determined to be complete, not paid within 45 days (60 days for a governmental entity) or objected to within 30 days, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).
- (b) Any non-electronically submitted complete bill for uncontested medical treatment provided or prescribed by the treating physician selected by the employee or designated by the employer not paid by the claims administrator within 45 days of receipt, or within 60 days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or billing agent/assignee is notified within 30 days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.

7.2 Penalty

- (a) Any electronically submitted bill determined to be complete, not paid or objected to within the 15 working day period, shall be subject to audit penalties per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).
- (b) In addition, any electronically submitted complete bill that is not paid within 45 working days of receipt, or within 60 working days if the employer is a governmental entity, shall be increased 15%, and shall carry interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill unless the health care provider, health care facility or billing agent/assignee is notified within 30 working days of receipt that the bill is contested, denied or considered incomplete. The increase and interest are self-executing and shall apply to the portion of the bill that is neither timely paid nor objected to.

Compliant EOR Information Requirements

Claims Administrator must send a complete EOR, that includes:

1. Required / Situational information per Table 3.0
2. Notification of items being contested, denied or considered incomplete, using DWC's Bill Adjustment Reason Codes (BARCs)
3. Details of additional information required for payment
4. Claims Administrator contact information

6.3 Explanation of Review on Original Treatment Bills That Are Contested, Denied, Or Considered Incomplete.

(a) The explanation of review shall address all of the required data items and all of the relevant situational data items listed in Appendix B, Table 3.0 and communicate the reason(s) the bill is contested, denied, or considered incomplete, including:

- (1) A clear and concise explanation of the basis for the objection to each contested procedure and charge using the DWC Bill Adjustment Reason codes and DWC Explanatory Messages contained in Appendix B, 1.0 California DWC Bill Adjustment Reason Code / CARC / RARC Matrix Crosswalk.
- (2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required.
- (3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection.


Complete Explanation of Review Requirements

3.0 Table for Paper Explanation of Review

California DWC Paper EOR Requirements			
Data Item No.	Field Description	Workers' Compensation Data Requirements R/S/O	Comments
1	Date of Review	R	Date of Review
2	Method of Payment	S	If there is a payment, indicate if Paper Check or EFT
3	Payment ID Number	S	If there is a payment, indicate Paper Check Number or EFT Tracer Number
4	Payment Date	S	If there is a payment, indicate the payment date.
5	Payer Name	R	
6	Payer Address	R	
7	Payer Identification Number	O	Payer Identification Number (FEIN). Required if there is no payment or payment less than billed charges: Additional claim administration administrator contact information information e.g., Adjustor ID reference for appeal billing dispute contact
8	Payer Contact Name	S	Required if there is no payment or payment less than billed charges: Additional claim administration administrator contact information information e.g., Adjustor ID reference for appeal billing dispute contact
9	Payer Contact Phone Number	S	Required if there is no payment or payment less than billed charges: Additional claim administration administrator contact information information e.g., Adjustor ID reference for appeal billing dispute contact
10	Jurisdiction	O	The state that has jurisdictional authority over the claim
11	Pay-To Provider Name	R	
12	Pay-To Provider Address	R	
13	Pay-To Provider TIN	R	
14	Pay-To Provider State License Number	S	If additional payee ID information is required. This applies only to billing provider health entities
15	Patient Name	R	Patient Name
16	Patient Social Security Number	R	
17	Patient Address	O	
18	Patient Date of Birth	O	
19	Employer Name	R	Employer Name
20	Employer ID	R	Employer ID assigned by Payer
21	Employer Address	O	
22	Rendering Provider Name	R	
23	Rendering Provider ID	R	Rendering Provider NPI Number
24	PPO/MPN Name	S	Required if a PPO / MPN reduction is used
25	PPO/MPN ID Number	S	State License Number or Certification Number
26	Claim Number	R	Workers' Compensation Claim Number assigned by payer

DWC Bill Adjustment Reason Code	Issue	DWC Explanatory Message	CA Payer Instructions	CARC	Claims Adjustment Reason Code Descriptions (CARC)	RARC	Remittance Advice Remark Code Descriptions (RARC)
G4	Billed charges exceed amount identified in your contract.	This charge was adjusted to comply with the rate and rules of the contract indicated.	Requires name of specific Contractual agreement from which the re-imbursment rate and/or payment rules were derived.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).		
G5	No standard EOR message applies.	This charge was adjusted for the reasons set forth in the attached letter.	Message to be used when no standard EOR message applies and additional communication is required to provide clear and concise reason(s) for adjustment/denial.	162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.	M118 N202	Alert: Letter to follow containing further information Additional information/explanation will be sent separately
G6	Provider charges for service that has no value.	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.		W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must refer to the provider's Class of Code Id Segment Other C Information adjustment	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.

**California Division of
Workers'
Compensation
Medical Billing and
Payment Guide
2011** Version 4.4 1.2



3. Provider Submits a Timely and Complete Second Bill Review (SBR) to Claims Administrator

For incorrect adjudications arising from either the Claims Administrator or the Provider's error, the Provider must submit a compliant SBR requesting additional payment.

8.0 Request for Second Review of a Paper or Electronic Bill

A health care provider, health care facility or billing agent/assignee who disputes the amount paid by the claims administrator on the original bill submitted may submit a Request for Second Review within 90 days of service of the explanation of review in accordance with title 8, section 9792.5.4 et seq. and relevant provisions of this guide and the Electronic Medical Billing and Payment Companion Guide.

Use the Most Recent SBR Rules

**Title 8, California Code of Regulations
Chapter 4.5 Division of Workers' Compensation
Subchapter 1 Administrative Director – Administrative Rules**

**Article 5.5.0 Rules for Medical Treatment Billing and Payment
on or after October 15, 2011**

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

(a) The *California Division of Workers' Compensation Medical Billing and Payment Guide* and *Electronic Medical Billing and Payment Companion Guide* versions listed below, which set forth billing, payment and coding for medical treatment bill submissions, are incorporated by reference into the Division of Workers' Compensation through the Department of Industrial Relations at www.dir.ca.gov or may be obtained by writing to:

CA.gov | Contact DIR

State of California
Department of Industrial Relations

CA.GOV

Home Labor Law Cal/OSHA - Safety & Health Workers' Comp Self Insurance Ap

Division of Workers' Compensation (DWC)

▶ Independent Bill Review; Standardized Paper Billing and Payment; Electronic Billing and Payment regulations

Workers' compensation proposed regulations
Independent Bill Review; Standardized Paper Billing and Payment; Electronic Billing and Payment regulations
Title 8, California Code of Regulations
Sections 9792.5.1, 9792.5.3, 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, 9792.5.15, 9793, 9794, 9795

Filed with Secretary of State - Feb. 12, 2014
Effective Feb. 12, 2014

• Clean copy of final regulations - IBR version [PDF version](#) [HTML version](#)

TIMELY SBR Required: Inaccurate Adjudication

SBR must be submitted within 90 days for receipt of an EOR or within 90 days of the WCAB resolving a threshold issue that prevented adjudication of the bill.

§ 9792.5.5. Second Review of Medical Treatment Bill or Medical-Legal Bill

(a) If the provider disputes the amount of payment made by the claims administrator on a bill for medical treatment services or goods rendered on or after January 1, 2013, submitted pursuant to Labor Code section 4603.2, or Labor Code section 4603.4, or bill for medical-legal expenses incurred 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.

(b) The second review must be requested within 90 days of:

(1) The date of service of the explanation of review provided by a claims administrator in conjunction with the payment, adjustment, or denial of the initially submitted bill, if a proof of service accompanies the explanation of review.

(2) The date of service of an order of the Workers' Compensation Appeal Board resolving any threshold issue that would preclude a provider's right to receive compensation for the submitted bill.

Consequences of Untimely SBR

(e) If the only dispute is the amount of payment and the provider does not request a second review within the timeframes set forth in subdivision (b), the bill shall be deemed satisfied and neither the claims administrator nor the employee shall be liable for any further payment.

A Compliant SBR Submission Must Be Complete

Compliant SBR submission consists of either:

1. A replica of the original bill modified per SBR regulations with required additional information

OR

2. A completed SBR-1 Form

Non-Electronic Bills: Modified Replica of Bill

For non-electronic bills, compliant submission of SBR is either:

1. A replica of the original bill modified per SBR regulations
 - a. CMS 1500 - Modified with “BGW3” in Box 10D
 - b. UB04 - Modified with “BGW3” in Boxes 18-28
 - c. ADA Dental Claim Form 2006 - “Request for Second Review” marked in Field 1
 - d. NCPDP - “Request for Second Review” written on form

(c) The request for second review shall be made as follows:

(1) For a non-electronic medical treatment bills, the second review shall be requested on either:

(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 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.

(B) The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6. The DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider.

Required Additional Information for Complete SBR if Modified Replica of Original Bill Submitted

(d) The request for second review shall include:

(1) The original dates of service and the same itemized services rendered as the original bill. No new dates of service or additional billing codes may be included.

(2) In addition to the bill as modified in this subdivision, the second review request shall include, as applicable, the following:

1 (A) The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review. **2**

3 (B) The item and amount in dispute. **4**

5 (C) The additional payment requested and the reason therefor. **6**

7 (D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

Non-Electronic Bills: SBR-1 Form


State of California
 Department of Industrial Relations
 Home | Labor Law | Cal/OSHA - Safety & Health | Workers' Comp | Self Insurance | Ap

Division of Workers' Compensation (DWC)

Independent Bill Review; Standardized Paper Billing and Payment; Electronic Billing and Payment regulations

Final forms

- Provider's Request for Second Bill Review
- Request for Independent Bill Review


 State of California
 Division of Workers' Compensation
Provider's Request for Second Bill Review
 California Code of Regulations, title 8, section 9792.5.6

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

Employee Information					
Employee Name (Last, First, Middle): Doe, John, E					
Date of Birth (MM/DD/YYYY): 05/05/1978			Social Security Number: 123456789		
Date of Injury (MM/DD/YYYY): 01/10/2012			Claim Number: WC1234567		
Provider Information					
Provider Name: Associated Foot Specialists			Contact Name: Sally Smith		
Address: 123 Grand Street		City: Anytown		State: CA	
Zip Code: 91234	Phone: 310-555-5555		Fax Number: 310-555-1234		
E-mail Address: anyemail@email.com			NPI Number: 1234567890		
Claims Administrator Information					
Claims Administrator Name: Zurich			Contact Name: Sue Jones		
Address: PO Box 968005		City: Schaumburg		State: IL	
Zip Code: 60196-8005	Phone: 310-123-4567		Fax Number: 310-987-6543		
E-mail Address: name@email.com			Employer Name: Company ABC		
Bill Information					
Provider's or Claims Administrator's Bill Identification Number (if any): ZU1-ZNCA-2739879					
Was Billed Service Authorized? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Date Explanation of Review Received by Provider: 1/9/13					
List of disputed procedures, goods, services (attach additional pages if necessary):					
Date of Service	Treatment/Service/Item in Dispute (include modifier, if any)	Amount Billed	Amount Paid	Amount in Dispute	Additional Supporting Information/Documentation Attached?
01/01/13	99214, 93	98.53	50	48.53	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Electronic Medical Treatment Bills: Electronic Submission of the SBR

(2) For an electronic medical treatment bills for professional, institutional or dental services, the request for second review shall be submitted on the correct electronic standard format, utilizing the National Uniform Billing Committee (NUBC) Condition Code Qualifier “BG” followed by NUBC Condition Code “W3” as specified in the Division of Workers’ Compensation Electronic Medical Billing and Payment Companion Guide.

DaisyBill Automatically Generates SBRs with Required Additional Information

Second Review of Medical Treatment Bill

This is Not a Duplicate Bill Submission

Additional payment is due per the Official Medical Fee Schedule (OMFS) promulgated by the DWC administrative director under Labor Code section 5307.1 found in sections 9789.10 et seq. of Title 8, California Code of Regulations.

HCPCS	Supplemental Data	Units	Charge	OMFS Fee	Allowed	Balance Due
3 99214		1.0	\$250.24	4 \$125.14	\$0.00	\$125.14 5
WC002		1.0	\$23.82	\$11.91	\$0.00	\$11.91
Total			\$274.10	\$137.05	\$0.00	\$137.05

Per the referenced regulations below, submission of the Explanation of Review (EOR) is not required.

Patient: [REDACTED]

DOS: 01/23/2014

1 Date of the explanation of review: 02/06/2014

Unique identifier found on the explanation of review: SF1-SFSC-6267038 2

This was submitted as an original claim--no duplicate claim was sent before this. This is a recent date of service and remains as of yet unpaid. We believe your initial review is in error. 6

Today's Date: 02/10/2014

Response Due from Claims Administrator: 02/24/2014

Thank You,

Medical-Legal Bills: SBR-1 Form Required

A replica of the original bill modified per SBR regulations IS NOT ALLOWED for medical-legal bills. The SBR-1 Form is mandated.

(4) For medical-legal bills, the second review shall be requested on the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6.

Consequences of Incorrect SBR Submission

If a Provider disputes the amount of payment made by a Claims Administrator, the Provider must submit compliant SBR, meaning that it is both timely and complete; otherwise the Claims Administrator has **no obligation** to pay or to respond to the SBR.

(f) A claims administrator may respond to a request for second bill review that does not comply with the requirements of subdivision (d). Any response to such a request is not subject to the requirements of subdivisions (g) and (h) of this section.

4. Claims Administrator Responds to the SBR with a Timely and Final EOR

Claims Administrators must respond timely to compliant non-electronic and electronic SBRs with a Final EOR within 14 days of receipt of the SBR from the Provider.

6.5 Timeframes: Treatment Bills that are Submitted as a Request for Second Review

Where a bill is submitted as a Request for Second Review, the claims administrator shall promptly evaluate and take appropriate action on the bill. The claims administrator must respond to the Request for Second Review within 14 days of receiving the request by issuing a final written determination on the bill utilizing the explanation of review specified in Appendix B. Payment of any balance not in dispute shall be made within 21 days of receipt of the request for second review. ~~This time limit may be extended by mutual written agreement.~~ **The 14-day time limit for responding to a request for second review and/or the 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator. See title 8, California Code of Regulations sections 9792.5.4 – 9792.5.6 for further rules relating to second review of medical bills.**

7.4 Timeframes: Treatment Bills that are Submitted as a Request for Second Review

Where an electronic bill is submitted as a Request for Second Review, the claims administrator shall promptly evaluate and take appropriate action on the bill. The claims administrator must respond to the Request for Second Review within 14 days of receiving the request by issuing a final written determination on the bill utilizing the explanation of review specified in Appendix B. The claims administrator shall issue the ASC X12/005010X221A1 Payment/Advice (835) Technical Report Type 3 as its explanation of review for an electronic bill that is a Request for Second Review. Payment of any balance not in dispute shall be made within 21 days of receipt of the Request for Second Review. ~~This time limit may be extended by mutual written agreement.~~ **The 14-day time limit for responding to a request for second review and/or the 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator. See title 8, California Code of Regulations sections 9792.5.4 – 9792.5.6 for further rules relating to second review of medical bills.**

Claims Administrator's SBR Payment Responsibility

Additional payment of sums due must be made by Claims Administrator within 21 days of receipt of compliant SBR.

(g) Within 14 days of receipt of a request for second review that complies with the requirements of subdivision (d), the claims administrator shall respond to the provider with a final written determination on each of the items or amounts in dispute by issuing an explanation of review. The determination shall contain all the information that is required to be set forth in an explanation of review under Labor Code section 4603.3, including an explanation of the time limit to raise any further objection regarding the amount paid for services and how to obtain independent bill review under Labor Code section 4603.6. The 14 day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the claims administrator.

(h) Based on the results of the second review, payment of any balance no longer in dispute, or payment of any additional amount determined to be payable, shall be made within 21 days of receipt of the request for second review. The 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator.

5. Provider Submits a Timely IBR or Files a Lien with the WCAB

(i) If the provider further contests the amount paid after receipt of the final written determination following a second review, the provider shall request an independent bill review pursuant to this Article.

§ 10451.2. Determination of Medical Treatment Disputes.

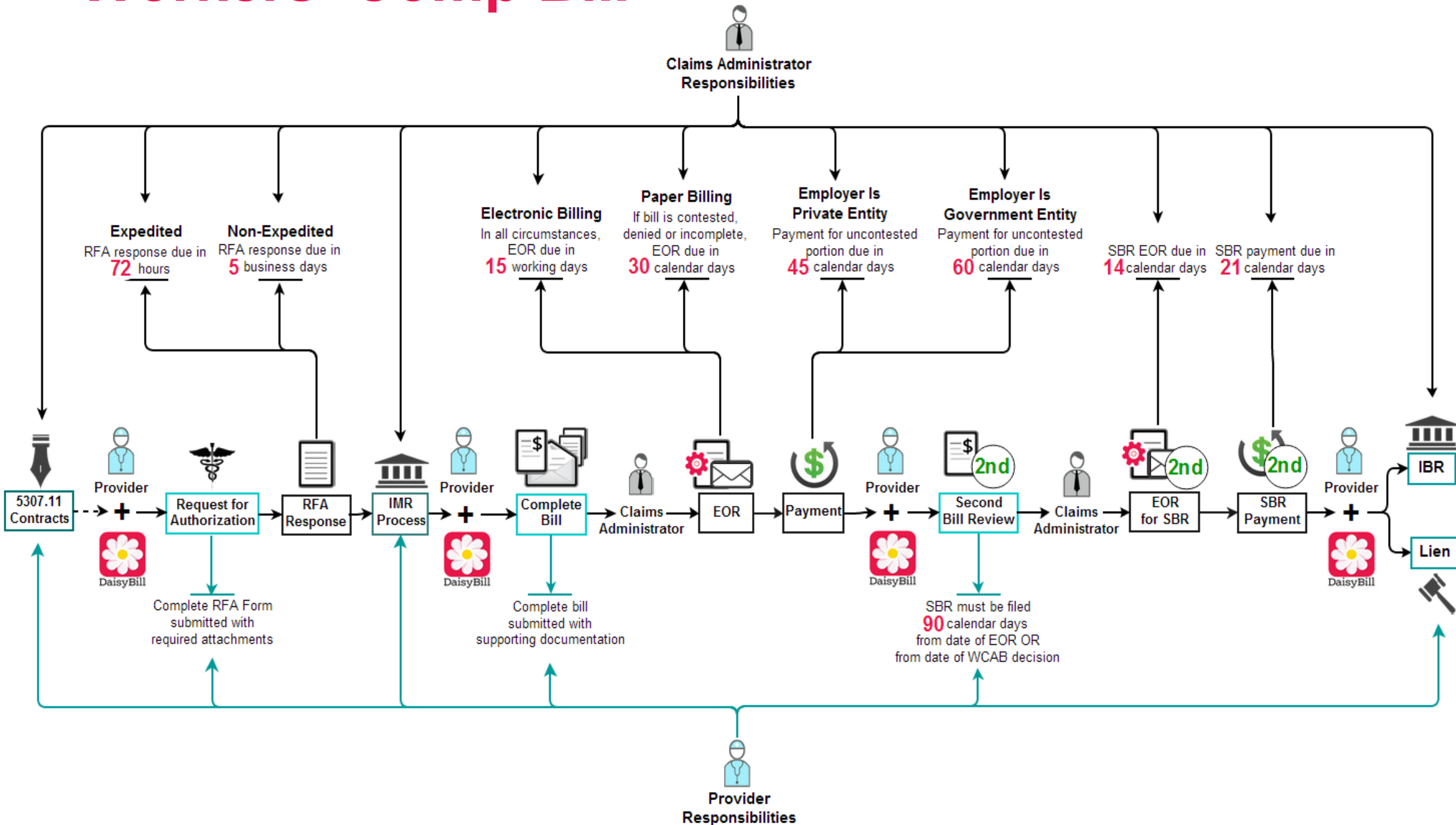
(a) The following procedures shall be utilized for the determination of all disputes over medical treatment and related goods and services.

(b) For purposes of this section, “medical treatment” means any goods or services provided in accordance with Labor Code section 4600 et seq., including but not limited to services rendered by an interpreter at a medical treatment appointment.

(c) Medical Treatment Disputes Not Subject to Independent Medical Review and/or Independent Bill Review

(D) an assertion by the medical treatment provider that the defendant has waived any objection to the amount of the bill because the defendant allegedly breached a duty prescribed by Labor Code sections 4603.2 or 4603.3 or by the related Rules of the Administrative Director;

As of 1/1/2013: Mandated Life Cycle of a Workers' Comp Bill




Independent Bill Review Submission Timeframe

IBR must be filed within 30 days of receipt of Second Bill Review determination.

After 30 days, the Claims Administrator is not liable for payment.

IBR Submission

IBR can be submitted electronically via the Maximus website, or mailed on the paper form (IBR-1).

PRINT CLEAR	
 State of California Division of Workers' Compensation Request for Independent Bill Review California Code of Regulations, title 8, section 9792.5.8	
Employee Information	
Employee Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Claim Number:
Date of Birth (MM/DD/YYYY):	Employer Name:
Provider Information	
Provider Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	NPI Number:
Provider Type: <input type="checkbox"/> Ambulance <input type="checkbox"/> Clinical Laboratory <input type="checkbox"/> DMEPOS Supplier <input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Interpreter <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Qualified Medical Evaluator <input type="checkbox"/> Agreed Medical Evaluator <input type="checkbox"/> Treating Physician <input type="checkbox"/> Other Practitioner – specify: _____	
Provider Specialty:	
Claims Administrator Information	
Claims Administrator Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	
Bill Information	
Applicable Fee Schedule(s): <input type="checkbox"/> Physician Services <input type="checkbox"/> Inpatient Hospital Services <input type="checkbox"/> Hospital Outpatient Departments and Ambulatory Surgical Centers <input type="checkbox"/> Pharmaceutical <input type="checkbox"/> Pathology and Laboratory Services <input type="checkbox"/> DMEPOS <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Medical-Legal Fee Schedule <input type="checkbox"/> Interpreter <input type="checkbox"/> Other – specify: _____ Or: <input type="checkbox"/> Contract for Reimbursement Rates	
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service (MM/DD/YYYY):	

Independent Bill Review Process

1. Fill out form (IBR-1 or electronic web version)
2. Pay \$250 (check for mail, credit card for web)
3. Include Supporting Documents
4. Submit
5. Send copy to the Claims Administrator

Independent Bill Review Supporting Documents

Related to Original Bill

1. Billing Itemization
2. Supporting Documents
3. EOR
4. Contract Provisions (if applicable)

Related to Second Review

5. Provider's Request
6. Supporting Documents
7. EOR (determination)

Related to IBR (if applicable)

8. Request for Consolidation

Independent Bill Review Consolidation

Each IBR Request:

- 1 Billing Code
- 1 Claims Administrator
- 1 Employee
- 1 Date of Service

Exception: IBR consolidations

Q. Can two or more disputes be combined into one request for IBR?

A. Yes. At the time a request for IBR is filed a provider may also request the consolidation of separate requests for IBR.

The request for consolidation must specify each dispute for which aggregation is being requested, along with a description of how the requests involve common issues of law and fact or delivery of similar or related services.

The explanation given by the provider must meet the following criteria:

- **Aggregation:** Two or more requests by a single provider may be aggregated if the AD or IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services.
- **Consolidation for service dates:** Requests for IBR by a single provider involving multiple dates of medical treatment services may be consolidated as one request if the requests involve one employee, one claims administrator and one billing code.

The total amount of the dispute cannot exceed \$4,000.00.

- **Consolidation for billing codes:** Requests for IBR by a single provider involving multiple billing codes may be consolidated as one request if the requests involve one employee, one claims administrator and one date of medical treatment service.
- **Consolidation upon good cause showing:** Requests for IBR by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes may be consolidated as one request where there are multiple employees and multiple dates of service but one claims administrator and one billing code.

Independent Bill Review Fees

The DWC reduced fees by 25%, effective April 1, 2014. Providers who submitted an IMR or IBR on or after April 1, 2014, and who had paid the old fee, will receive a refund of the difference.

IBR	Old Fee	New Fee
Completed IBR	\$335	\$250
Terminated IBR Not Sent to Review	\$65	\$50

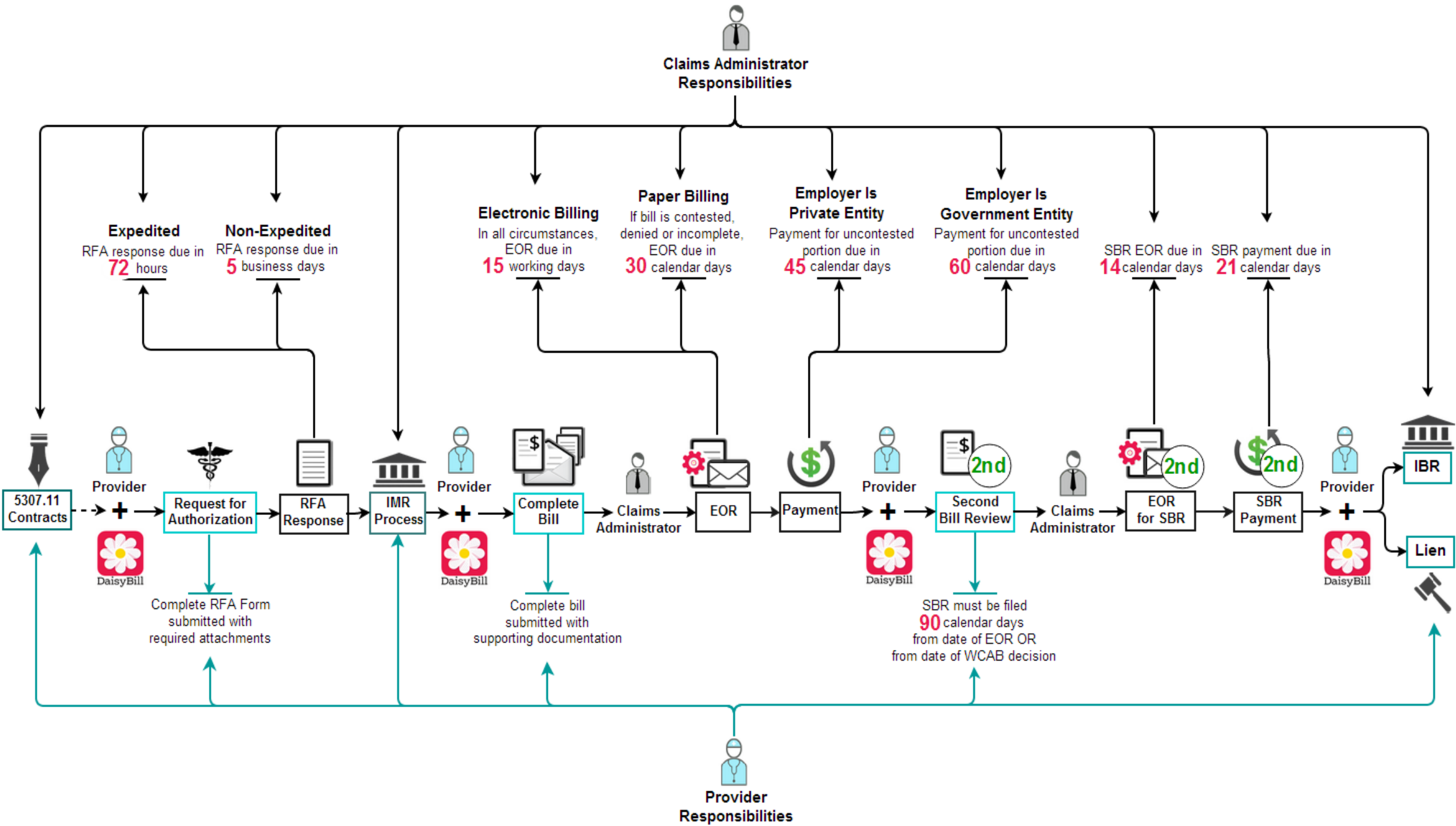
Independent Bill Review Submission Timeframe

IBR written determination issued within 60 days of the assignment to IBR.

Mandated Responsibilities and Timeline for Claims Administrators and Providers

www.daisybill.com

347.676.1548



Questions?

Contact Us

Sarah Moray
smoray@daisybill.com
347.676.1548

Catherine Montgomery
cmontgomery@daisybill.com
646.504.6733

www.DaisyBill.com