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

COA 2014 Annual Meeting

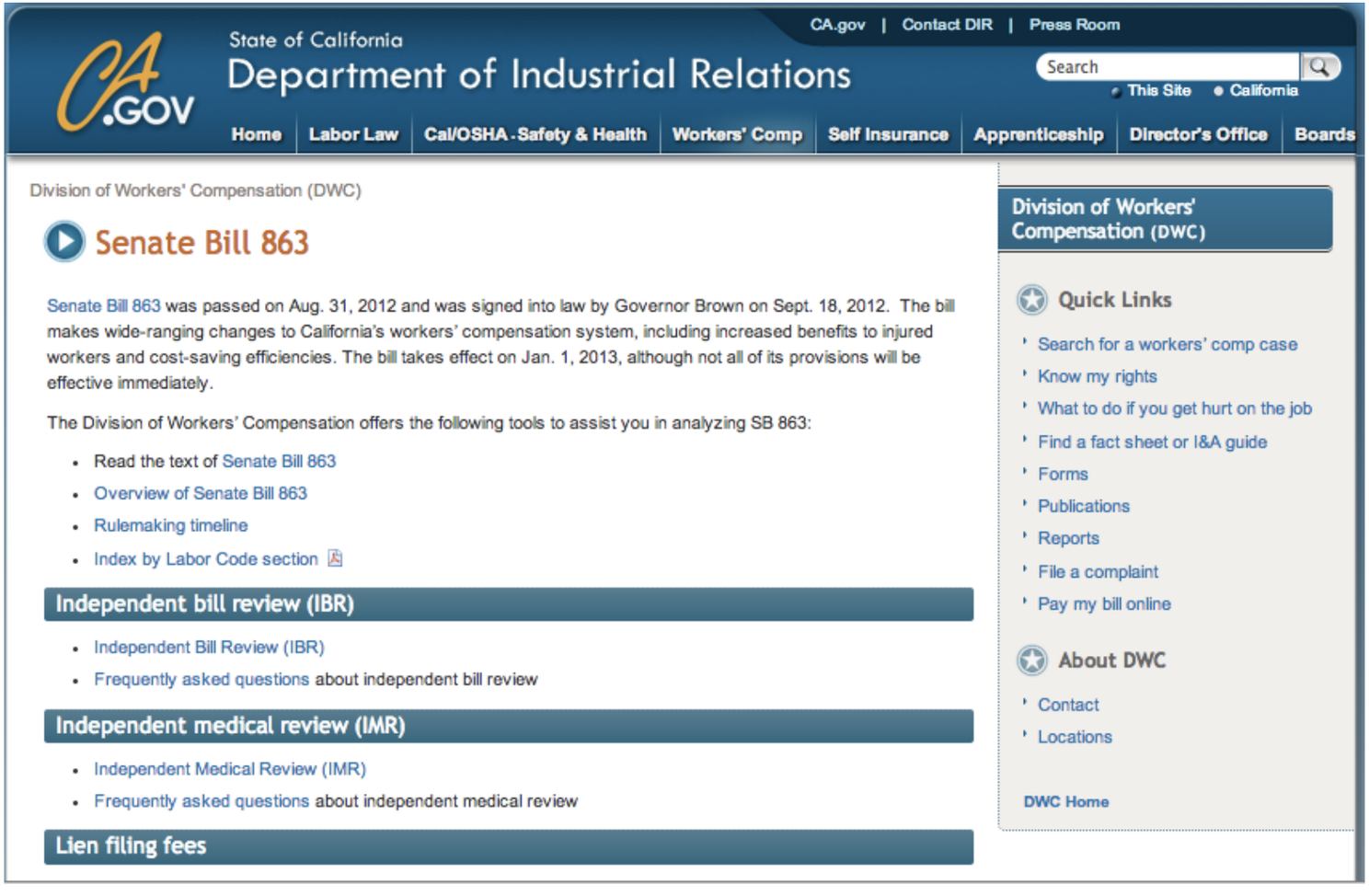
"Keeping You Active"

California Orthopaedic Association

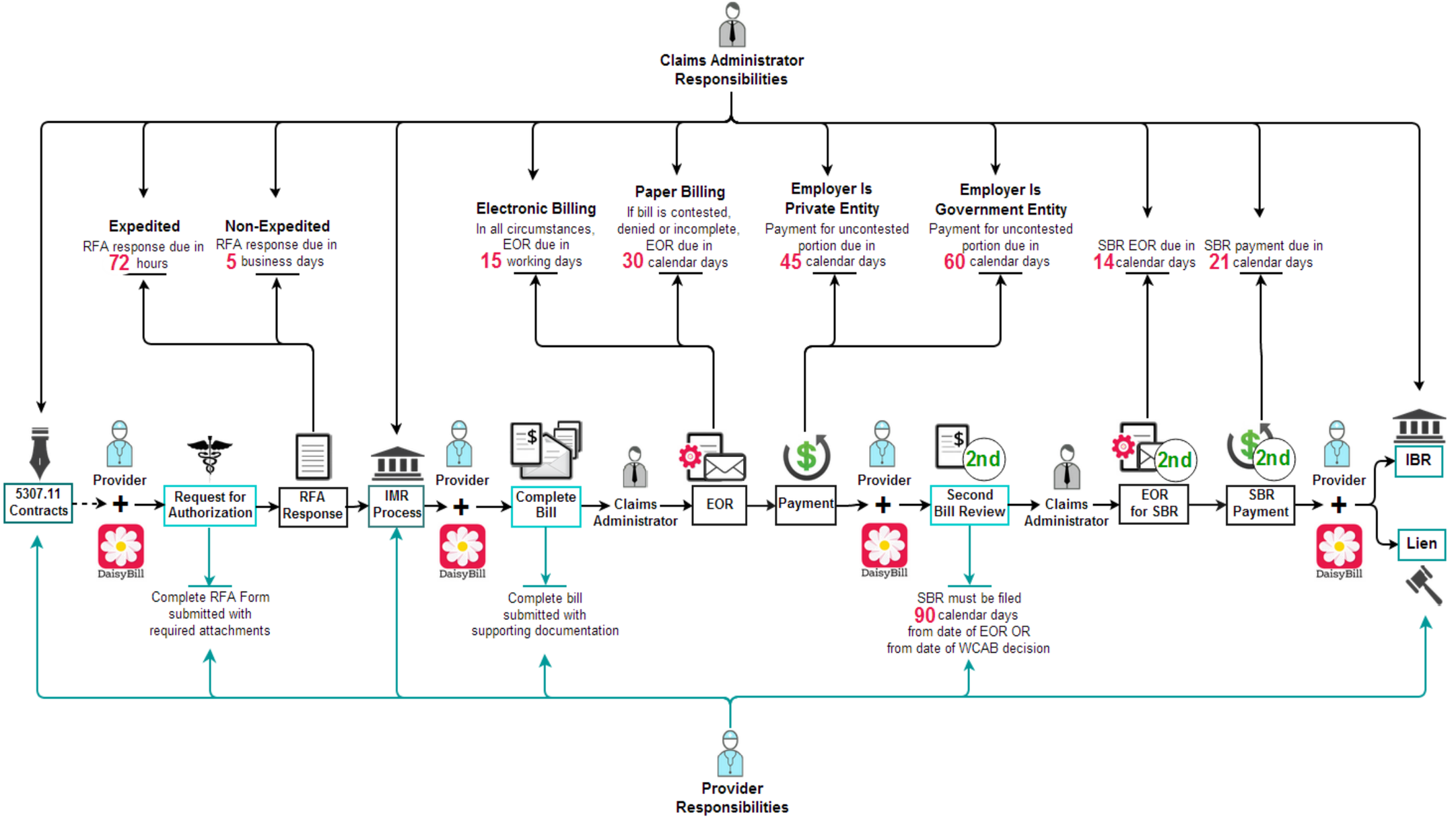
DaisyBill
e-Billing That Works

SB 863 Changed Workers' Compensation

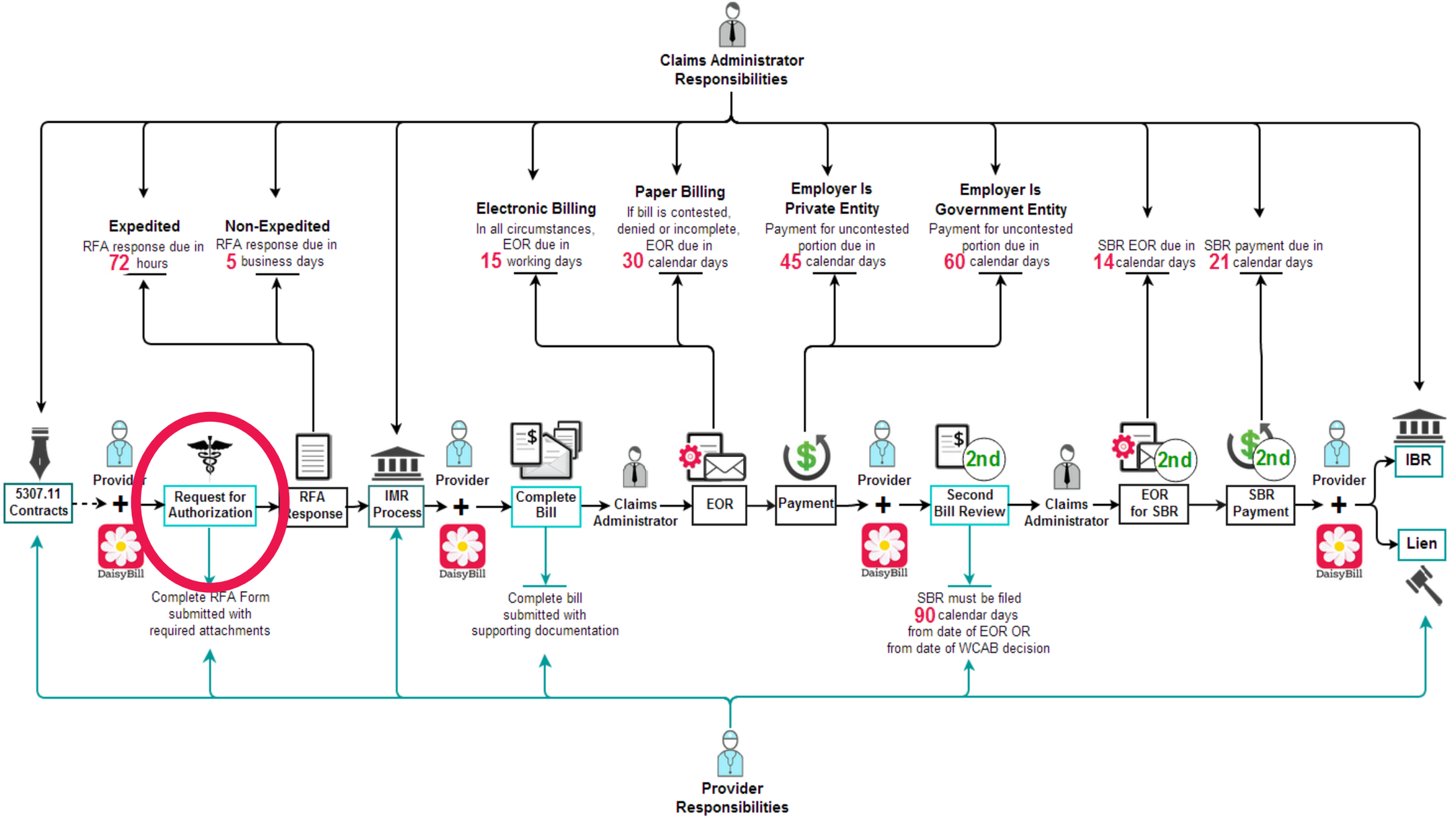
MAJOR changes impacting every Provider's revenue



Mandated Responsibilities and Timeline for Claims Administrators and Providers

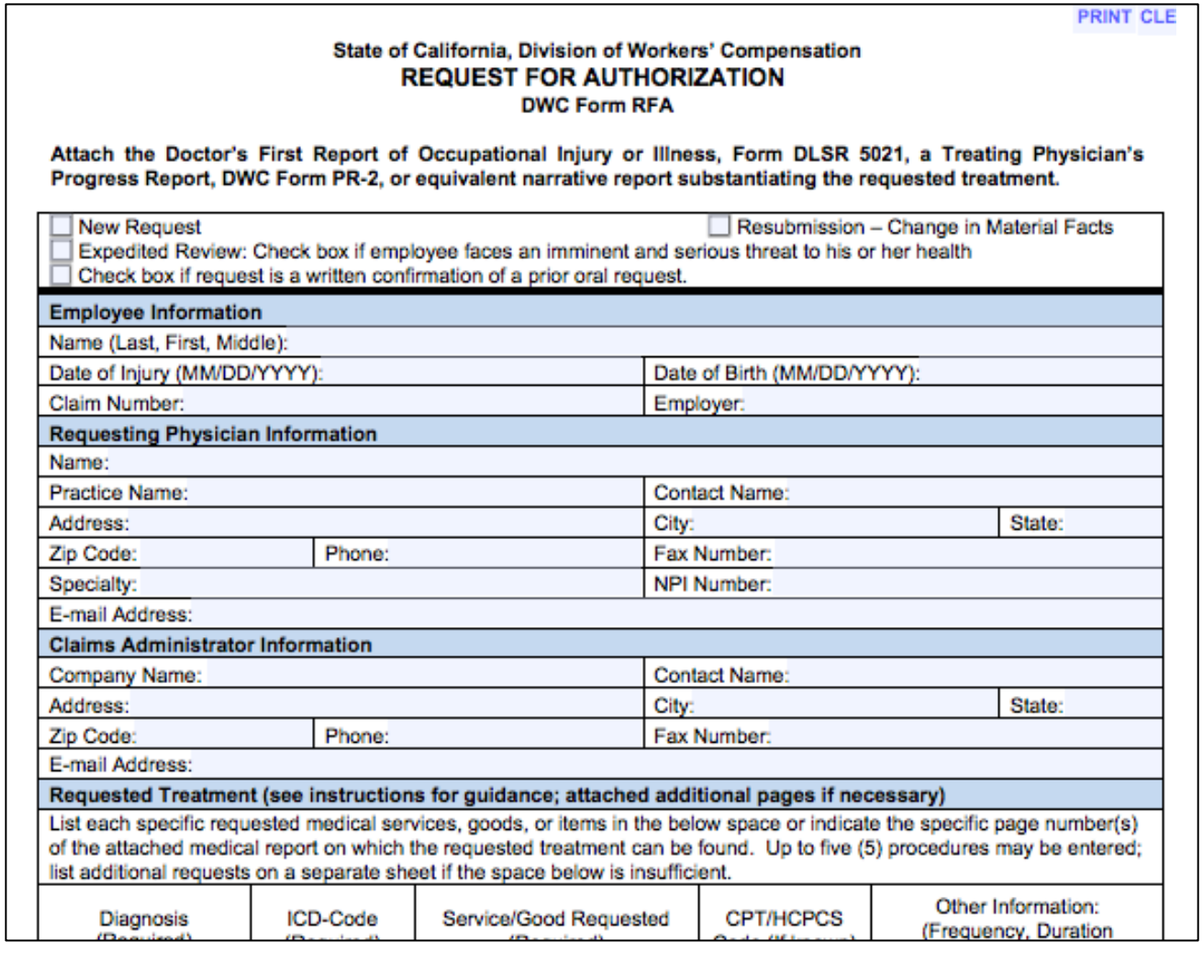


Request For Authorization (RFA) Form



Request for Authorization Form - MANDATED

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



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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	ICD-Code	Service/Good Requested	CPT/HCPCS	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.

RFAs: 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

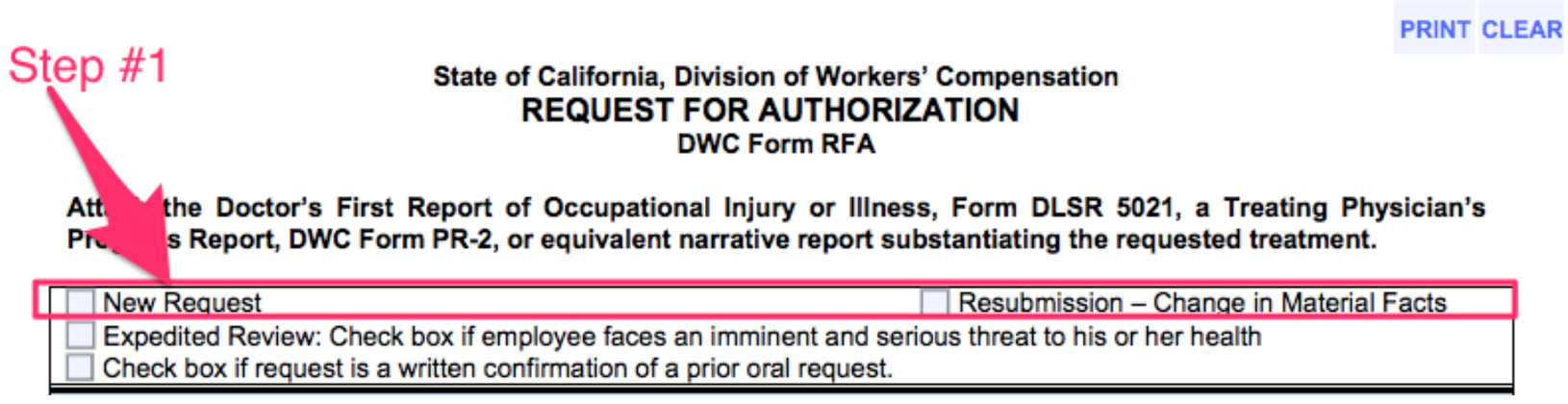
- Doctor's First Report (Form DLSR 5021),
- Treating Physician’s Progress Report (DWC Form PR-2), or
- Equivalent narrative report substantiating request for treatment

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

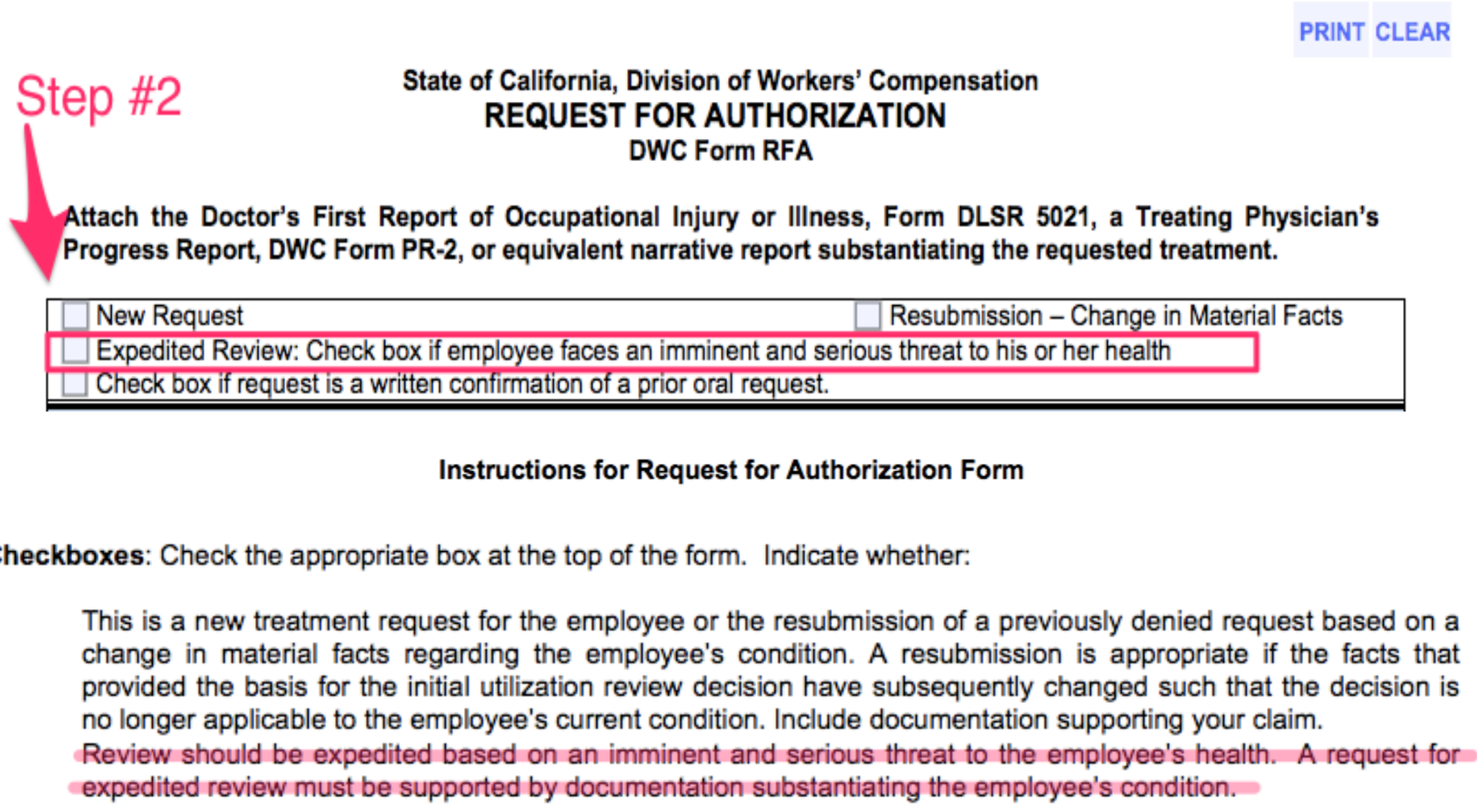


Instructions for Request for Authorization Form

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



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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.

☐ 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.	

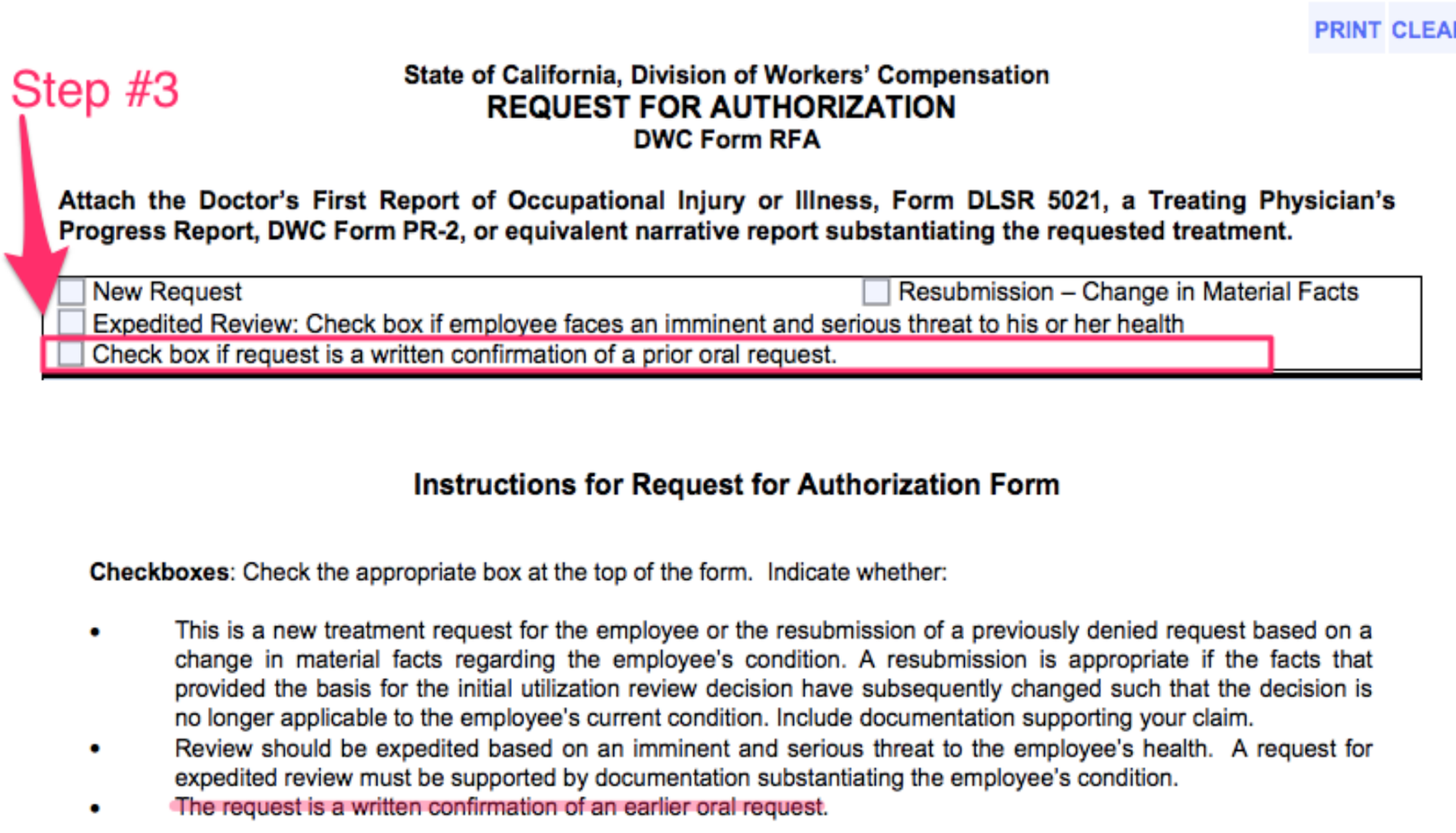
Instructions for Request for Authorization Form

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



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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.

☐ 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.

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.

☐ 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:			

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

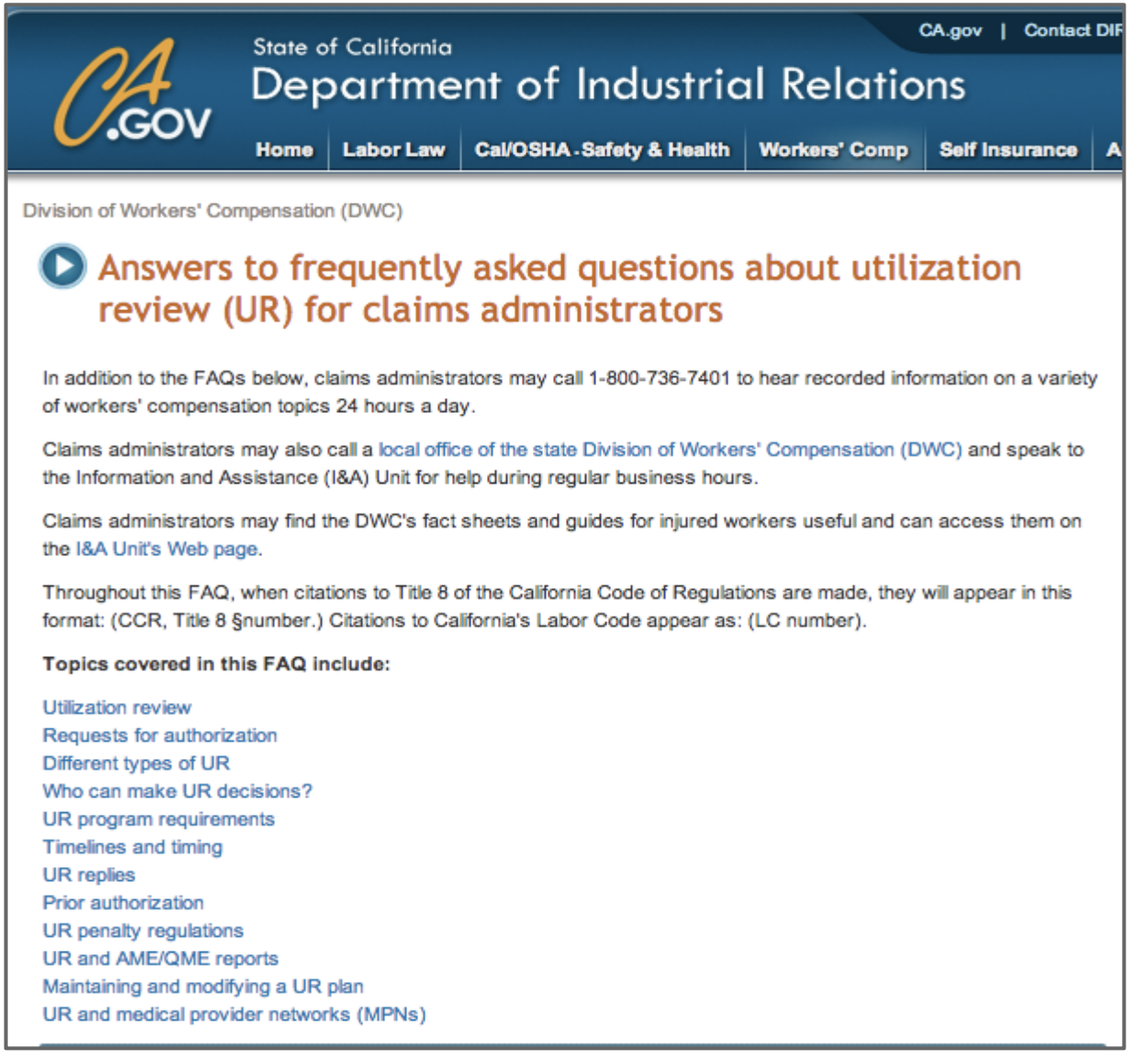
Requested Treatment (see instructions for guidance; attached additional pages if necessary)				
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to 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 | Contact DIR

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.

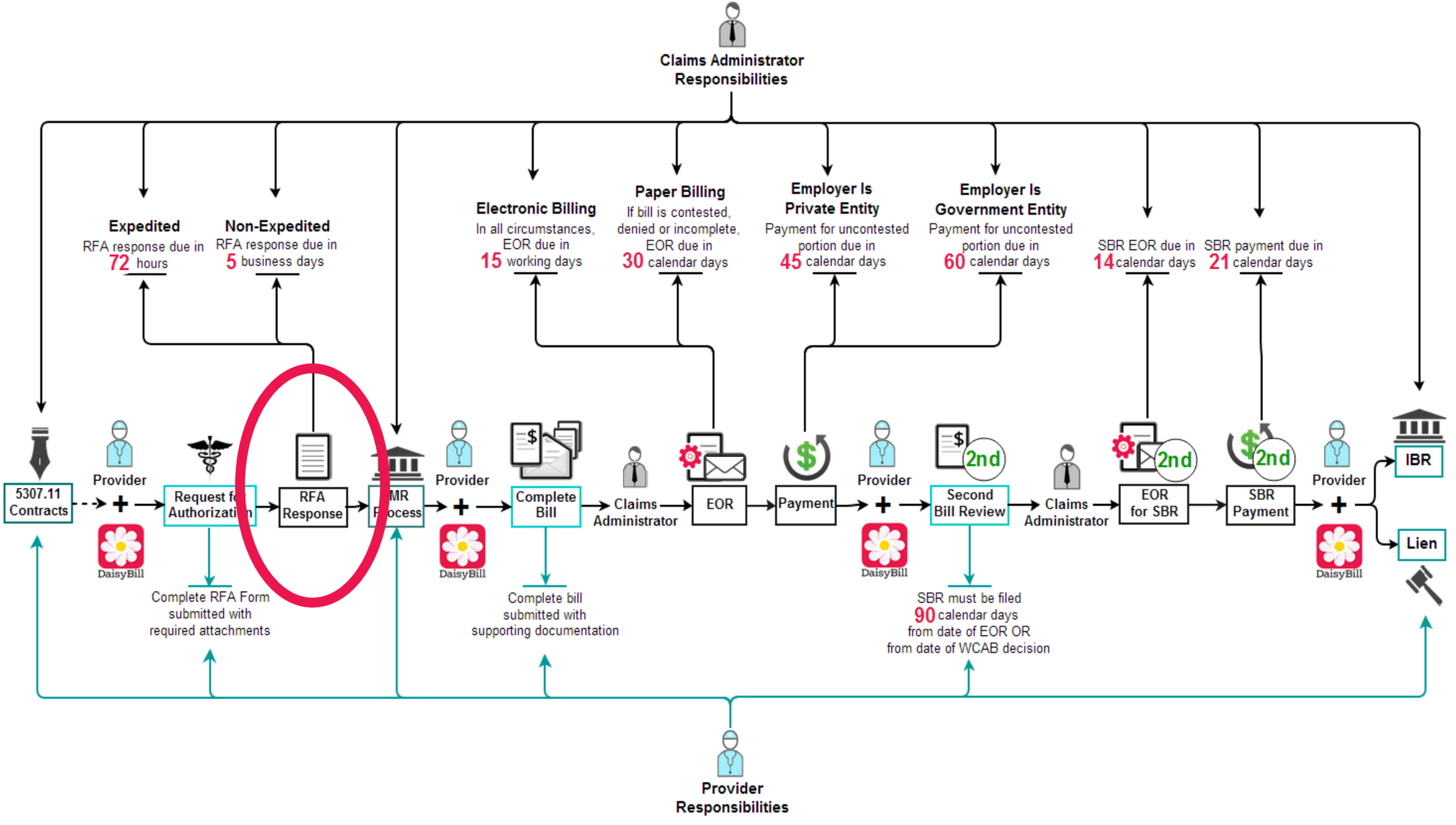
Claims administrators may find the DWC's fact sheets and guides for injured workers useful and can access them on the I&A Unit's Web page.

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).

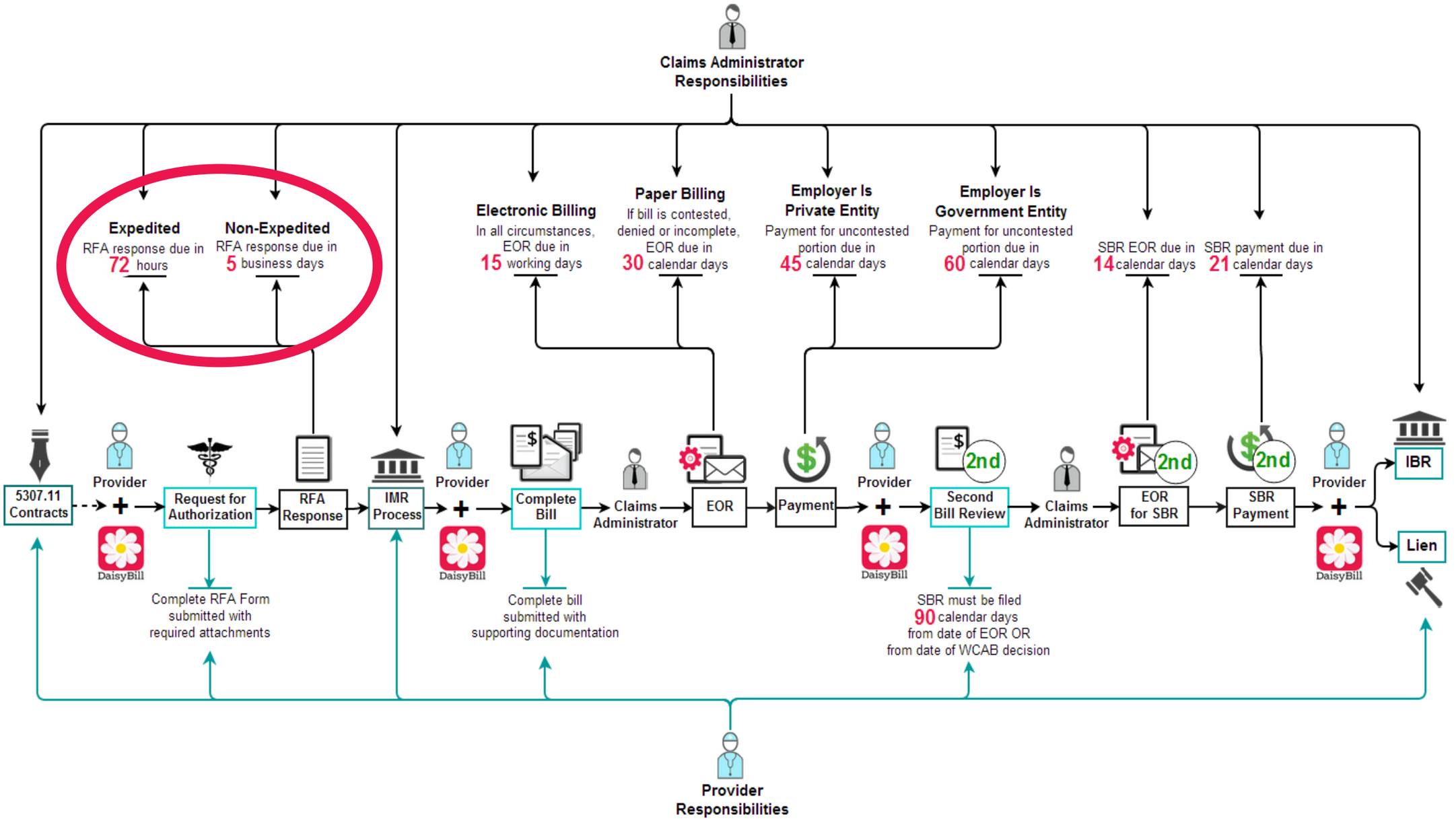
Topics covered in this FAQ include:

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



Request For Authorization Response Timeline



5 Business Days For Non-Expedited RFAs

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 For Expedited RFAs

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.

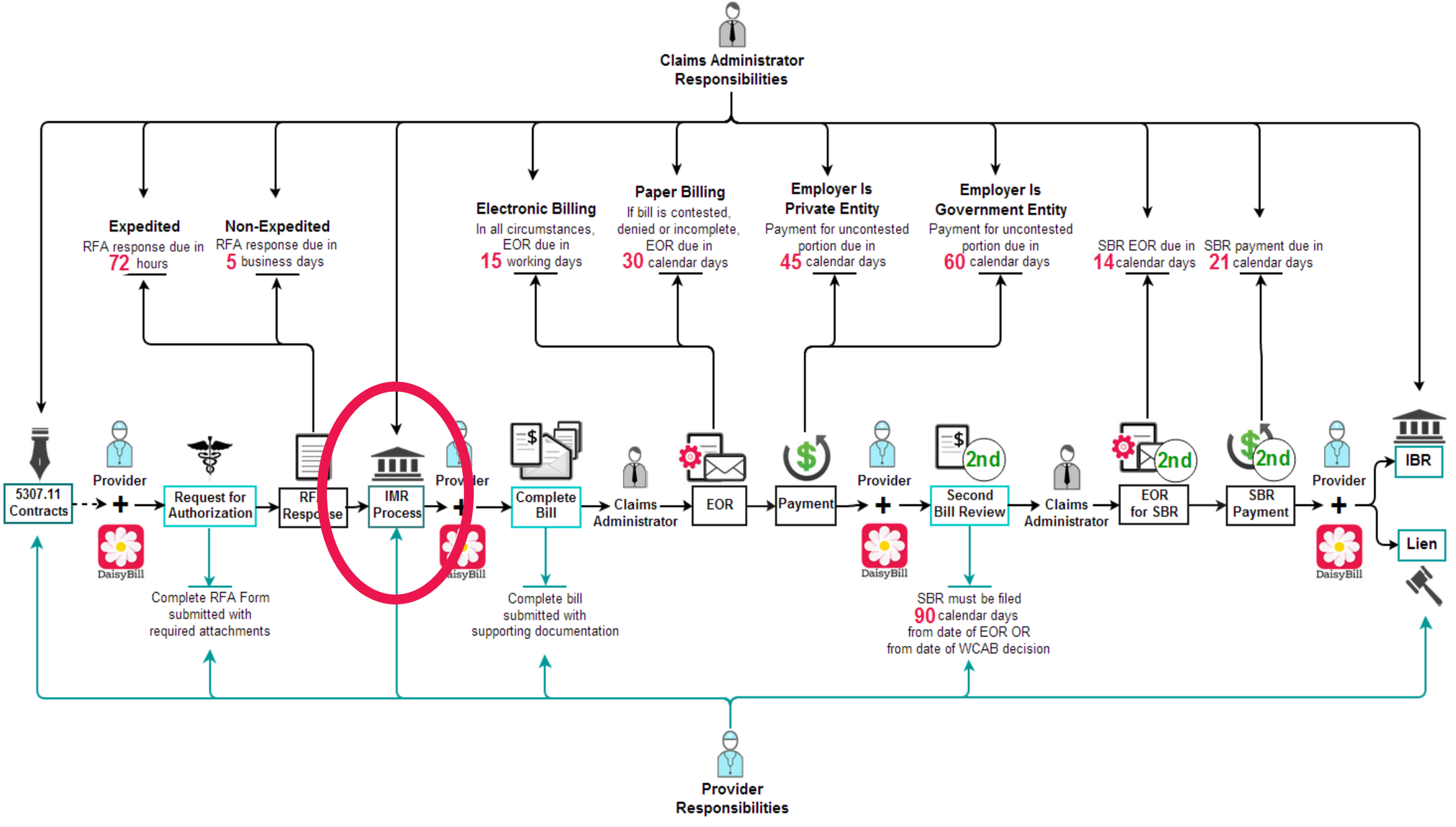
Q. If a request for an expedited review, with all necessary information, is received at 9 a.m. on a Friday morning, when is the decision due?

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.

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)

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

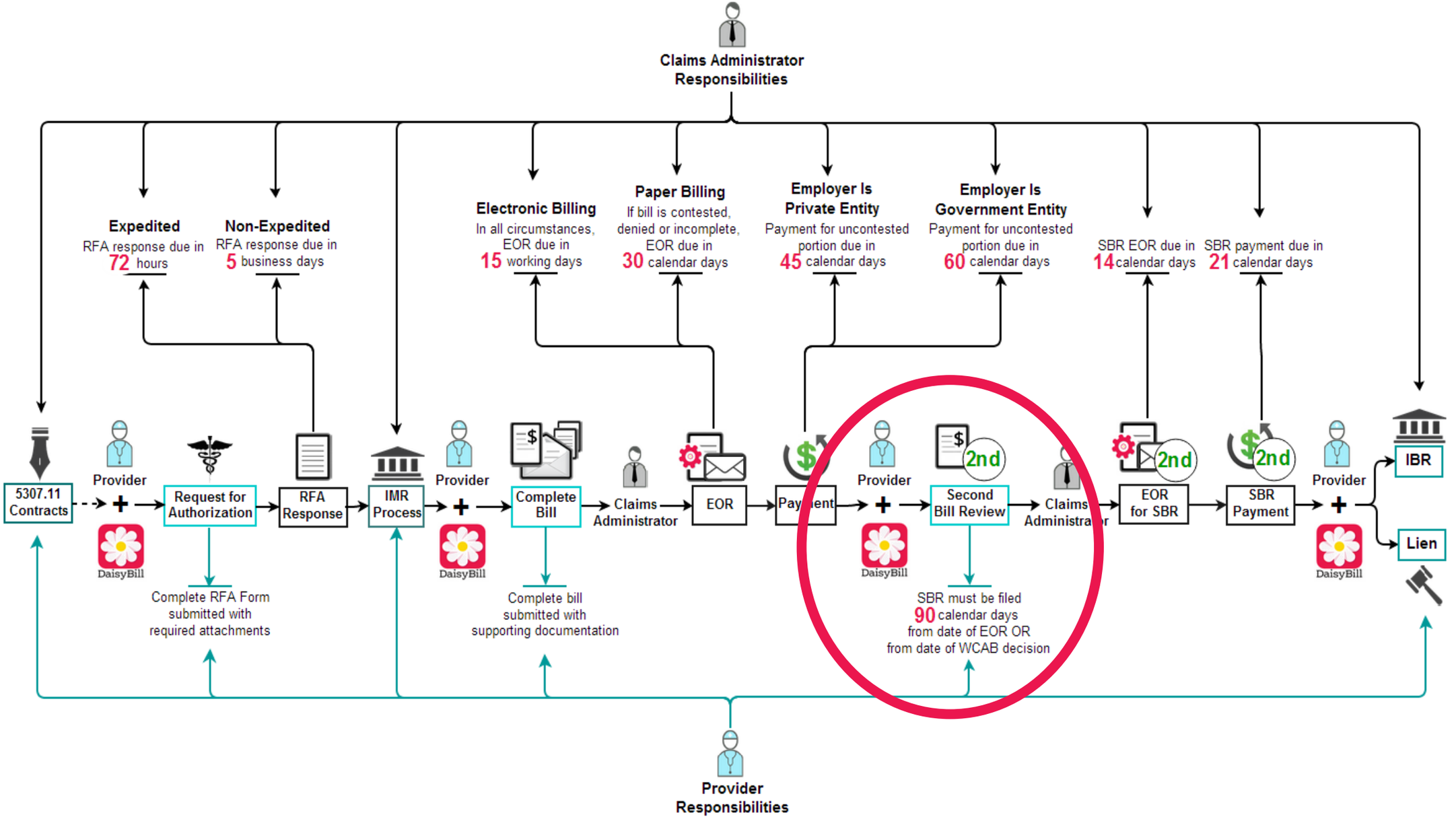
Treatment **has** been provided: within 30 days of receipt of request & supporting documentation

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.

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

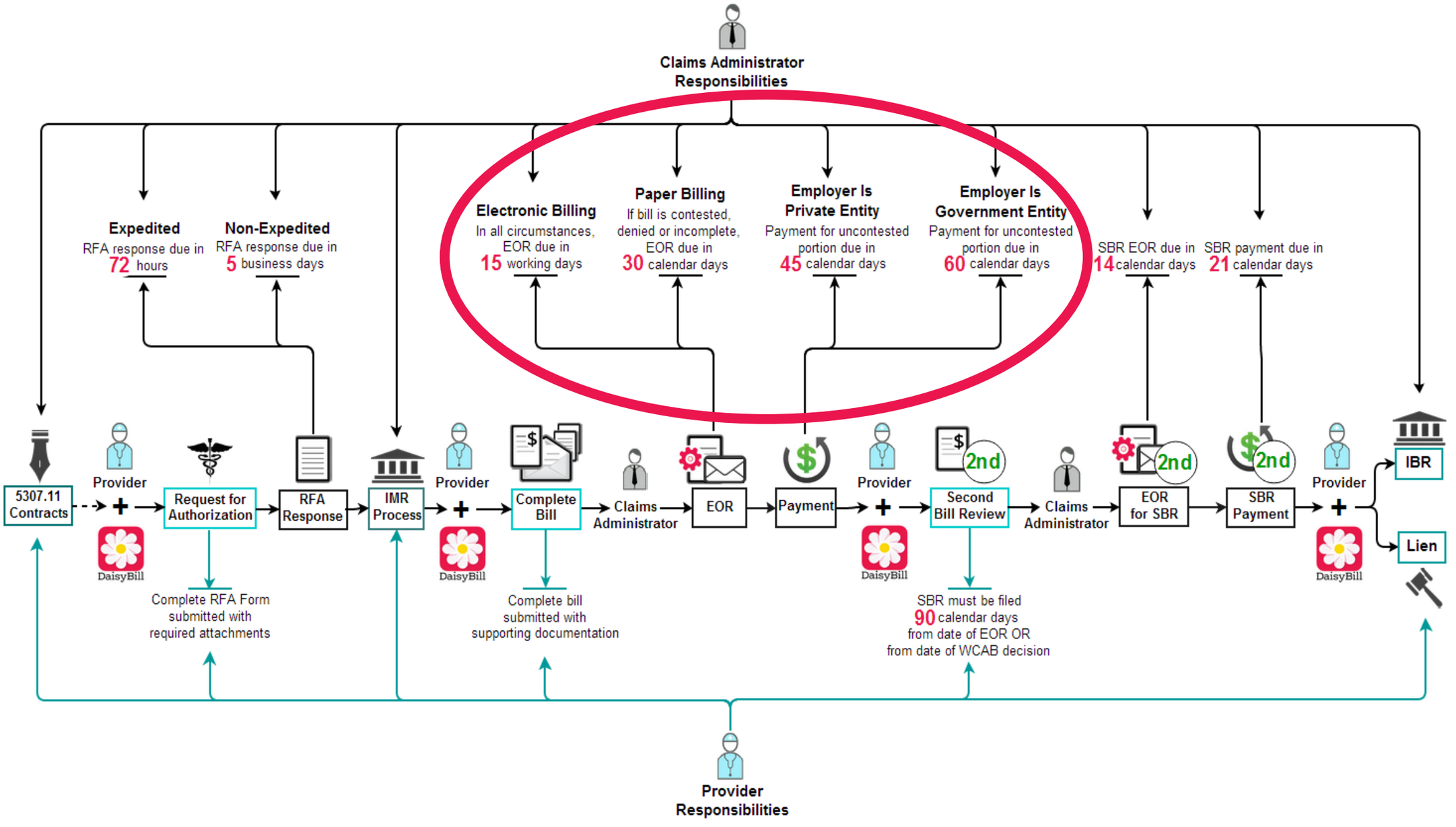
Procedure Code	Units	Charge	Allowed	Expected	Total Allowed	Total Percent Allowed	Write Off	Balance
99214:25	1	$250.28	$89.57	$125.14	$89.57	72%	$35.57	$0.00
WC002	1	$23.82	$11.91	$11.91	$11.91	100%	$0.00	$0.00
L3908	1	$165.42	$81.90	$82.71	$81.90	99%	$0.81	$0.00
Total		$439.52	$183.38	$219.76	$183.38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

Correct 2014 RBRVS reimbursement is $125.14

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

Brilliant Billing for Workers' Comp

Mandated EOR Requirements



Complete Explanation of Review Requirements

3.0 Table for Paper Explanation of Review

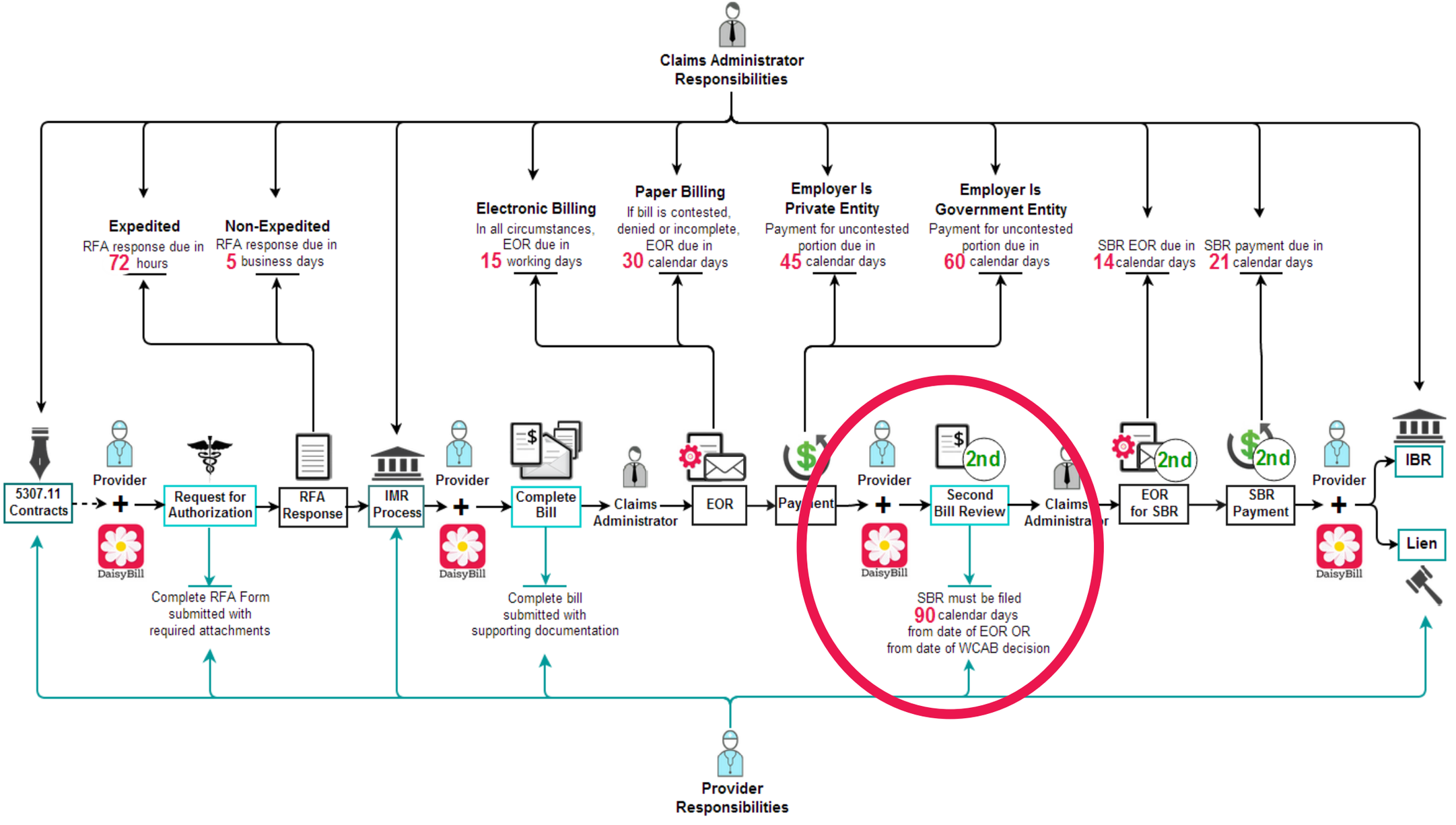
California DWC Paper EOR Requirements			
Data Item No.	Field Description	Workers' Compensation Data Requirements R/S/O	Comments
1	Date of Review	R	Date of Review
2	Method of Payment	S	If there is a payment, indicate if Paper Check or EFT
3	Payment ID Number	S	If there is a payment, indicate Paper Check 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).
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-imbursement 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 m… the prov… refer to … Class of… Code Id… Segmen… Other C… Informa… adjustm…	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 ~~1.1~~ 1.2

Second Bill Review



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.

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.

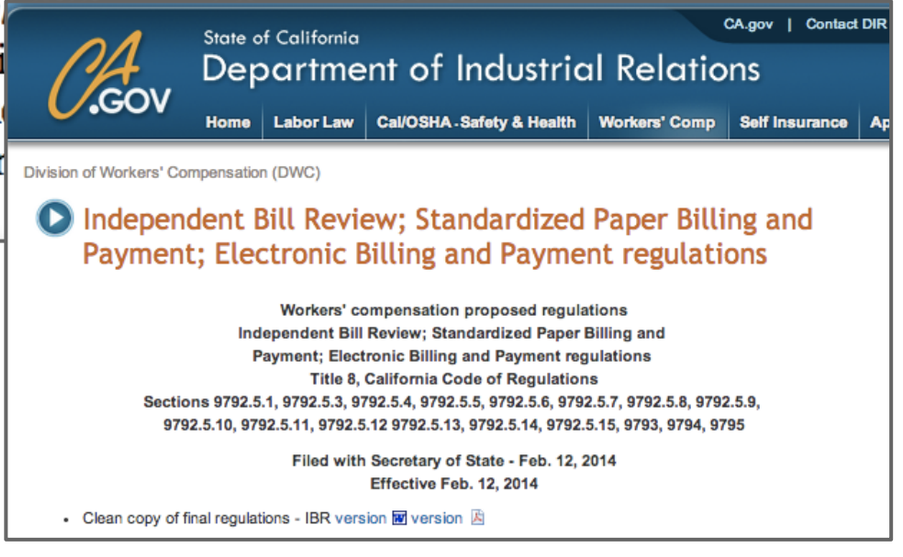
Use the Most Recent SBR Rules

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* versions listed below, which set forth billing, payment and codi medical treatment bill submissions, are incorporated by referen the Division of Workers' Compensation through the Departmer at www.dir.ca.gov or may be obtained by writing to:



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: SBR-1 Form

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? ☒ Yes ☐ No					
Date Explanation of Review Received by Provider: 1/9/13					
List of disputed procedures, goods, services (attach additional pages if necessary):					

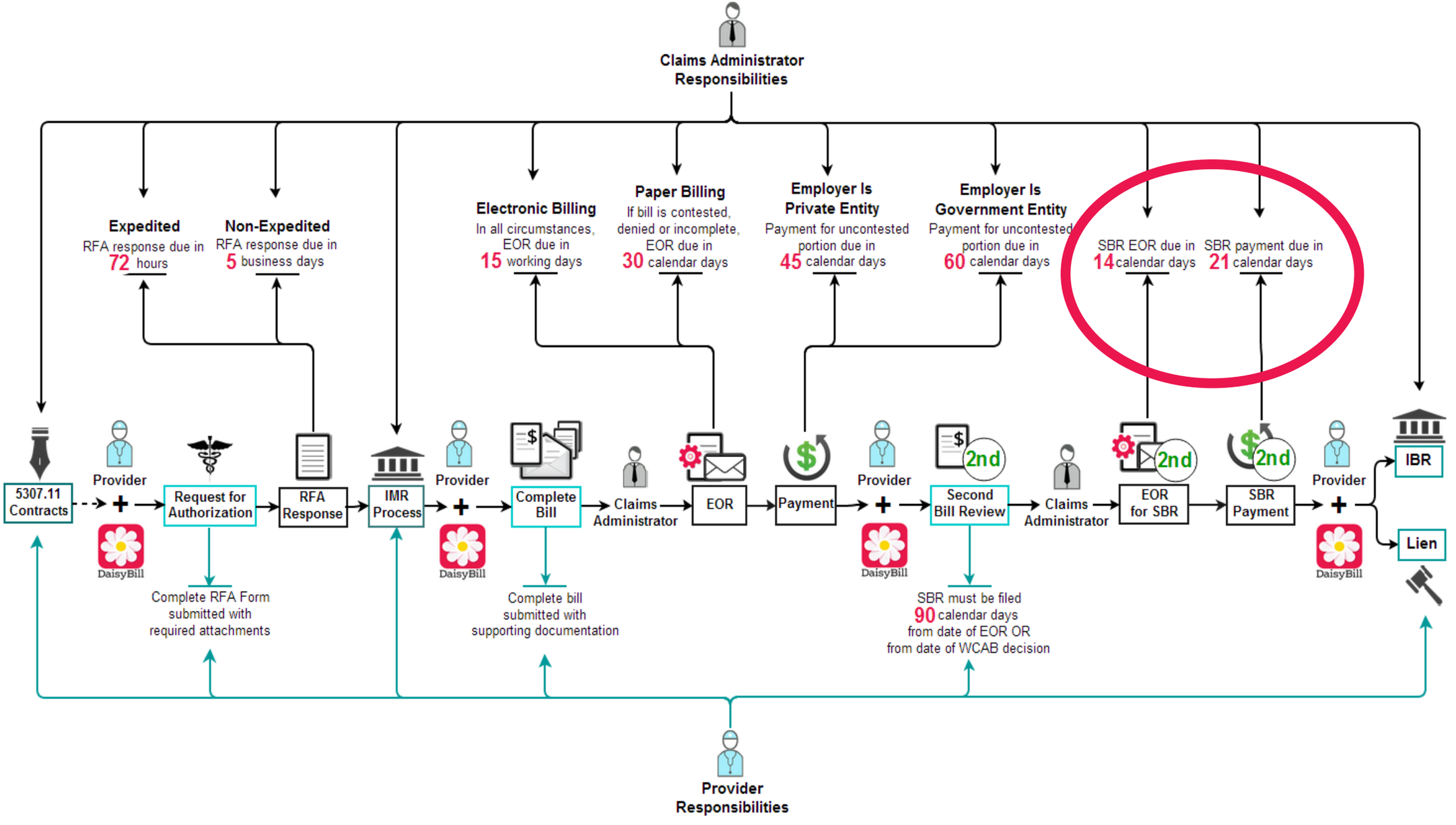
Date of Service	Treatment/Service/ Item in Dispute (include modifier, if any)	Amount Billed	Amount Paid	Amount in Dispute	Additional Supporting Information/Documentation Attached?
01/01/13	99214, 93	98.53	50	48.53	☒ Yes ☐ No

Consequences of Incorrect SBR Submission

If a Provider disputes the amount of payment made by a Claims Administrator, the Provider must a 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.

Second Bill Review



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 X12/005010X221**A1** 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.**

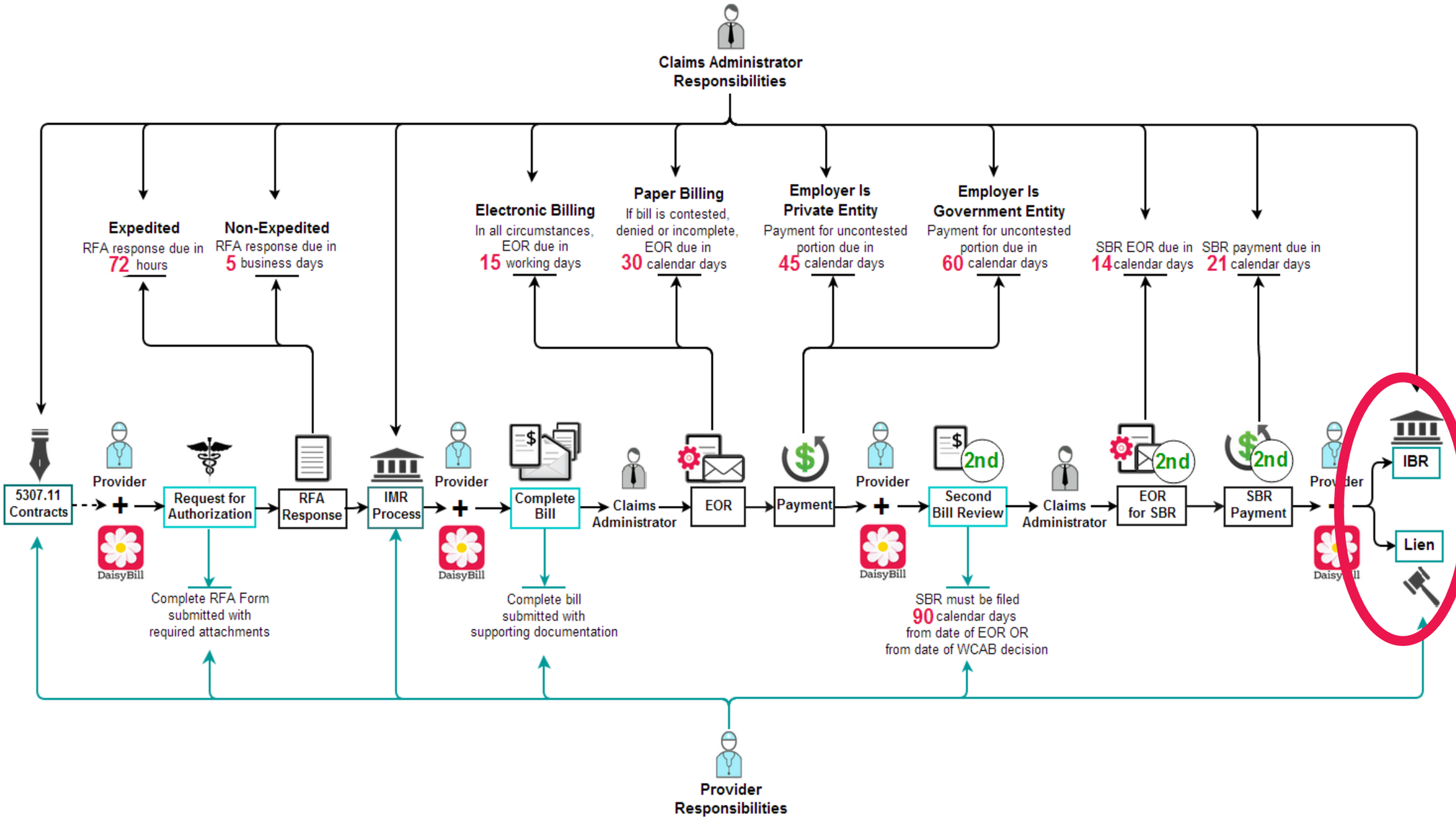
Claims Administrator's SBR Payment Responsibility

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.

Independent Bill Review (IBR) or Lien



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;

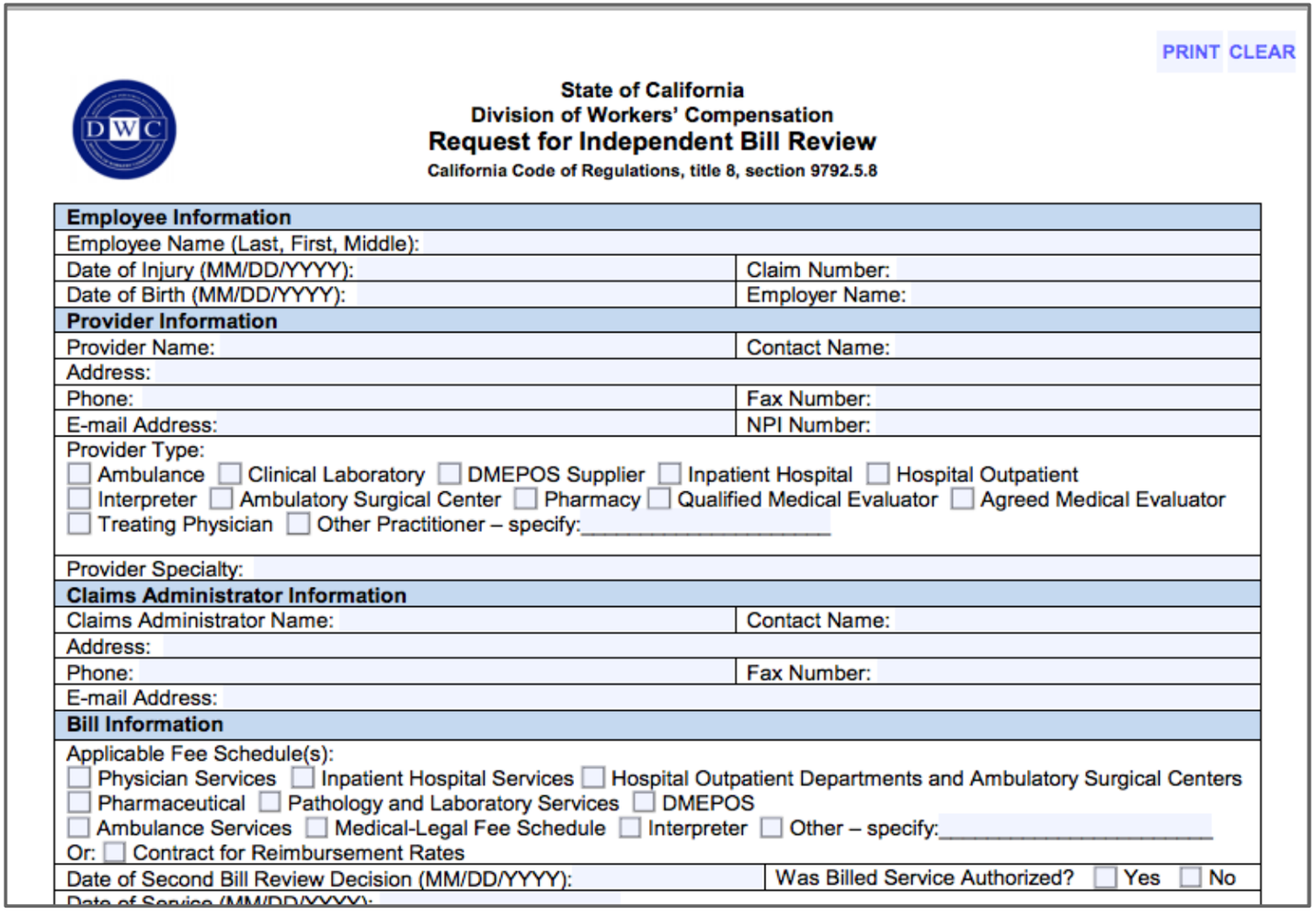
Independent Bill Review Submission Timeframe

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: ☐ Ambulance ☐ Clinical Laboratory ☐ DMEPOS Supplier ☐ Inpatient Hospital ☐ Hospital Outpatient ☐ Interpreter ☐ Ambulatory Surgical Center ☐ Pharmacy ☐ Qualified Medical Evaluator ☐ Agreed Medical Evaluator ☐ Treating Physician ☐ 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): ☐ Physician Services ☐ Inpatient Hospital Services ☐ Hospital Outpatient Departments and Ambulatory Surgical Centers ☐ Pharmaceutical ☐ Pathology and Laboratory Services ☐ DMEPOS ☐ Ambulance Services ☐ Medical-Legal Fee Schedule ☐ Interpreter ☐ Other – specify:_____ Or: ☐ Contract for Reimbursement Rates	
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Billed Service Authorized? ☐ Yes ☐ 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 of 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.

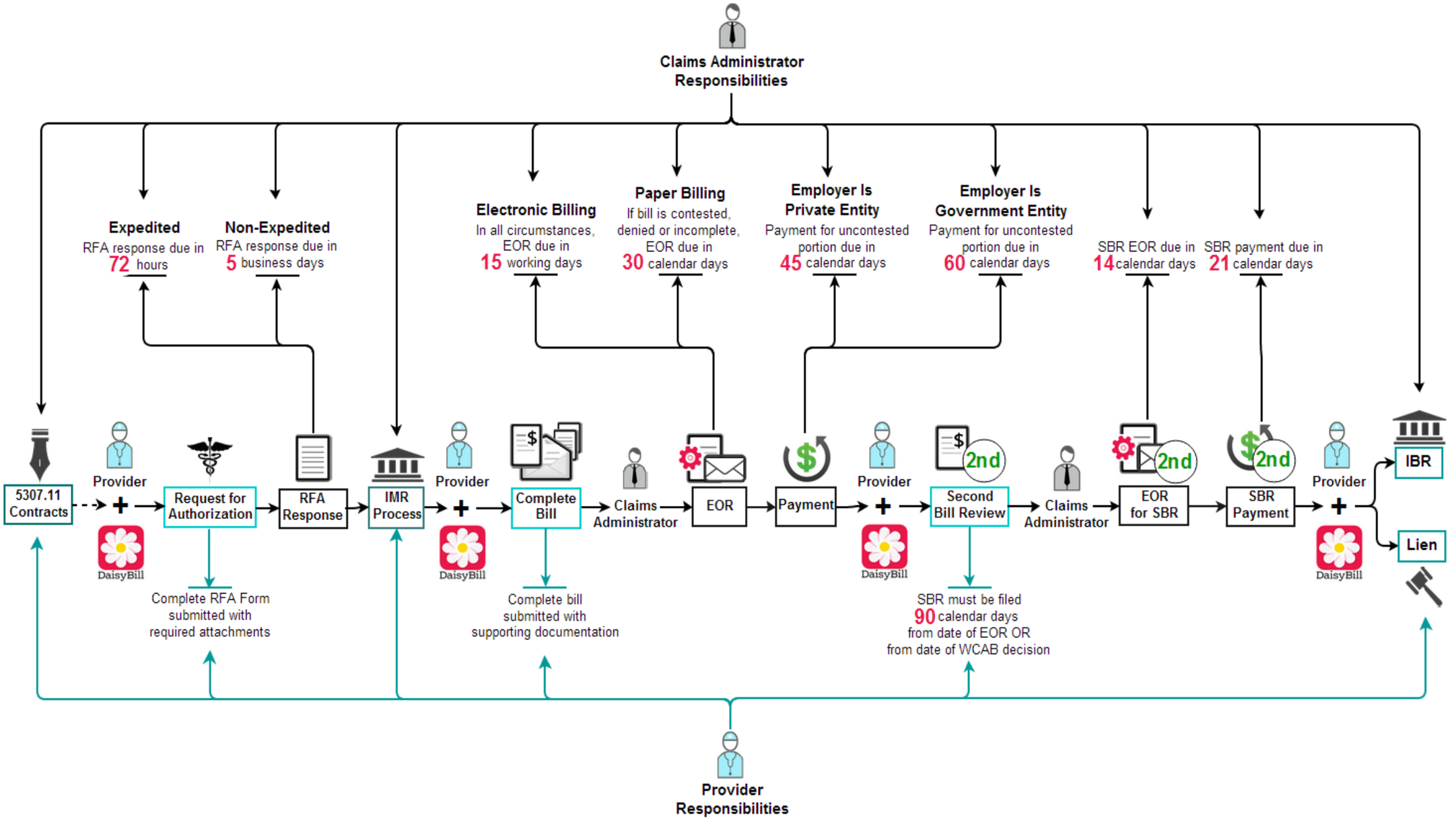
Independent Bill Review Fees

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

Mandated Responsibilities and Timeline for Claims Administrators and Providers

www.daisybill.com **347.676.1548**



Questions?

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