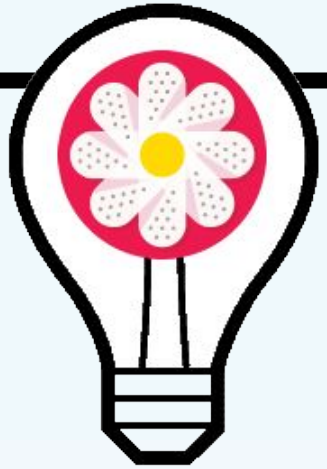
DaisyBill

2018 Workers' Compensation Billing Update

05.31.2018



Today's Topics

1. E&M Codes Aren't Being Reimbursed Properly

2. Automatic Authorization

3. Second Bill Reviews (appeals) are more important than ever

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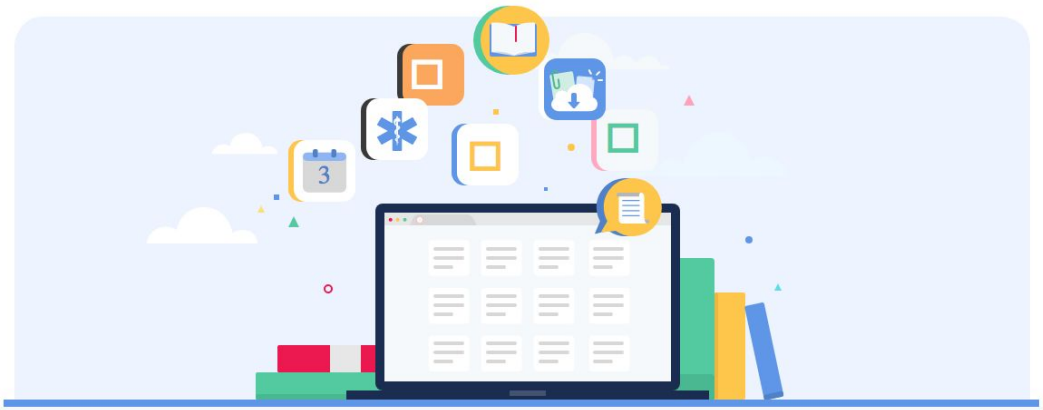


Education about California workers' comp rules and regulations

Today's Topics

1. E&M Codes Aren't Being Reimbursed Properly

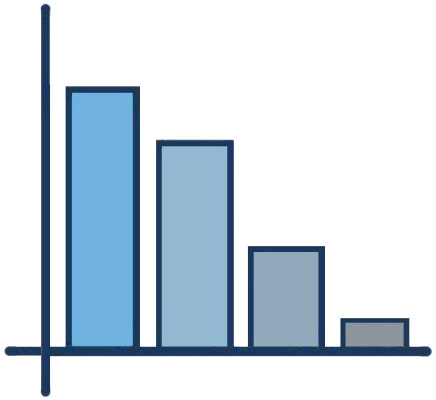
2. Automatic Authorization

3. Second Bill Reviews (appeals) are more important than ever

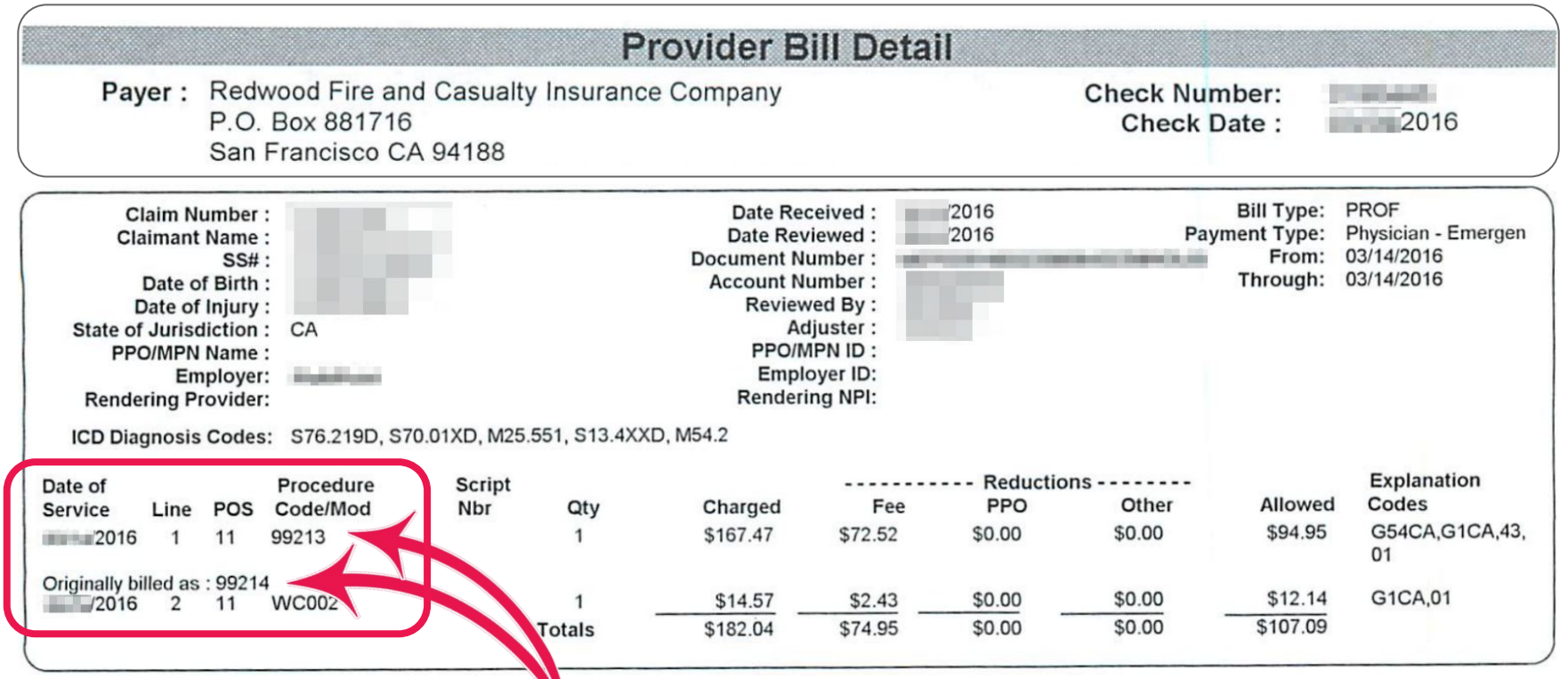
E/M Visits Downcoded

Downcoding = Lost Revenue

CPT	OMFS 2018	Downcode OMFS	Lost Revenue	Lost Revenue Percentage
99211	$30.90			
99212	$61.67	$30.90	-$30.77	-49%
99213	$101.39	$61.67	-$39.72	-39%
99214	$149.32	$101.39	-$47.93	-32%
99215	200.52	$149.32	-$51.20	-26%



Incorrect Downcoding



Provider Bill Detail

Payer : Redwood Fire and Casualty Insurance Company
P.O. Box 881716
San Francisco CA 94188

Check Number: [redacted]
Check Date : [redacted]2016

Claim Number : [redacted]
Claimant Name : [redacted]
SS# : [redacted]
Date of Birth : [redacted]
Date of Injury : [redacted]
State of Jurisdiction : CA
PPO/MPN Name :
Employer: [redacted]
Rendering Provider:

Date Received : [redacted]2016
Date Reviewed : [redacted]2016
Document Number : [redacted]
Account Number : [redacted]
Reviewed By :
Adjuster :
PPO/MPN ID :
Employer ID:
Rendering NPI:

Bill Type: PROF
Payment Type: Physician - Emergen
From: 03/14/2016
Through: 03/14/2016

ICD Diagnosis Codes: S76.219D, S70.01XD, M25.551, S13.4XXD, M54.2

Date of Service	Line	POS	Procedure Code/Mod	Script Nbr	Qty	Charged	Reductions: Fee	Reductions: PPO	Reductions: Other	Allowed	Explanation Codes
[redacted]2016	1	11	99213		1	$167.47	$72.52	$0.00	$0.00	$94.95	G54CA,G1CA,43, 01
Originally billed as : 99214											
[redacted]/2016	2	11	WC002		1	$14.57	$2.43	$0.00	$0.00	$12.14	G1CA,01
					Totals	$182.04	$74.95	$0.00	$0.00	$107.09	

Originally billed as CPT 99214;
downcoded to CPT 99213

Reasons for Downcoding

1. Carrier incorrectly downcoded

2. Documentation is incomplete

3. Documentation doesn't support level billed

§ 9789.12.11 Evaluation and Management: Coding

(b) To properly document and determine the appropriate level of evaluation and management service, physicians and qualified non-physician practitioners must use either one of the following guidelines but not a combination of the two guidelines for a patient encounter. If the physician's or qualified non-physician practitioner's documentation for a medically necessary service conforms to either one of the guidelines, the maximum reasonable fee shall be according to the documented level of service:

(1) The "1995 Documentation Guidelines for Evaluation & Management Services," or

(2) The "1997 Documentation Guidelines for Evaluation and Management Services."

§ 9789.12.11 Evaluation and Management: Coding

(b) To properly document and determine the appropriate level of evaluation and management service, physicians and qualified non-physician practitioners must use either one of the following guidelines but not a combination of the two guidelines for a patient encounter. If the physician's or qualified non-physician practitioner's documentation for a medically necessary service conforms to either one of the guidelines, the maximum reasonable fee shall be according to the documented level of service:

(1) The "1995 Documentation Guidelines for Evaluation & Management Services," or

(2) The "1997 Documentation Guidelines for Evaluation and Management Services."

Documentation Guidelines

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
   - assessment, clinical impression, or diagnosis;
   - plan for care; and
   - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Reason for Requesting Second 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 services or goods, or medical-legal services, provided to the injured employee.

Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
		☐ Yes ☐ No				☐ Yes ☐ No

Reason for Requesting Second Bill Review and Description of Supporting Documentation:

Today's Topics

1. E&M Codes Aren't Being Reimbursed Properly

2. Automatic Authorization

3. Second Bill Reviews (appeals) are more important than ever

Automatic Authorization

SB 1160 Section 3.5

§ 4610. amended

Effective:

January 1, 2018

(j) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

LC 4610 Repealed Effective January 1, 2018

California Labor Code Section 4610

4610. (a) For purposes of this section, utilization review means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical tre[illegible] Section 4600.

(b) [illegible]

REPEALED

(c) Each utilization review p[illegible] and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

SB 1160 Replaces Labor Code 4610

Section	Labor Code	Summary	Effective
1	138.4. amended	Employee medical treatment when claim denied	Jan 1, 2018
2	138.6. amended	Increase WCIS penalty for failure to report data	Jan 1, 2017
3.5	4610. amended	Utilization review language clarified. Removes 'delay'	Jan 1, 2017
4.5	**4610. added**	**Replaces current utilization review Labor Code**	**Jan 1, 2018**
5	4610.05. amended	Adds medication formulary to IMR disputes	Jan 1, 2017
6	4610.6. amended	Clarifies IMR decision time requirements	Jan 1, 2017
7	4615. added	Physician liens stayed upon filing of criminal charges	Jan 1, 2017
8	4903.5. amended	Lien declaration amended	Jan 1, 2017
9	4903.8. amended	Lien ownership requirements clarified	Jan 1, 2017
10	5307.27. amended	MTUS update change notification	Jan 1, 2017
11	5710. amended	Deposition costs	July 1, 2018
12	5811. amended	Court witness interpreter fees	Jan 1, 2018
13	6409. amended	Physician report of occupational injury/illness	Jan 1, 2017

New Labor Code 4610 Effective 1/1/2018

SEC. 4.5. Section 4610 is added to the Labor Code, to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 4609 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1) Pharmaceuticals, to the extent they are neither expressly excepted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.

(2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.

(3) Psychological treatment services.

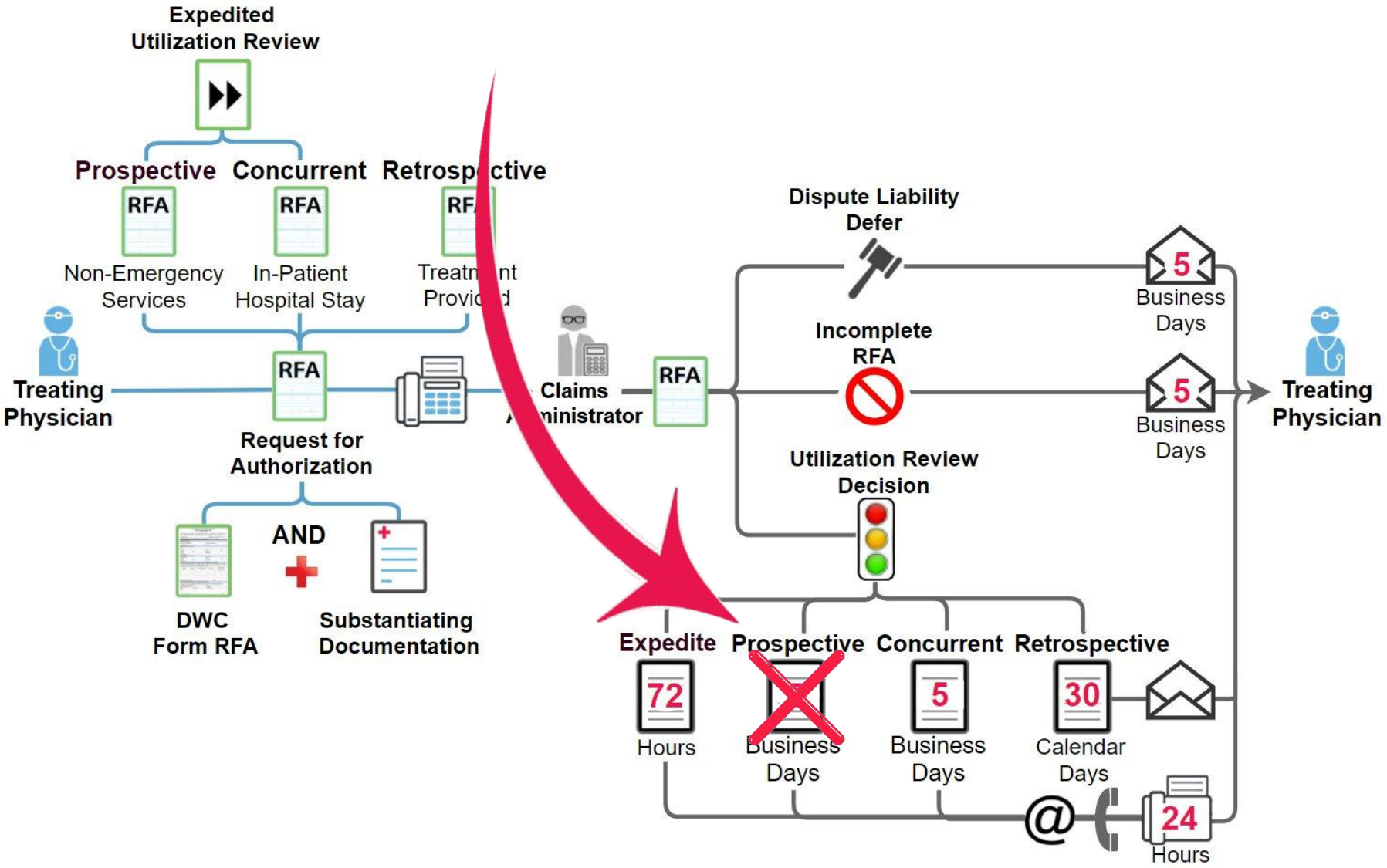
(4) Home health care services.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical ...

...

Prospective Utilization Review Eliminated



SB 1160 Section 4.5

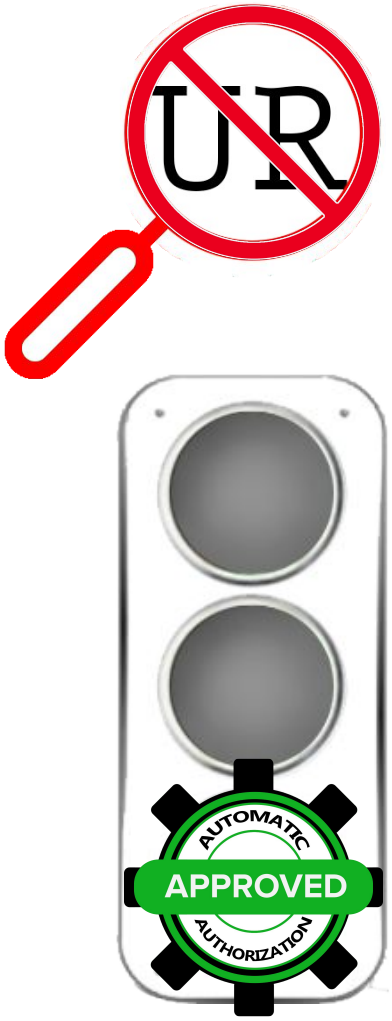
§ 4610. added

Effective:

January 1, 2018

Prospective Utilization Review NOT Required

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized **without** prospective utilization review, except as provided in subdivision (c).



Prospective Utilization Review NOT Required

SB 1160 Section 4.5

§ 4610. added

Effective:

January 1, 2018

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized **without** prospective utilization review, except as provided in subdivision (c).

Automatic Authorization - **Six** Required Conditions

1. Dates of injury as of January 1, 2018
2. Within 30 days of initial injury
3. Body part or condition accepted as compensable
4. Treatment included in MTUS
5. Treatment provided by an MPN or HCO member or a predesignated physician
6. Treatment is not listed in subdivision (c) as ineligible
   - ❑ Pharmaceuticals
   - ❑ Non-emergency inpatient / outpatient surgery
   - ❑ Psychological treatment
   - ❑ Home health care
   - ❑ Imaging and radiology services, excluding x-ray
   - ❑ DME exceeding a combined total of $250 per the OMFS
   - ❑ Electrodiagnostic medicine
   - ❑ Any other services designated by Administrative Director

SB 1160 Section 4.5

§ 4610. added

Effective:

January 1, 2018

6

Ineligible Services - Require UR

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1) Pharmaceuticals, to the extent th[illegible] neither expressly exempted from prospective [illegible]w nor auth[illegible]ed by the drug formulary adopted pursu[illegible]o Section 5307.27.

(2) Nonemergency inpa[illegible] and outpatient surge[illegible]ncluding all presurgical and pos[illegible]gical ser[illegible]ces.

(3) Psychological treat[illegible]t service[illegible]

(4) Home health care s[illegible]ce[illegible]

(5) Imaging and radiolo[illegible]rvices, excluding X-[illegible]

(6) All durable medical eq[illegible]ent, whose com[illegible] total value exceeds two hundre[illegible] [illegible]mined by the official medical fe[illegible]e.

(7) Electrodiag[illegible]dicine, including, but not limited to, electromyo[illegible]d nerve conduction studies.

(8) Any ot[illegible]ice designated and defined through rules adopted by the administrative director.

SB 1160 Section 4.5

§ 4610. added

Effective:

January 1, 2018

Ineligible Unless Employer Authorized

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

Labor Code

SB 1160 Section 4.5

§ 4610. added

Effective:

January 1, 2018

Ineligible Unless Emergency

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

Automatic Authorization - **Six** Required Conditions

1. Dates of injury as of January 1, 2018
2. Within 30 days of initial injury
3. Body part or condition accepted as compensable
4. Treatment included in MTUS
5. Treatment provided by an MPN or HCO member or a predesignated physician
6. Treatment is not listed in subdivision (c) as ineligible
   - ❑ Pharmaceuticals
   - ❑ Non-emergency inpatient / outpatient surgery
   - ❑ Psychological treatment
   - ❑ Home health care
   - ❑ Imaging and radiology services, excluding x-ray
   - ❑ DME exceeding a combined total of $250 per the OMFS
   - ❑ Electrodiagnostic medicine
   - ❑ Any other services designated by Administrative Director

Post-Treatment Requirements of Automatic Authorization

Post-Treatment Requirements and Deadlines

1. DLSR 5021, Doctor's First Report of Injury
   - Within 5 days
2. Request for Authorization
   - Within 5 days
3. Request for Payment
   - Non-Emergency
     - Within 30 days
   - Emergency
     - Within 180 days

Labor Code

SB 1160 Section 4.5

§ 4610. added

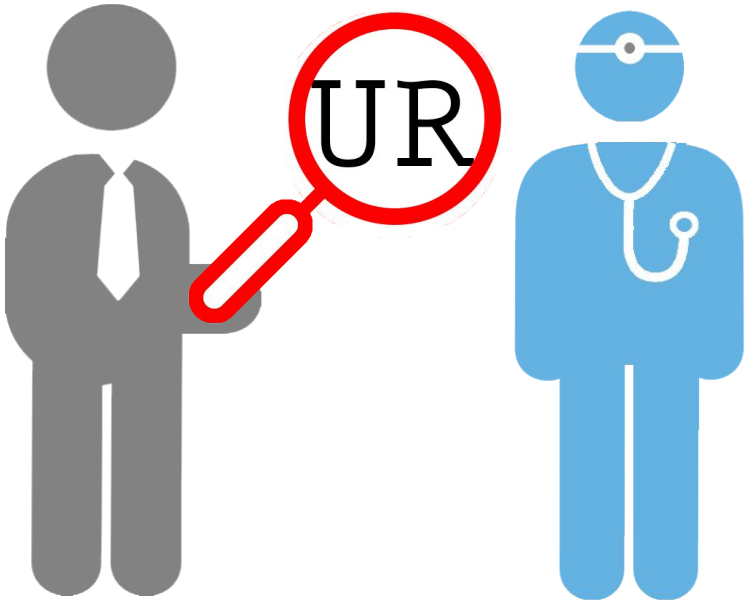
Effective:

January 1, 2018

(f) An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.

Employer May Perform Retrospective UR to Investigate Physician

Solely to determine if physician is prescribing treatment consistent with the MTUS.



Provider Pattern of Inconsistency With MTUS

SB 1160 Section 4.5

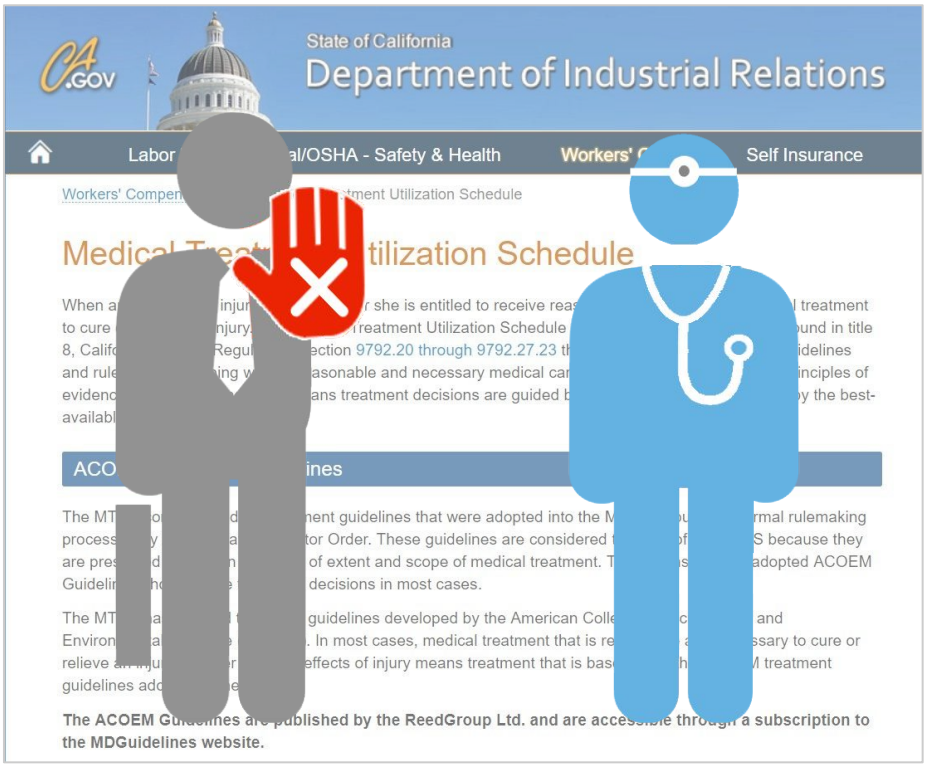
§ 4610. added

Effective:

January 1, 2018

(f)(1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

Employer may remove provider's ability to provide treatment that is exempt from UR.



Labor Code

SB 1160 Section 4.5

§ 4610. added

Effective:

January 1, 2018

(f)(2) The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

Provider Pattern of Inconsistency With MTUS

Employer may terminate provider from the MPN or HCO.

Post-Treatment Requirements and Deadlines

1. DLSR 5021, Doctor's First Report of Injury
   - Within 5 days
2. Request for Authorization
   - Within 5 days
3. Request for Payment
   - Non-Emergency
     - Within 30 days
   - Emergency
     - Within 180 days

SB 1160 Section 4.5

§ 4610. added

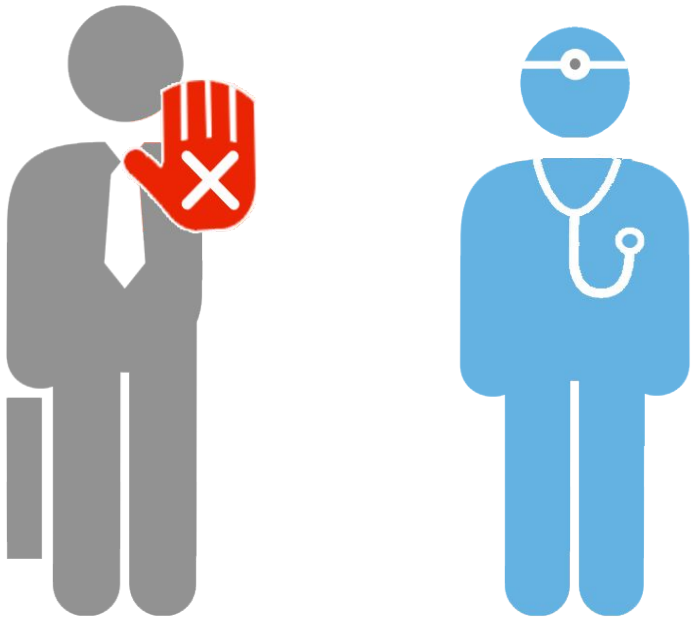
Effective:

January 1, 2018

(e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

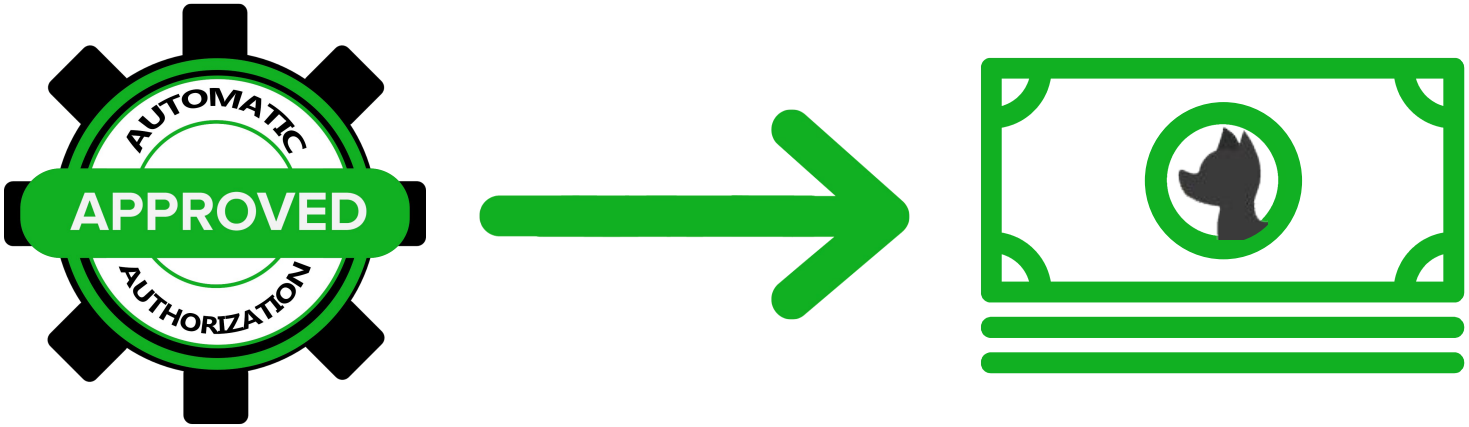
Failure to Timely Submit DLSR Report or RFA

Employer may remove physician's ability to provide treatment that is exempt from UR.



Bill Payment Due for Automatic Authorization

Even if Doctor's First Report of Injury and /or RFA not timely submitted.



§9792.6. Utilization Review Standards - Definitions - On or After January 1, 2013

(a) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code

Approve = Authorization

Claims Administrator

Utilization Review Decision

Approve

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

Q. Does sending the requesting physician an approval of an RFA mean that payment must be made for the authorized service?

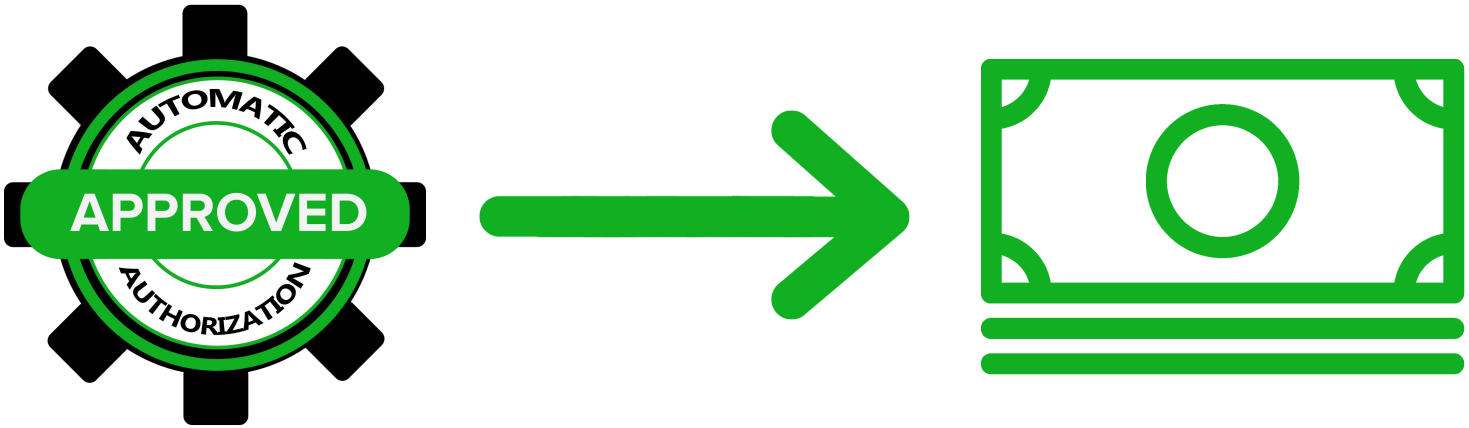
A. Yes. Authorization means "assurance that appropriate reimbursement" for the treatment specified will be paid. The California Labor Code provides that once an employer (or its insurer or URO) authorizes medical treatment, **that authorization shall not be rescinded or modified for any reason after the medical treatment has been provided based on the authorization, even if the employer later determines the physician was not eligible to treat (e.g. was not an MPN provider)**. Under the UR regulations, treatment is "authorized" when the decision to approve the RFA is communicated to the requesting physician

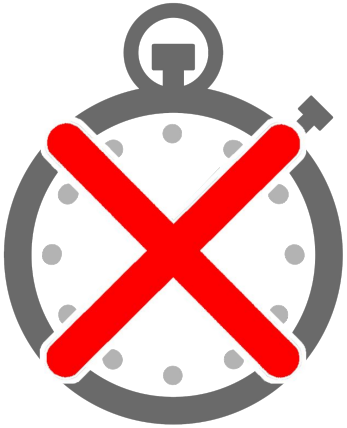
Post-Treatment Requirements and Deadlines

1. DLSR 5021, Doctor's First Report of Injury
    - Within 5 days
2. Request for Authorization
    - Within 5 days
3. Request for Payment
    - Non-Emergency
        i. Within 30 days
    - Emergency
        i. Within 180 days

Bill Payment Due For Automatic Authorization

Even if request for payment not timely submitted.





Labor Code

4603.2

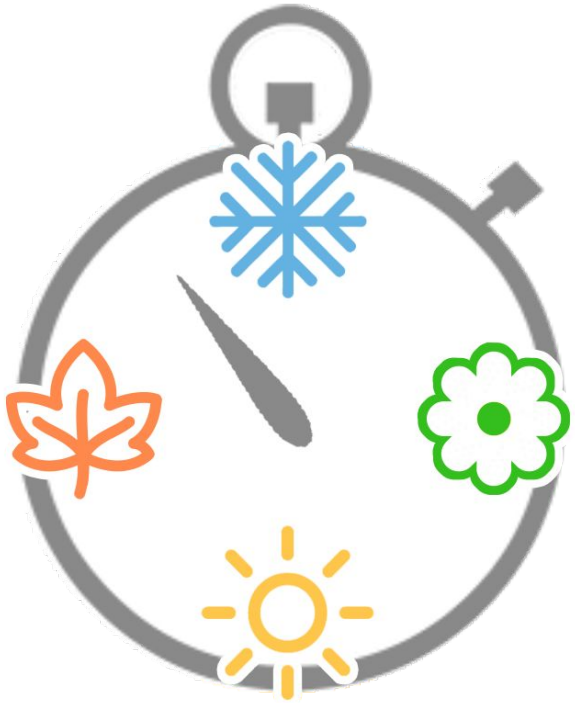
Effective:

January 1, 2017

(b)(1)(B) Effective for services provided on or after January 1, 2017, the request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer **within 12 months of the date of service** or within 12 months of the date of discharge for inpatient facility services. The administrative director shall adopt rules to implement the 12-month limitation period. The rules shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. The request for payment is barred unless timely submitted.

Timely Bill Submission Within 12 Months of Date of Service

Within 12 months of rendering a service, the provider must submit the bill for services.



Labor Code

4603.2

Effective:

January 1, 2017

(b)(1)(B) Effective for services provided on or after January 1, 2017, the request for payment with an itemization of services provided and the charge for each service shall be submitted to the employer within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The administrative director shall adopt rules to implement the 12-month limitation period. The rules shall define circumstances that constitute good cause for an exception to the 12-month period, including provisions to address the circumstances of a nonoccupational injury or illness later found to be a compensable injury or illness. **The request for payment is barred unless timely submitted.**

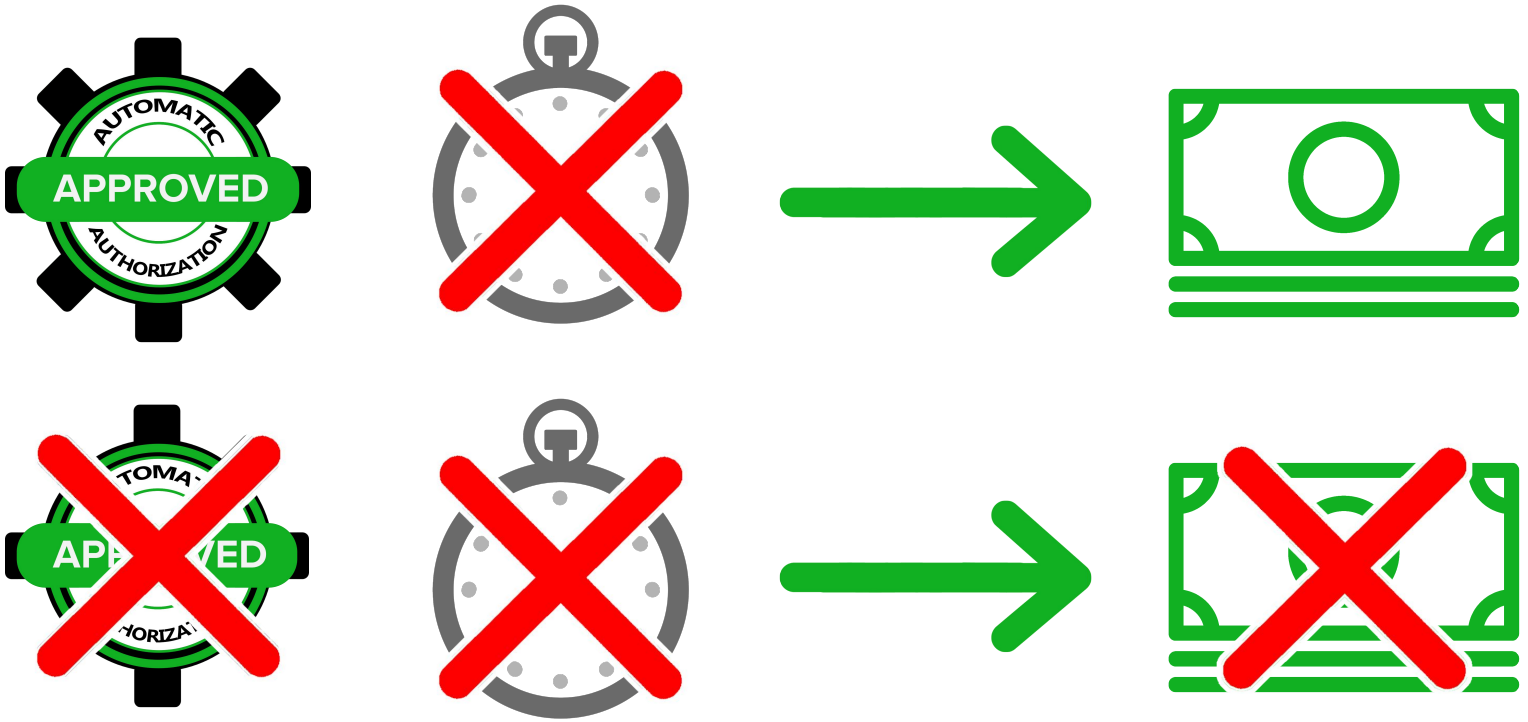
Payment Barred for Untimely Filing

No payment due for untimely bill submissions.

Untimely Bill

Automatically Authorized = Payment

Non-Automatically Authorized = No Payment

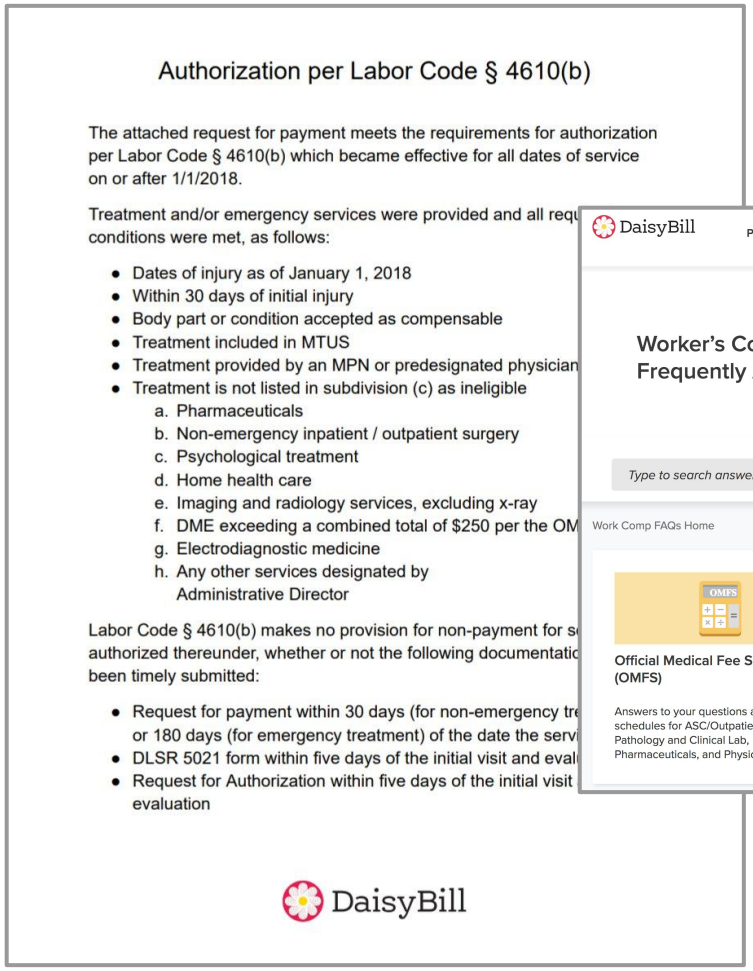


Post-Treatment Requirements and Deadlines

1. DLSR 5021, Doctor's First Report of Injury
    - Within 5 days
2. Request for Authorization
    - Within 5 days
3. Request for Payment
    - Non-Emergency
        i. Within 30 days
    - Emergency
        i. Within 180 days

Second Review Appeal

For denied bills, use Second Review to appeal incorrect denials



Authorization per Labor Code § 4610(b)

The attached request for payment meets the requirements for authorization per Labor Code § 4610(b) which became effective for all dates of service on or after 1/1/2018.

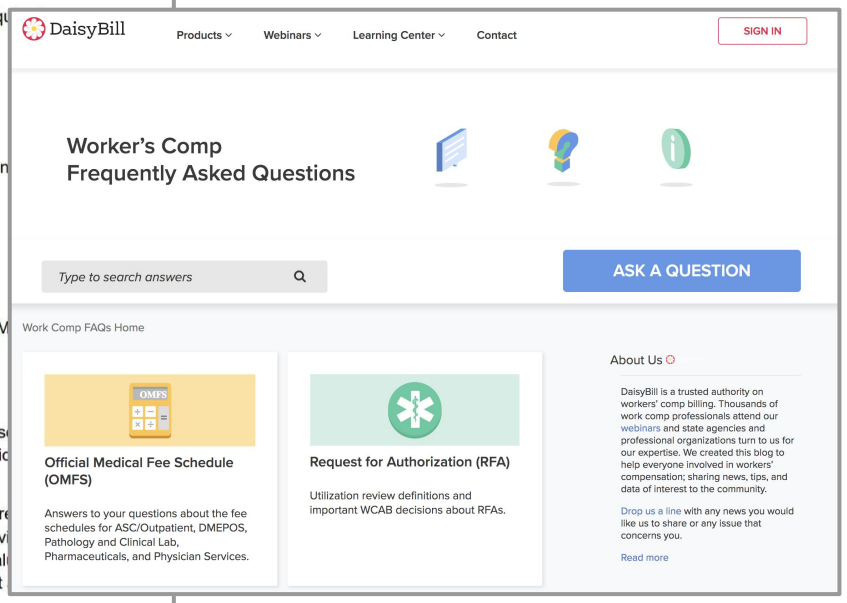
Treatment and/or emergency services were provided and all requ conditions were met, as follows:

- Dates of injury as of January 1, 2018
- Within 30 days of initial injury
- Body part or condition accepted as compensable
- Treatment included in MTUS
- Treatment provided by an MPN or predesignated physician
- Treatment is not listed in subdivision (c) as ineligible
  a. Pharmaceuticals
  b. Non-emergency inpatient / outpatient surgery
  c. Psychological treatment
  d. Home health care
  e. Imaging and radiology services, excluding x-ray
  f. DME exceeding a combined total of $250 per the OM
  g. Electrodiagnostic medicine
  h. Any other services designated by Administrative Director

Labor Code § 4610(b) makes no provision for non-payment for s authorized thereunder, whether or not the following documentatio been timely submitted:

- Request for payment within 30 days (for non-emergency tr or 180 days (for emergency treatment) of the date the servi
- DLSR 5021 form within five days of the initial visit and eval
- Request for Authorization within five days of the initial visit evaluation

DaisyBill



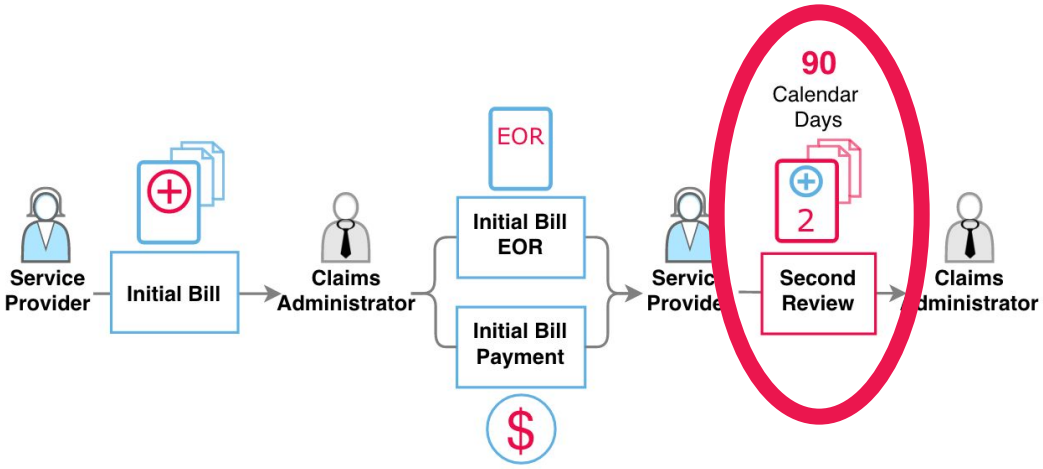
Today's Topics

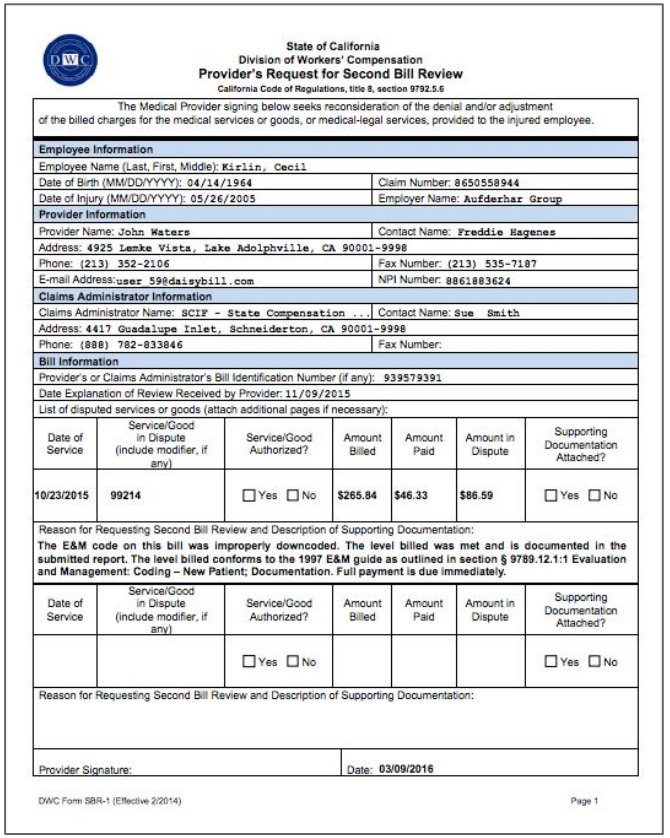
1. E&M Codes Aren't Being Reimbursed Properly

2. Automatic Authorization

3. Second Bill Reviews (appeals) are more important than ever

Incorrect Payments Require Second Bill Review (SBR-1 Form)





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 services or goods, or medical-legal services, provided to the injured employee.

Employee Information

Employee Name (Last, First, Middle): Kirlin, Cecil
Date of Birth (MM/DD/YYYY): 04/14/1964 | Claim Number: 8650558944
Date of Injury (MM/DD/YYYY): 05/26/2005 | Employer Name: Aufderhar Group

Provider Information

Provider Name: John Waters | Contact Name: Freddie Hagenes
Address: 4925 Lemke Vista, Lake Adolphville, CA 90001-9998
Phone: (213) 352-2106 | Fax Number: (213) 535-7187
E-mail Address: user_59@daisybill.com | NPI Number: 8861883624

Claims Administrator Information

Claims Administrator Name: SCIF - State Compensation ... | Contact Name: Sue Smith
Address: 4417 Guadalupe Inlet, Schneiderton, CA 90001-9998
Phone: (888) 782-833846 | Fax Number:

Bill Information

Provider's or Claims Administrator's Bill Identification Number (if any): 939579391
Date Explanation of Review Received by Provider: 11/09/2015
List of disputed services or goods (attach additional pages if necessary):

Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
10/23/2015	99214	☐ Yes ☐ No	$265.84	$46.33	$86.59	☐ Yes ☐ No

Reason for Requesting Second Bill Review and Description of Supporting Documentation:
The E&M code on this bill was improperly downcoded. The level billed was met and is documented in the submitted report. The level billed conforms to the 1997 E&M guide as outlined in section § 9789.12.1:1 Evaluation and Management: Coding – New Patient; Documentation. Full payment is due immediately.

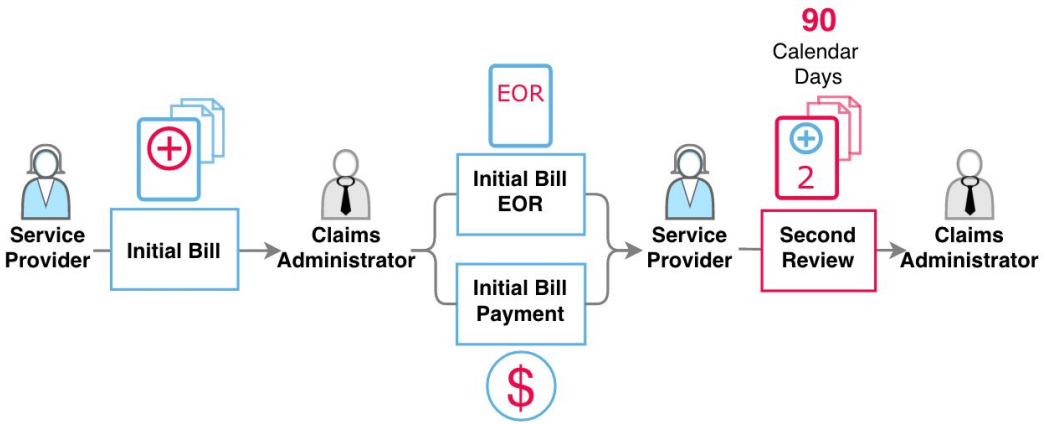
Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
		☐ Yes ☐ No				☐ Yes ☐ No

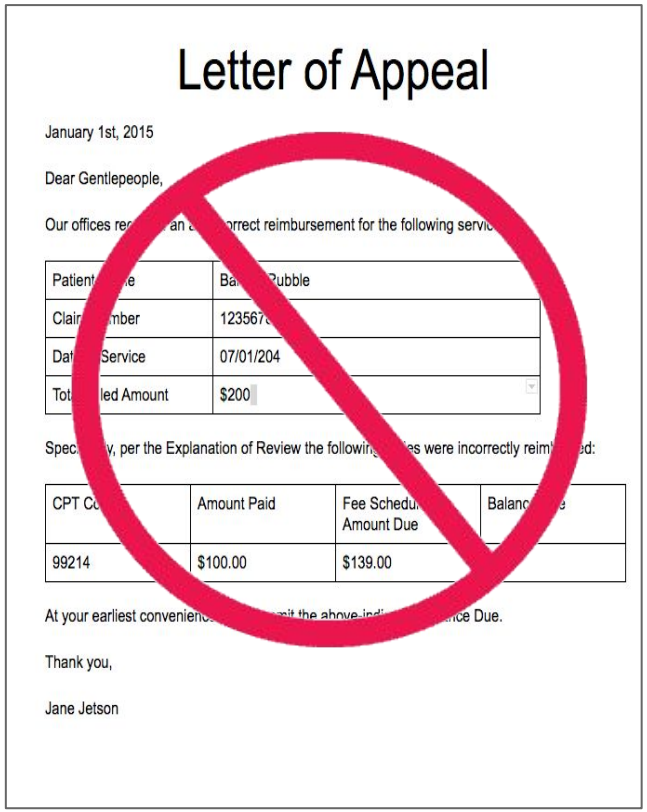
Reason for Requesting Second Bill Review and Description of Supporting Documentation:

Provider Signature: | Date: 03/09/2016

DWC Form SBR-1 (Effective 2/2014) Page 1

Letter of Appeal / Reconsideration Noncompliant

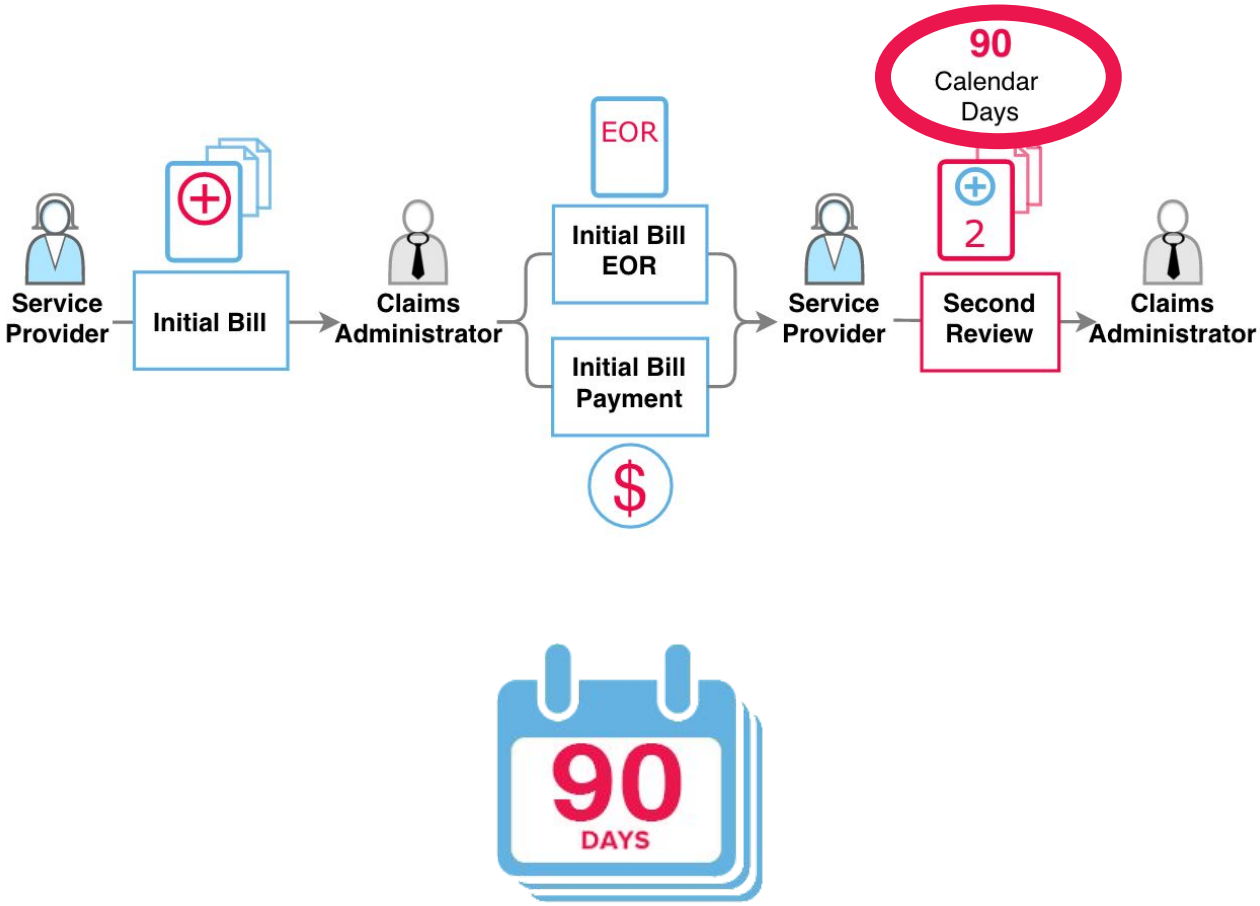




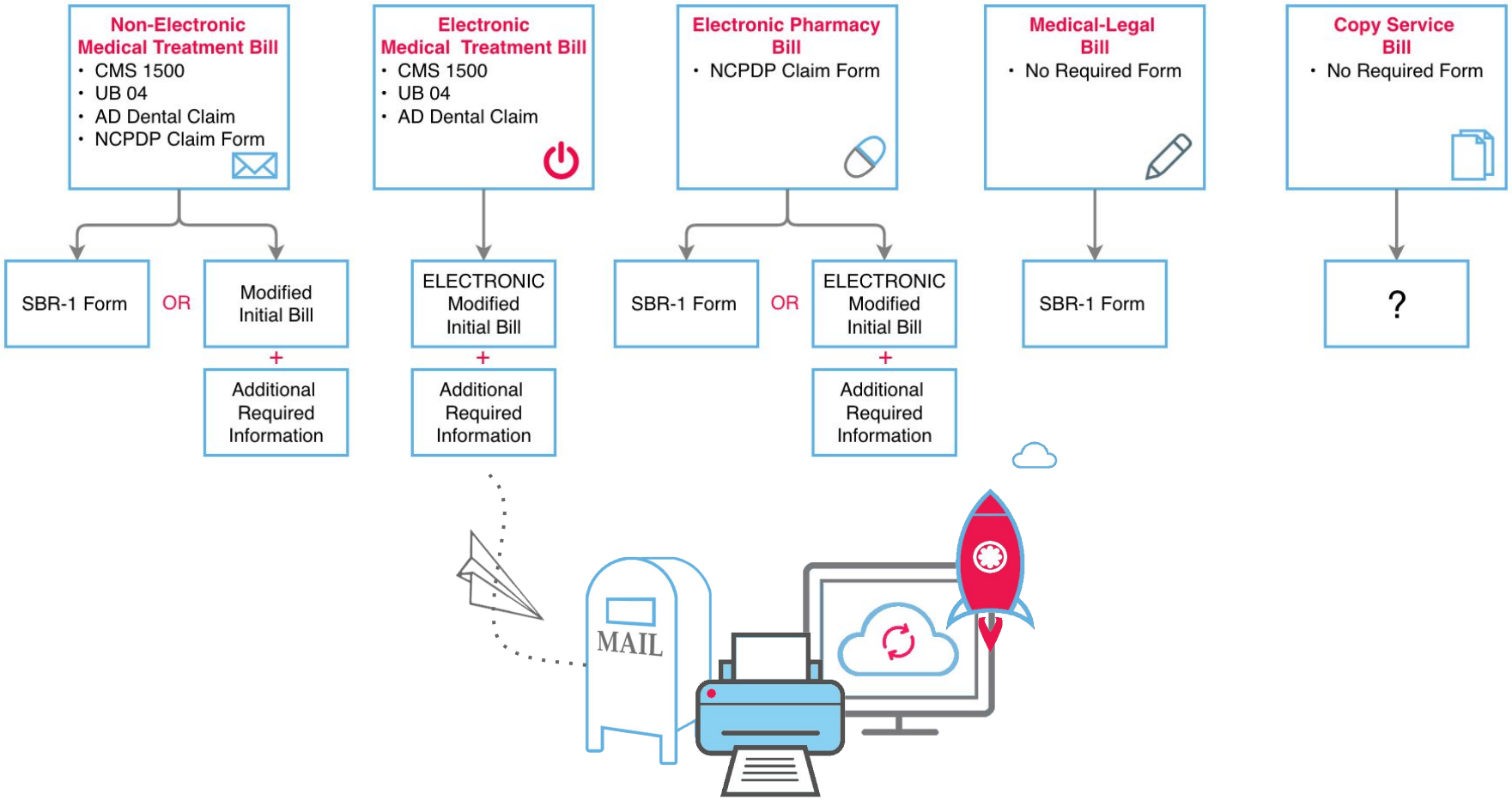
CCR § 9792.5.5 Second Review of Medical Treatment Bill or Medical-Legal Bill

(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:

90 Days to Submit Second Review



Second Review Format Depends on Initial Bill Format and Bill Type



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

(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:

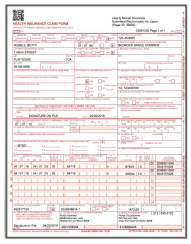
(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The second review bill shall be marked using the National Uniform Billing Committee (NUBC) Condition Code Qualifier "BG" followed by NUBC Condition Code "W3" in the field designated for that information 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.

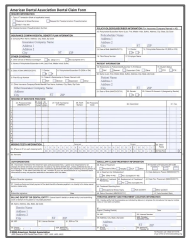
Modified Initial Bill

Non-Electronic Medical Treatment Bill

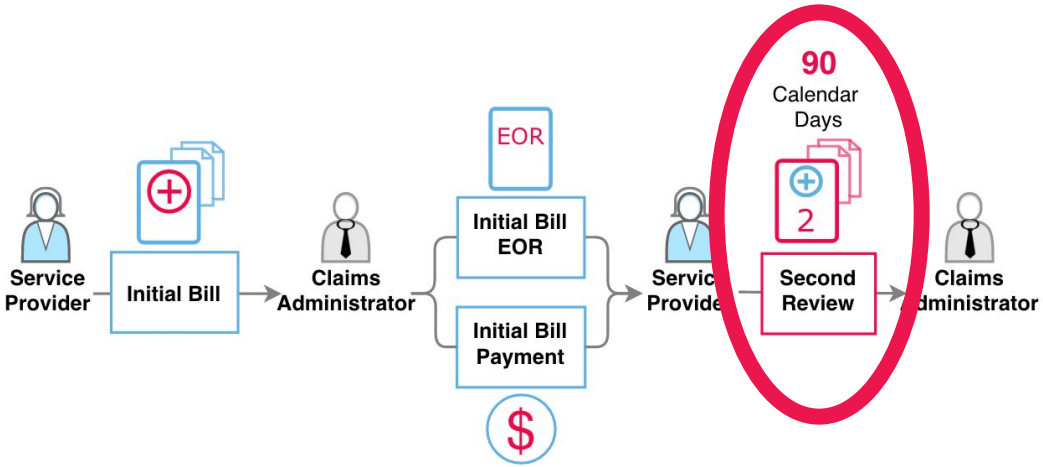
- CMS 1500
- UB 04
- AD Dental Claim
- NCPDP Claim Form

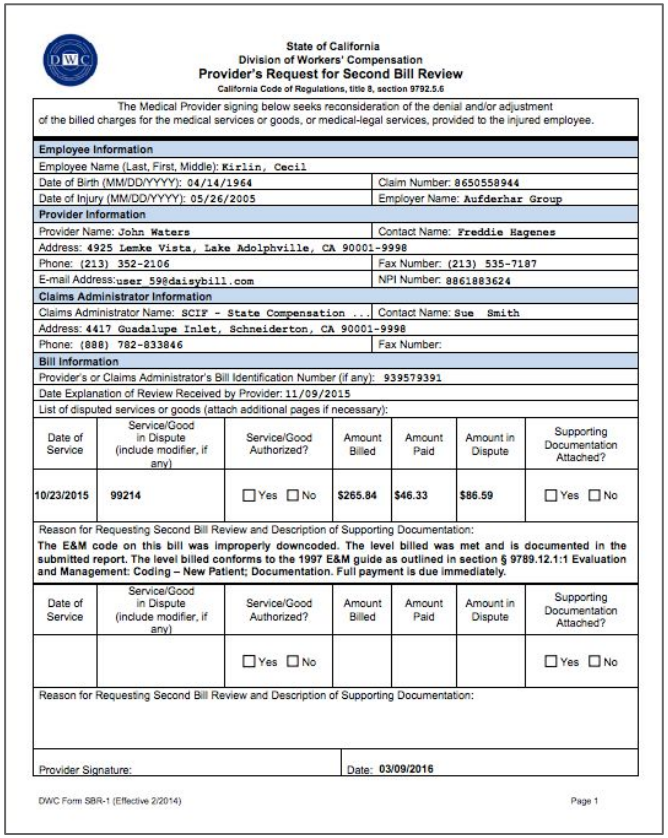
Bill Type	Modified Initial Bill
CMS 1500	Box 10d: BGW3
UB04	Box 18-28: BGW3
ADA Dental Claim Form 2006 or ADA Claim Form 2012	Field 1: Words "Request for Second Review"
NCPDP WC/PC Claim Form	Words: "Request for Second Review"






Medical-Legal Bills REQUIRE Second Bill Review (SBR-1 Form)





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

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Date of Birth (MM/DD/YYYY): 04/14/1964	Claim Number: 8650558944
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Provider Name: John Waters	Contact Name: Freddie Hagenes
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Phone: (213) 352-2106	Fax Number: (213) 535-7187
E-mail Address: user_59@daisybill.com	NPI Number: 8861883624
Claims Administrator Information	
Claims Administrator Name: SCIF - State Compensation ...	Contact Name: Sue Smith
Address: 4417 Guadalupe Inlet, Schneiderton, CA 90001-9998	
Phone: (888) 782-833846	Fax Number:
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10/23/2015	99214	☐ Yes ☐ No	$265.84	$46.33	$86.59	☐ Yes ☐ No

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		☐ Yes ☐ No				☐ Yes ☐ No

Reason for Requesting Second Bill Review and Description of Supporting Documentation:

Provider Signature: Date: 03/09/2016

DWC Form SBR-1 (Effective 2/2014) Page 1

Make Life Easier: Submit the SBR-1 Form

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

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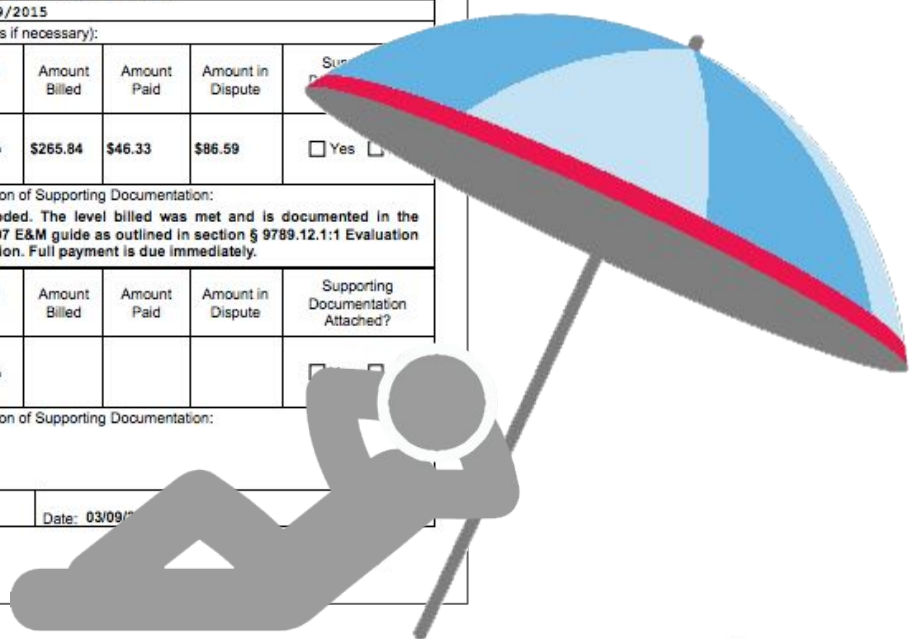
Reason for Requesting Second Bill Review and Description of Supporting Documentation:

Provider Signature: Date: 03/09/

DWC Form SBR-1 (Effective 2/2014)



IMPORTANT: Reason for Requesting Second 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

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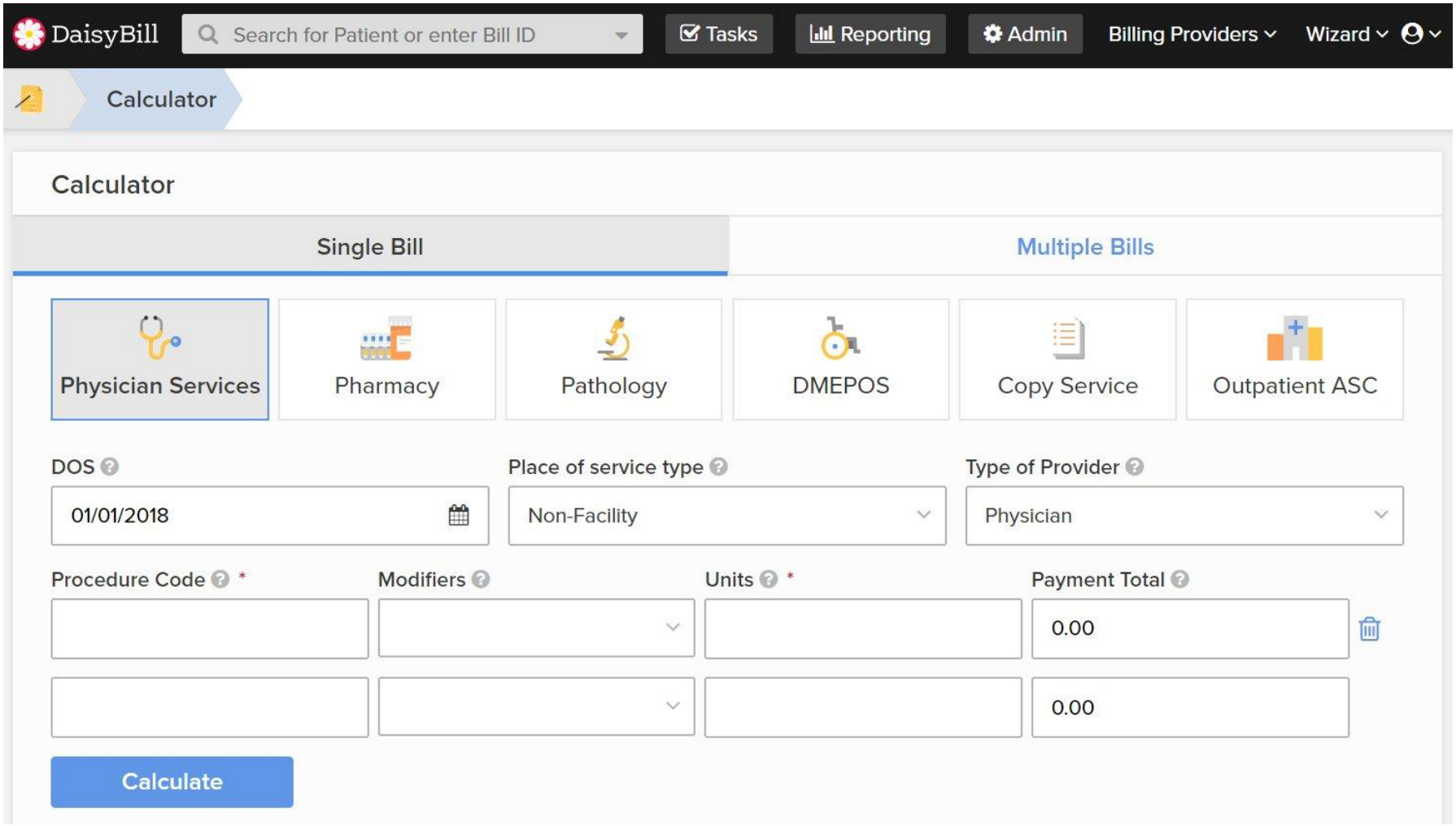
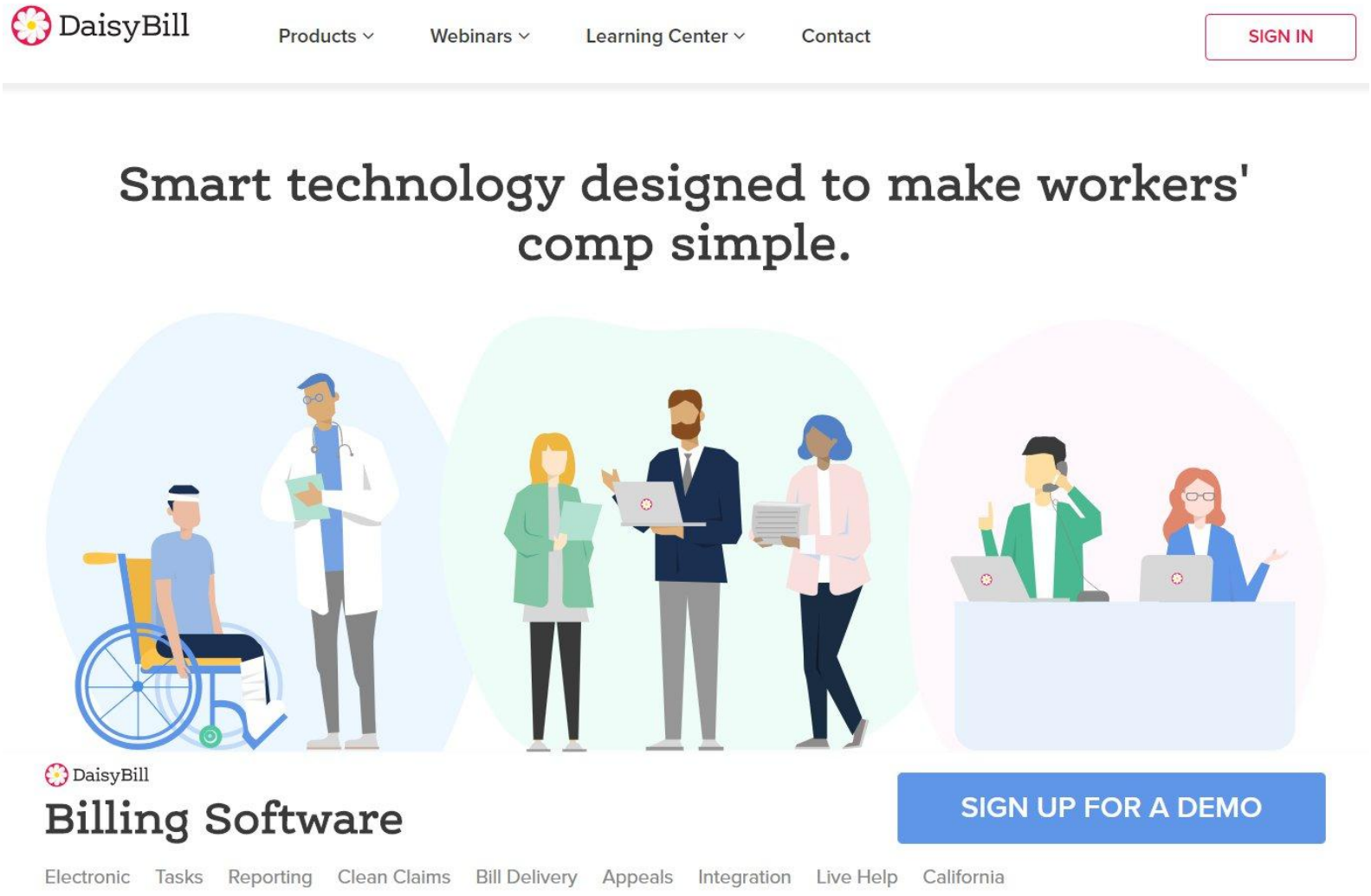
		☐ Yes ☐ No				☐ Yes ☐ No

Reason for Requesting Second Bill Review and Description of Supporting Documentation:

Know the Fee Schedule: Easy OMFS Calculator



Electronic Billing Software



2017 Days to Payment

Electronic Billing Means FAST Payment

Claims Administrator Name	Business Days to Payment Average
Sedgwick Claims Management Services	10
State Compensation Insurance Fund	8
Gallagher Bassett	8
Liberty Mutual Insurance	6
York Risk Services Group	16
Zurich Insurance North America	21
CorVel	13
Tristar Risk Management	17
Travelers	10
AmTrust North America	15
The Hartford	11
ESIS, Inc.	12
Berkshire Hathaway Homestate Companies	10
The Zenith	8
Intercare Holdings Insurance, Inc.	13

DaisyBill

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347.676.1548