HOW DO I GET PAID FOR MY MEDICAL LEGAL SERVICES?

MEDICAL-LEGAL RULES TO LIVE BY.

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CALIFORNIA ORTHOPEDIC ASSOCIATION 2022

I examined John Doe as a panel Qualified Medical Evaluator in the field of orthopedics on _____ (date). This evaluation took place at my office located at _____. I spent in excess of 20 minutes face to face with the applicant. I reviewed _____ pages of records which were forwarded to me by the party/parties with proper statements under penalty of perjury of compliance with Labor Code § 4062.3 and an attestation as to the number of pages sent. That documentation is attached hereto and incorporated herein as an attachment to my report. The total number of pages I reviewed less 200 pages [less 50] was _____ pages. This is/is not consistent with the attestation of pages by the parties. (Explain if there's a difference).

CALIFORNIA ORTHOPEDIC ASSOCIATION 2022

Modification Code 93 provides a .1 increase in the fee for utilization of an interpreter. If an interpreter is used you must include with the first paragraph that the evaluation took place with an interpreter and the time for the evaluation was increased by _____ percentage (20 percent/25 percent) in compliance with Title 8 California Code of Regulations Section 9795. Please also indicate the name of the interpreter and the certification number and take a photocopy of the certification badge with a picture of the interpreter and attach it to your report.

LABOR CODE § 4628

Memorize this code section and keep a copy.

(a) The medical-legal evaluator must:

1. Examine the patient.

2. Take a complete history.

3. Review and Summarize the Records

4. Compose and draft the conclusions of the report (Labor Code § 4628(a)).

LABOR CODE § 4628(b)

The medical-legal report must:

1. Disclose the date when and the location where the evaluation was performed.
2. The doctor signing the report actually performed the evaluation.
3. State whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the administrative director pursuant to Paragraph (5) of Subdivision (j) of Labor Code § 139.2 or Labor Code § 5307.6 and shall disclose the name and qualifications of each person who performed any services in connection with the report..

PERSONS PROVIDING SERVICES

1. The name of any person doing diagnostic studies relating to the examination and report

2. Name of person who took the initial outline of the patient history if any

3. Name of person who excerpted prior medical records or reviewed records to remove duplicates or place records in chronological order, etc.

(Note distinction between excerpt and summarize.)

See Labor Code § 4628(b).

PERSONS PROVIDING SERVICES

The medical-legal evaluator must/shall review the excerpts, entire outline and history with the patient and make additional inquires necessary to identify and determine relevant medical issues.

LABOR CODE § 4628(d)

The medical-legal evaluator may not charge any amount in excess of the direct charges for the physician's professional services.

LABOR CODE § 4628(d)

The physician may charge the reasonable costs of laboratory examinations, diagnostic studies, other medical tests and reasonable cost of clerical expense necessary to producing the report.

Physician charges for professional services shall include reasonable overhead expenses.

* See 8 CCR 9795 (b) which states no charge allowed for clerical expense.

LABOR CODE § 4628(g)

A physician who is assessed a civil penalty under this section may be terminated, suspended or placed on probation as a Qualified Medical Evaluator pursuant to Subdivisions (k) and (l) of Section 139.2.

LABOR CODE § 4628(J) REQUIRES THE FOLLOWING DECLARATION BY THE MEDICAL-LEGAL PHYSICIAN SIGNING THE REPORT UNDER PENALTY OF PERJURY:

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

That declaration must be included at the end of the report dated and signed by the medical-legal physician and indicate the county wherein it was signed.

Labor Code § 5307.6(d)(1)

"No provider may request nor accept any compensation, including, but not limited to, any kind of remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct of indirect payment, whether in money or otherwise, from any source for medical-legal expenses if such compensation is in addition to the fees authorized by this section. In addition to being subject to discipline pursuant to the provisions of Subsection (k) of Section 139.2, any provider violating the subdivision, is subsequent to disciplinary action by the appropriate licensing board."

Labor Code § 5307.6(d)(1) (statement)

I have not requested nor accepted any compensation, including, but not limited to, any kind of remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, from any source for medical-legal expenses in addition to the fees authorized by statute and regulation."

This will be added to the required statement at the end of the report pursuant to Labor Code § 4728(j).

LABOR CODE § 139.2(O)

ATTESTATION

"I have not requested or accepted any compensation or other thing of value from any source that does or could create a conflict with my duties as a medical-legal evaluator under the Labor Code and regulations governing medical-legal providers."

How to get paid for your reports

Labor Code § 4622 requires the employer/carrier or administrator to issue payment within 60 days of receipt of the report and bill. They may pay the medical-legal invoice in full or may dispute the medical-legal invoice by utilization of an explanation of review within 60 days of receipt of the report and pay in accordance with that explanation of review within 60 days of receipt of the report.

MEDICAL-LEGAL REPORT

The charges for the medical-legal report are governed by Title 8, California Code of Regulations, Section 9795. The diagnostic studies are reviewed pursuant to the Official Medical Fee Schedule, Labor Code § 5307.1. 5307.1(i) specifically indicates it does not apply to medical-legal reports.

Explanation of Review denying bill as in excess of OMFS is invalid.

Labor Code § 4603.3

- The Explanation of Review must comply with this section and provide the basis for any adjustment, change or denial of the item or procedure billed.
- It must include any additional information required to make a decision for an incomplete itemization.
- If a denial of payment is for some reasons other than a fee dispute the reason for denial.
- It must include the information as to whom to contact if a dispute arises and inform the medical-legal provider of the time frames and time limits to object regarding the disputed or unpaid amounts and how to obtain independent review of the medical bill pursuant to Labor Code § 4603.6. See 8 CCR 9794 (f)

(f) If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid pursuant to the fee schedule set forth in section 9795, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which shall also contain the following statements:

(1) The physician may object to the denial of the medical-legal expense issued under this subdivision by notifying the claims administrator in writing of their objection within ninety (90) days of the service of the explanation of review; and

(2) If the physician does not file a written objection with the claims administrator challenging the denial of the medical-legal expense issued under this subdivision, neither the employer nor the employee shall be liable for the amount of the expense that was denied.

TITLE 8 CALIFORNIA CODE OF REGULATIONS § 9794(f)

"If the claims administrator denies liability for the medical-legal expense in whole or in part, for any reasons other than the amount to be paid pursuant to the fee schedule set forth in Section 9795, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review …"

PROVIDER REQUEST FOR SECOND BILL REVIEW

The medical-legal provider has 90 days to issue a provider request for second bill review if the doctor feels that he or she has been paid inappropriately. The provider request for second bill review can be obtained by contacting my office or obtainable at the Department of Workers' Compensation website. It should detail the basis for the request for review. It should be tailored to the explanation of review received.

Labor Code § 4622(b)

Once the physician does a Provider Request for Second Bill Review, the defendant employer/administrator has 14 calendar days from receipt to issue a final written determination on an Explanation of Review form.

Please note the second explanation of review must comply with 4603.3 and the administrative director regulations. Many second Explanations of Review are untimely which results in a waiver of all objections to the billing. Many of the second explanations of review merely state this is a duplicate billing already denied. That is not a proper and adequate Explanation of Review.

Labor Code § 4622(c)

If you receive an Explanation of Review which is not related to the amount to be paid under the fee schedule, you have 90 days from the second explanation of review to issue an objection letter relating to the non-payment or partial payment.

Labor Code § 4622(c).

- If the medical-legal provider issues an objection letter within 90 days, the employer/administrator must/shall file a Petition for Medical-Legal Expense Dispute and a Declaration of Readiness to Proceed within 60 days of receipt of the objection letter.

- Failure to file the Petition and Declaration of Readiness to Proceed within 60 days, results in a waiver of all objections to the medical-legal billing.

TITLE 8, CALIFORNIA CODE OF REGULATIONS SECTION 10451.1

This section is effective through January 1, 2020. It went into effect in 2013 as required by Labor Code § 4622. It relates to non-IBR medical-legal disputes. If a medical-legal provider asserts that the employer/administrator has failed to comply with the statutory and administrative regulatory guidelines, procedures or timeframes, it is a non-IBR issue.

10451.1(f)(1)(A)(i) indicates defendant waives any and all objections to the medical-legal billing if they fail to issue an Explanation of Review within 60 days complying with Labor Code § 4603.3 and the Administrative Director regulations which include 9794, 9795.

TITLE 8 CALIFORNIA CODE OF REGULATIONS 10786

This is a renumbered section effective January 1, 2020 and replaced 10451.1. the Department of Industrial Relations specifically indicated there's no substantive difference between the two regulations. If defendant does not issue and explanation of review within 60 days, they waive any objection to the billing pursuant to Subsection (e). If they fail to issue an explanation of review within 14 calendar days of receipt of a provider request for second bill review, they waive any objection to the billing. If they fail to respond to an objection within 60 days by filing a petition and Declaration of Readiness to Proceed, they waive any objection to the billing.

EXAMPLES OF IMPROPER EXPLANATIONS OF REVIEW

1. The claim has been adjudicated as non-compensable.
2. The claim is denied.
3. The services weren't pre-authorized.
4. The doctor's not in the medical provider network.
5. This code does not exist.
6. The adjuster told us to pay zero.

Labor Code § 10451.1(g)
Bad Faith Actions or Tactics from January 1, 2013 through December 31, 2019

The enumerated bad faith tactics or actions were:

1. Failure to timely pay any uncontested portion of a medical-legal providers billing,

2. Failure to make a good faith effort to timely comply with applicable statutory or regulatory medical-legal timelines or procedures,

3. Contesting liability for the a medical-legal providers billing based on a dispute over injury, or injury to a particular body part.

BAD FAITH ACTIONS OR TACTICS.

The above-referenced bad faith actions or tactics were not included in 10786. The Department of Industrial Relations indicated they were removed because many in the community thought those were the only bad faith actions or tactics and emphasized that any failure to follow statutory or regulatory requirements would give rise to sanctions, costs, penalty, interest and attorney's fees pursuant to 8 CCR 10421 sanction regulation.

I didn't get the report and/or bill.

- Carriers often make this assertion. All medical reports are required to be served with a proof of service. The proof of service must show what's being served. For example, medical-legal report of Dr. Jones dated _____, and invoice dated _____. No document should be sent out of your office without this one-page form, as it is the cheapest insurance to overcome the argument that the carrier did not receive the documents.

- If the bill is substantial, I suggest that you also utilize US Postal Service Priority Mail 2-day delivery with tracking, which is approximately $7.50. That establishes definitively they received the report and bill. All of the above-referenced time frames are governed by when they receive documents.

Why hasn't my bill been paid?

It's fine to call the adjuster or defense attorney, or both and indicate your bill hasn't been paid and request payment. However, those calls should be documented in a log. Additionally, they should be followed up with a letter with proof of service and/or an email to the defense attorney and adjuster that you have not been properly or timely paid. Your file must be documented in order to obtain full payment, penalty, interests, costs, sanctions and attorney's fees.

What can be collected?
How do I get paid?

If your billings have been improperly denied or untimely denied or reduced, you can obtain payment for any of those invoices back to 2013 and perhaps before. You would be entitled to the bill in full, 10 percent penalty and 7 percent interest, and costs, sanctions of the defendant which go to the state of $500.00 minimum up to $2,500.00, and attorneys' fees. If you have cases where you've written off as uncollectible and you were paid zero dollars, they can probably be collected with penalty and interest.

Example of bill penalty and interest.

Medical-legal bill $5,000.00 received by carrier November 1, 2013 and improperly not paid.

Labor Code § 4622(a) penalty $500.00.

Labor Code § 4622(a) 7 percent interest per annum from date of receipt of report and bill yields $350.00 per year which is .96 per day.

November 1, 2013 through April 7, 2022 yields 3,080 days.

3,080 days times .96 yields interest of $2,956.80.

Total money owed to doctor $8,456.80.

QUESTION

How much does it cost me to get paid?

NOTHING, NO ATTORNEY FEES TO THE DOCTOR.

How much does it cost?

No, really, nothing to the doctor I promise.

DWC — Proposed QME Emergency Regulation in Response to COVID-19

§ 36.7 QME Electronic Service Emergency Regulation in Response to COVID-19

(a) During the period that this emergency regulation is in effect, a QME, AME, or other medical-legal report and required documents may be served electronically as follows:

(1) For purposes of this section:

A. "Electronic service" means service of the medical-legal report and all documents required by section 36, on a party or other person, by either electronic transmission or electronic notification. Electronic service may be performed directly by the physician or by an agent of the physician, or through an electronic service provider.

B. "Electronic transmission" means the transmission of a document by electronic means to the electronic service address at or through which a party or other person has authorized electronic service.

C. "Electronic notification" means the notification of the party or other person that a document is served by sending an electronic message to the electronic address at or through which the party or other person has authorized electronic service, specifying the exact name of the document served, and providing a hyperlink at which the served document may be viewed and downloaded.

(2) Electronic service shall be permitted only where the parties agree and a written confirmation of that agreement is made. At the time of giving consent to electronic service, a party or entity shall provide the party's electronic address for the purpose of receiving electronic service.

(3) Electronic service shall not be permitted on any unrepresented party or unrepresented injured worker.

(4) For purposes of electronic service, the medical-legal report or other papers must be transmitted to an electronic address maintained by the person or entity on whom it is served, using the most recent electronic address provided to the physician by the party who consented to accept service electronically.

(5) Service is complete at the time of transmission. Any period of notice and any right or duty to act or make any response within any period or on a date certain after service of the document, shall be extended by two business days.

(b) For purposes of service of a medical-legal report in claims of injury to the psyche, all of the terms of section 36.5 shall apply to electronic service, except the service requirements in section 36.5(b)(6) may be accomplished by electronic service pursuant to the terms of this regulation.

(c) For purposes of service of all medical-legal reports, all of the terms of section 36 shall apply to electronic service, except that the manner of service of the report may be accomplished by electronic transmission, where appropriate, pursuant to the terms of this regulation.

(d) For purposes of electronic service of all medical-legal reports, the mandatory form 122 (AME or QME Declaration of Service of Medical-Legal Report, see 8 Cal. Code Regs. § 122) may be replaced by an Affidavit of Proof of Electronic Service. The Affidavit of Proof of Electronic Service shall set forth the exact title of the document served in the action, showing (A) the name and residence or business address of the person making the service, (B) that he or she is a resident of, or employed in, the county where the electronic service occurs, (C) that he or she is over the age of 18 years, (D) that he or she is readily familiar with the business' practice for serving electronically, and (E) that the document would be electronically served that same day in the ordinary course of business following ordinary business practices. The Affidavit of Proof of Electronic Service shall be signed under penalty of perjury under the laws of the State of California. The Affidavit of Proof of Electronic Service shall also include all of the following:

1. The electronic service address and the residence or business address of the person making the electronic service.

2. The date of electronic service.

3. The name and electronic service address of the person or entity served.

4. A statement that the document was served electronically.

(e) For purposes of electronic service, the physician shall maintain an original copy of all documents electronically served, pursuant to the terms of section 39.5 of title 8, California Code of Regulations. The documents maintained by the physician pursuant to this section shall contain an original signature.

Note: Authority cited: Sections 133, 139.2, 4627 and 5307.3

8 CCR 31.3 SCHEDULING APPOINTMENT WITH PANEL QME

The panel QME has to set an appointment within 60 days of the date of the appointment request. Upon the agreement by the parties that can be extended to 90 days. If not scheduled within 90 days of the parties' initial appointment request, either party may report the unavailability of the QME, and the medical director shall issue a replacement panel.

TITLE 8 CALIFORNIA CODE OF REGULATIONS § 31.3

During the pandemic, the timeframes outlined above were moved to 90 through 120 days. It is presently back at 60 to 90 days. The administrative director has proposed a change to permanently move it to 90 to 120 days. That will in all likelihood be approved by the Office of Administrative Law within the next 2 months.

ELECTRONIC SERVICE OF REPORTS AND BILLS

During the pandemic, electronic service was permitted. That expired, and regular service by mail is again required. However, a new regulation has been submitted to the Office of Administrative Law and is anticipated to be approved by May 1, 2022, which will allow for electronic service. There are some requirements, which include the parties agreeing to accept electronic service in advance of the appointment.

PROPOSED QME SERVICE 36.7 REGULATION

I attach the entire proposed regulation. Please note that pursuant to 36.7(a)(2), electronic service shall be permitted only where the parties agree, and a written confirmation of that agreement is made. It cannot be utilized in any case with an unrepresented party or unrepresented injured worker. The parties must provide their electronic address for purposes of service of the report. Service is complete at the time of transmission.

PROPOSED 36.7 ELECTRONIC SERVICE

It is agreed between the parties pursuant to 8 CCR 36.7 that electronic service is agreed to. This requires an agreement in writing with the email address to be utilized upon electronic service. Please sign below with the electronic address to receive service of the medical-legal report and invoice.

_____
Applicant's attorney
Email address for service

_____
Defense attorney
Email address for service

_____
Claims Adjuster
Email address for service

TITLE 8 CALIFORNIA CODE OF REGULATION § 38

The emergency regulations have expired. We are back to the prior number of days to issue reports. The initial comprehensive report must be issued within 30 days and the supplemental report must be issued within 60 days.

This regulation is not going to change. It will remain at 30 and 60 days with no amendment to the regulation.

PAGE COUNT ISSUES

In accord with 8 CCR 9793(n), the medical legal provider cannot review records unless they receive an attestation from either party or any party as to the compliance under penalty of perjury, with Labor Code § 4062.3 and attestation as to the pages being sent to the doctor. DO NOT REVIEW ANY RECORDS IN THE ABSENCE OF THAT ATTESTATION. If you get records from one party with the proper attestation, you can review those records, but not records from the other party.

If the page count by the doctor is different than the page count of the records received with the proper attestation, the doctor shall note in his report and explain the page difference and bill according to the page count of the doctor. Recently, it's been found that some attorneys are sending records with a lower page count than the actual records being sent. The medical-legal provider must also attest to the number of pages he or she reviewed. The total number of pages for the comprehensive report will be reduced by 200 pages, which are included in the value of the report. The total number of pages for a supplemental report will be reduced by 50 pages.

LANGUAGE REGARDING PAGE COUNT

I, Dr. _____, received statements under penalty of perjury in compliance with 4062.3 and attestation of page count from [applicant attorney, defense attorney, claims adjuster]. The total number of pages sent with proper attestation is noted to be ____. However the actual page number received by my office was ____. I so declare under penalty of perjury.

_____

Dr. Jones

LANGUAGE TO BE INCLUDED IN MEDICAL LEGAL REPORTS

At the beginning of the report put the following language:

I examined John Doe as a panel QME/AME in the field of orthopedics on _____ (date). This evaluation took place at my office located at _____. I spent in excess of 20 minutes face to face with the applicant. I reviewed _____ pages of records which were forwarded to me by the party/parties with proper statements under penalty of perjury of compliance with Labor Code § 4062.3 and an attestation as to the number of pages sent. That document is attached hereto and incorporated herein as an attachment to my report. The total number of pages I reviewed, less 200 pages for the comprehensive report [less 50 pages for the supplemental report] was _____ pages. This is/is not consistent with the attestations of the pages provided by the parties. (Explain if there is a difference in the number of pages.).

Then bill the page number you reviewed less the appropriate page count.

At the end of the report, put in the following language

“I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

I have not requested nor accepted any compensation, including, but not limited to, any kind of remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, from any source for medical-legal expenses in addition to the fees authorized by statute and regulation."

"I have not requested or accepted any compensation or other thing of value from any source that does or could create a conflict with my duties as a medical-legal evaluator under the Labor Code and regulations governing medical-legal providers. I further declare under penalty of perjury that I have not violated the provisions of Labor Code § 139.3 with regard to the evaluation of this patient or in the preparation of this report. These declarations are in compliance with Labor Code § 4628, 139.2, and 5307.6

Please note, the above combined declarations must be included at the end of the report dated and signed by the medical-legal physician and indicating the county wherein it was signed."

EXAMPLE REGARDING COMPLIANCE OF INDIVIDUALS INVOLVED IN PREPARATION OF THE REPORT

HISTORY TAKEN BY: _____

HISTORY REVIEWED WITH PATIENT AND EDITED BY: Dr. Jones

PHYSICAL EXAMINATION BY: Dr. Jones

X-RAYS AND/OR DIAGNOSTIC STUDIES TAKEN BY: _____

X-RAYS AND/OR DIAGNOSTIC STUDIES RECORDED BY: Dr. Jones

PREPARATION OF A PRELIMINARY EXCERPT OF THE MEDICAL RECORDS AND PLACE MEDICAL RECORDS IN ORDER FOR REVIEW: _____

PERFORMED A DETAILED FINAL REVIEW AND ANALYSIS OF ALL SUBMITTED RECORDS AND SUMMARIZED THE RECORDS: Dr. Jones

REPORT TRANSCRIBED BY: _____

PREPARATION OF THE REPORT, INTERPRETATION OF ALL MEDICAL RECORDS, ALL DIAGNOSTIC TEST, X-RAYS, MEDICAL EVALUATION AND DIAGNOSIS AND CONCLUSIONS BY: Dr. Jones

8 C.C.R. 9794(c)(1)

This requires an administrator who can test all or any part of a medical-legal billing or contest the billing on the basis the expense does not constitute a medical-legal expense, so any uncontested amount and notify the physician or other provider of the objection within 60 days after receipt of the report and documents required by using an Explanation of Review.

The Explanation of Review shall include the basis for the objection to each contested procedure and charge. The original procedure codes used by the physician or other provider shall not be altered. If the objection is based on appropriate coding of a procedure, the explanation of review shall include both the code reported by the provider and the code believed to be reasonable by the claims administrator, and shall include the claims administrator's rationale as to why its code more accurately reflects the service provided."

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):	
Date of Birth (MM/DD/YYYY):	Claim Number:
Date of Injury (MM/DD/YYYY):	Employer Name:
Provider Information	
Provider Name:	Contact Name:
Address:	
Phone:	Fax Number:
E-mail Address:	NPI Number:
Claims Administrator Information	
Claims Administrator Name:	Contact Name:
Address:	
Phone:	Fax Number:
Bill Information	
Provider's or Claims Administrator's Bill Identification Number (if any):	
Date Explanation of Review Received by Provider:	
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?
		Yes No				Yes No

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

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:

	Dat

1) **Instructions for Provider's Request for Second Bill Review**

2) **Overview:** The Provider's Request for Second Bill Review (DWC Form SBR-1) is used to initiate the second bill review process required by Labor Code sections 4603.2(e), for medical treatment services and goods, and by Labor Code section 4622, for medical-legal services, to dispute the amount of payment. The Division of Workers' Compensation's (DWC) regulation outlining the process can be found at California Code of Regulations, title 8 (8 C.C.R.), section 9792.5.5. Under this process, a medical provider who disputes the amount paid by a claims administrator on either a bill for medical treatment services or goods, or a bill for medical-legal expenses, must request a second review of the bill from the claims administrator. The second bill review process must be completed before a provider can seek independent bill review of a billing dispute.

3) **How to Apply:** To apply for a second review of a non-electronic medical treatment bill, you can use either this form or a modified standardized bill. See 8 C.C.R. section 9792.5.5(c)(1) and the California Division of Workers' Compensation Medical Billing and Payment Guide, version 1.2, for instructions as to how to submit a request for second review using a non-electronic standardized bill. For an electronic medical treatment bill, refer to 8 C.C.R. section 9792.5.5(c)(2) and (3) and the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide, version 1.2, for instructions as to how to submit a request for second review under that format. Both guides can be found at the DWC website at http://www.dir.ca.gov/dwc/EBilling/EBilling.html. For medical-legal bills, the second review must be on this form.

4) **When to Apply:** A request for second bill review must be made within 90 days of service of the explanation of review that explained why the payment you sought in the initial bill was reduced or denied. If an issue that would preclude your right to receive compensation for the submitted bill is under consideration by the Workers' Compensation Appeal Board (WCAB), you have 90 days from the date of the service of the WCAB order that resolves the issue to request the second bill review. If the only dispute is the amount of payment and you do not timely request a second bill review, the bill will be considered satisfied and neither the claims administrator nor the employee shall be liable to you for any further payment.

5) **Routing Information:** The Request for Second Bill Review form can either be mailed or faxed to the claims administrator. The requesting provider must complete all fields in the Employee Information, Provider Information, and Claims Administrator Information sections.

6) **Bill Information:** Complete all fields in this section for each disputed service or good, or medical-legal service. Attach additional pages if necessary.

7) Provide your or the claims administrator's bill identification number, if any.
8) State the date when the explanation of review that either denied or reduced the amount billed was received.
9) State the date of service.
10) State the service or good for which payment is in dispute. Include the code and modifier, if any.
11) Indicate whether the billed service was authorized.
12) State the amount billed, the amount paid, and the amount in dispute.
13) State whether supporting documentation is attached. (For example, documents provided in response to a request by the claims administrator in the explanation of review.)
14) State the reason for requesting the second bill review and describe the supporting documentation.

15) **Provider Signature:** Signature/Date line is located at the bottom of the form.
16) **A SECOND BILL REVIEW REQUEST MUST BE COMPLETED FOR A PROVIDER TO SEEK**
17) **INDEPENDENT BILL REVIEW OF A BILLING DISPUTE.**

Date

OBJECTION LETTER

Attn: Insurer; Administrator, Employer

Address of Insurer, Admin, Empl.

RE: APPLICANT V. EMPLOYER; INSURER

Eams No: ADJ_____

Dear_____,

Please note, we object to the improper and non-payment of the Medical-Legal Bill of Dr._____ M.D. (PQME, AME, etc.) dated_____.

Please note payment must issue within 60 days of the Report and Bill per Labor Code 4622. Please issue payment in full along with penalty and interest as outlined in Labor Code 4622.

Thank you,

Very Truly Yours,

(Signature)

DECLARATION OF SERVICE

(1013A (3), 2015.5 CCP)

STATE OF CALIFORNIA)

)

COUNTY OF LOS ANGELES)

RE:

EAMS NOS.:

I declare that I am a citizen of the United States, over eighteen (18) years of age, and not a party to the within action. My business address is 110 E. Montecito Ave. Suite A, Sierra Madre, CA 91024.

On **January 6, 2022,** I served the following: **PETITION FOR DETERMINATION OF NON-IBR MEDICAL-LEGAL DISPUTE AND VERIFICATION** with attachments (Exhibits on disc), on the interested parties listed below as follows:

PLEASE SEE SERVICE LIST ATTACHED

(__X__by, U.S. MAIL) On **January 6, 2022,** I caused such document(s) to be mailed in a sealed envelope, by first-class mail, postage fully prepaid. I am readily familiar with the practices for collection and processing of the correspondence of the law firm in which I am employed, for mailing with the U.S. Postal Service on the same day in the ordinary course of business. I am aware that on motion of party served, service is presumed invalid if the postal cancellation date or postage meter date is more than one (1) day after the date of deposit for mailing as stated in this declaration.

(__X__by FACSIMILE / E-MAIL) On **January 6, 2022,** I caused such document(s) to be sent via facsimile or e-mail transmission with confirmation of transmittal indicated by the individual transmission journal(s) attached hereto the individual(s) at the address(es) as facsimile number(s) / e-mail address shown.

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct.

Executed **January 6, 2022**, at Sierra Madre, California.