AMLS BILLING AND PAYMENT TRAINING

2021

DISCLAIMER

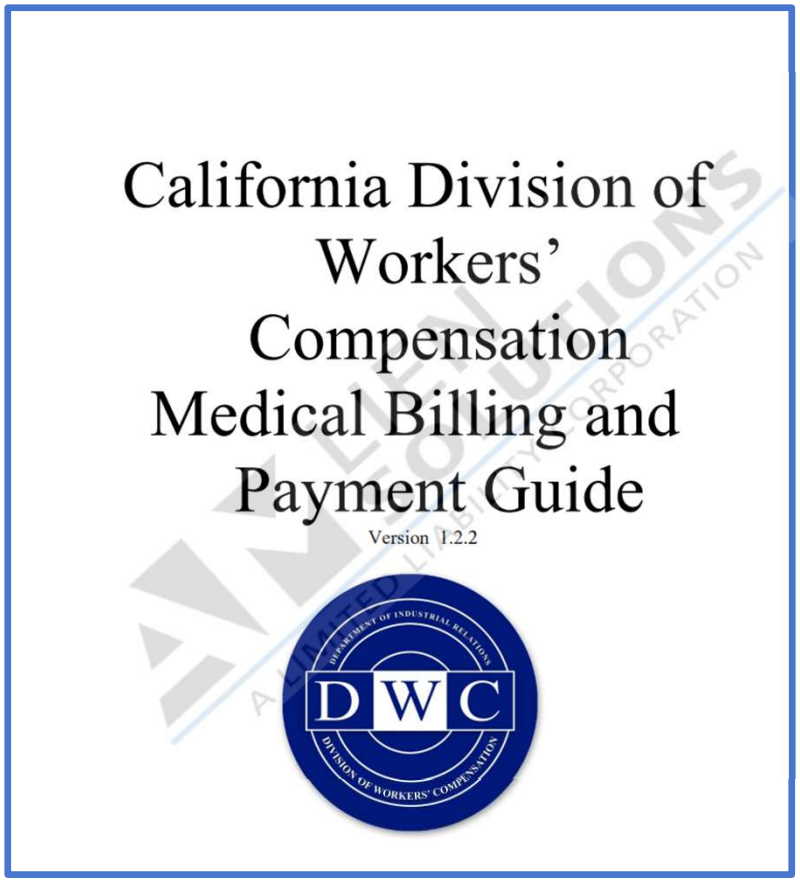
THE INFORMATION IN THIS TRAINING PRESENTATION WAS COMPILED FOR EDUCATIONAL PURPOSES ONLY. IT IS INTENDED TO PROVIDE YOU WITH GENERAL INFORMATION AND A GENERAL UNDERSTANDING OF THE AUTHORITIES MENTIONED.

EXAMPLES HAVE BEEN PULLED FROM OUR (AM LIEN SOLUTIONS) OWN INTERNAL DATABASE AS WELL AS THE DEPARTMENT OF INDUSTRIAL RELATIONS AND OTHER CITED SOURCES.

EXAMPLES AND RECOMMENDATIONS SHOULD NOT BE RELIED UPON AS LEGAL ADVICE.

AGENDA

- Billing and Payment Guides and Rules
- Deadlines to Pay and Object
- Explanation of Reviews (Timeliness and Compliance)
- SBR/IBR
- MEADOWBROOK INSURANCE COMPANY, Petitioner, v. WORKERS' COMPENSATION APPEALS BOARD and DFS INTERPRETING et al., Respondents
- Common Reasons Liens are filed that may be subject to SBR/IBR



THE GUIDE COVERS DEFINITIONS, BILLING AND PAYMENT TIMEFRAMES, EXPLANATION OF REVIEWS, PENALTY AND INTEREST, AND THE SBR/IBR PROCESS

HTTPS://WWW.DIR.CA.GOV/DWC/EBILLING/STANDARDIZEPAPERBILLING.HTML

LABOR CODES REFERENCED IN THE BILLING GUIDE

Authority: Sections

133, 4603.3, 4603.4, 4603.5 and 5307.3, Labor Code.

Reference: Section

4600, 4603.2, 4603.3 and 4603.4, Labor Code.

LABOR CODE 133

"The Division of Workers' Compensation, including the administrative director, the court administrator, and the appeals board, shall have power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it under this code."

Administrative Director	WCAB
Official Medical Fee Schedules Fee Schedules (ML, Interpreting, Copy Service) Second Bill Review Independent Bill Review	Retains jurisdiction over all other provider / employer disputes

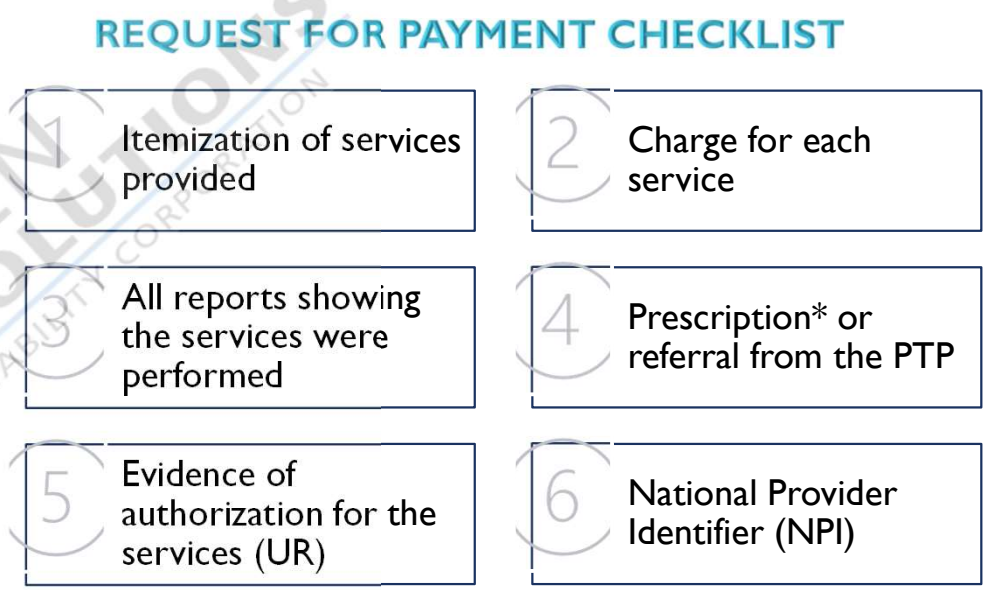
LABOR CODE 4600

EMPLOYER PAYS FOR:	Medical	Surgical	Chiropractic	Acupuncture
Hospital treatment	Nursing	Medicines	DME	Services

- Medical necessity is pursuant to Section 5307.27 – MTUS GUIDELINES AND DRUG FORMULARY
- **SERVICES** = Copy Service, Transportation, and Interpreting when required

LABOR CODE 4603.2 – EFFECTIVE FOR DOS ≥ 01/01/2017

- Billing Submission Rule
- Providers of service MUST submit COMPLETE bills within 12 months of the date of service or inpatient service discharge date.
- Provider of service may include physicians, hospitals, pharmacies, interpreters, copy services, transportation services, and home health care services



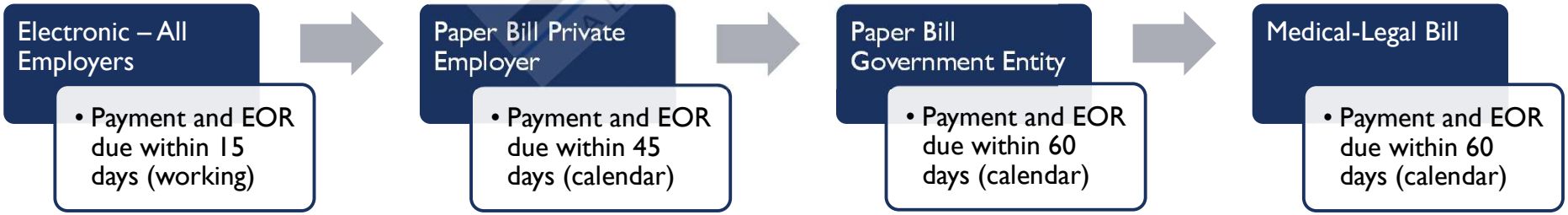
* a copy of the prescription shall **not** be required with a request for payment for **pharmacy services**

UNCONTESTED BILLS

LABOR CODE 4603.2 – UNCONTESTED PAYMENT TIMEFRAMES

FOR ALL COMPLETE UNCONTESTED BILLS PAYMENT MUST

- be made according to the official medical fee schedule in effect on the date of service
- be accompanied by an explanation of review pursuant to Section 4603.3 according to the deadlines below:



LABOR CODE 4603.2 – UNCONTESTED SBR/IBR TIMEFRAMES

- IF a provider disagrees with the amount paid, they have 90 Calendar Days to submit a request for Second Bill Review on the form approved by the DIR.
- The payor then has 14 Calendar Days to issue a final EOR (if payment is due, they have 21 Calendar Days to Pay)
- IF the provider disagrees with the final EOR, they have 30 Calendar Days to file a request for IBR or 18 months to file a lien if the payment amount is not subject to IBR

PENALTY AND INTEREST

Complete uncontested bills NOT paid within 45-days *shall* be paid: OMFS + 15% PENALTY + INTEREST

Contested bills NOT objected to within 30 days will be under the WCAB jurisdiction and subject to P&I if later found to be compensable/reasonable

DIR Audit penalties may also apply, per Title 8, California Code of Regulations section 10111.2 (b) (10), (11).

MISTAKES HAPPEN!

Penalty and Interest is not optional! It is the law and if due must be self imposed

Reach out to the provider and document any agreements to waive penalty and interest or negotiated amount

Do not ignore penalty and interest! Especially on large balances or providers who balance bill. You will end up litigating at the WCAB, be subject to costs and sanctions, AND subject to DIR audit penalties

CONTESTED BILLS

LABOR CODE 4603.2 – CONTESTED PAPER BILL TIMEFRAME

- If the itemization or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in the explanation of review, that the itemization is contested, denied, or considered incomplete, within 30 days after receipt of the itemization by the employer.
- An explanation of review that states an itemization is incomplete *shall* also state all additional information required to make a decision

CLAIMS ADMIN MEDICAL-LEGAL EXPENSE COMPLIANT EOR LANGUAGE

Uncontested Service / Contested Billed Amount (OMFS) = EOR due in 60 Calendar Days - CCR § 9794 (c)	Contested Billed Service (Liability) = EOR due in 60 Calendar Days - CCR § 9794 (f)
(1) the basis for the objection to each contested procedure and charge. (2) If additional information is necessary as a prerequisite to payment of the contested bill or portions thereof, a clear description of the information required. (3) The name, address, and telephone number of the person or office to contact for additional information concerning the objection. (4) A statement pursuant to Labor Code section 4622(b)(1) that the physician may seek a second review using rules in California Code of Regulations, title 8, section 9792.5.5. (5) A statement that the SBR is a prerequisite to seeking independent bill review provided in Labor Code section 4603.6. (6) A statement that if the provider does not seek SBR and the only issue in dispute is the amount of payment, the bill shall be deemed satisfied.	(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.

PROVIDER MEDICAL-LEGAL EXPENSE OBJECTION TYPES/DEADLINES

Provider Contests Payment Amount (OMFS) - CCR § 9794 (d-e)	Provider Contests Reason for Denial (Liability) - CCR § 9794 (f-g)
Providers must follow the SBR/IBR Process. • Providers have 90 days from date of service of the Explanation of Review or compliant objection letter to submit a Request for SBR on the form provided by the Administrative Director. • After receipt of timely SBR, Claims Administrator has 14 calendar days to review and issue a final determination. • If the provider disputes the final determination, they have 30 Calendar Days to request IBR on the form provided by the Administrative Director. If the provider fails to comply with the deadlines, the payment made by the Claims Administrator deems the bill satisfied. If the Claims Administrator fails to comply, the provider may file a lien.	• Provider must submit an objection to the denial of the CL expense by notifying the claims administrator in writing of their objection within 90 days of the service of the explanation of review (NOTE: THERE IS NOT A REQUIRED FORM FOR THIS TYPE OF OBJECTION) • If a timely objection is received by the Claims Administrator, they *shall* file a petition to review the denial of medical-legal expense and a declaration of readiness to proceed pursuant to Section 10228 et. seq. • "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"

EXPLANATION OF REVIEWS

COMPLIANCE AND ENFORCEMENT

Who gets an EOR?
What should the EOR say?
What happens if the provider disputes the EOR?
We did everything correct within the timeframes, why did the provider file a lien?

WHO GETS AN EOR?

YOU ALL GET AN EXPLANATION OF REVIEW!

WHAT SHOULD THE EOR SAY?

LABOR CODE 4603.3 - EFFECTIVE JANUARY 1, 2013
EXPLANATION OF REVIEW

1. A statement of the items or procedures billed and the amounts requested by the provider to be paid.
2. The amount paid.
3. The basis for any adjustment, change, or denial of the item or procedure billed.
4. The additional information required to make a decision for an incomplete itemization.
5. If a denial of payment is for some reason other than a fee dispute, the reason for the denial.
6. Information on whom to contact on behalf of the employer if a dispute arises over the payment.

The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6 .

RESPOND WITHIN 30 DAYS AND INCLUDE 1-6 FROM THE LAST SLIDE – SOUNDS EASY ENOUGH

WHAT ABOUT NONMEDICAL TREATMENT?

YOU HAVE 30 CALENDAR DAYS TO OBJECT TO NONMEDICAL BILLS WITH A COMPLIANT TIMELY EOR

COSTLY CONSEQUENCES FOR FAILURE TO COMPLY

CONSEQUENCES OF NONCOMPLIANCE

> What do we do when we do not receive a compliant or timely Explanation of Review?

Claims Administrator Noncompliance

Chapter 4.5. Division of Workers' Compensation
Subchapter 2. Workers' Compensation Appeals Board--Rules and Practice Procedure
Article 5. Pleadings and Forms

§10451.2. Determination of Medical Treatment Disputes.

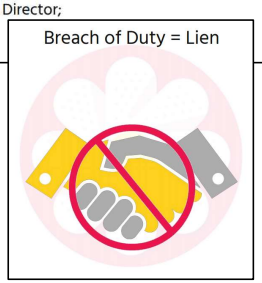
(c) Medical Treatment Disputes Not Subject to Independent Medical Review and/or Independent Bill Review

(1) ....Where applicable, independent bill review (IBR) applies solely to disputes directly related to the amount payable to a medical treatment provider under an official fee schedule in effect on the date the medical treatment was pr... treatment disputes are non-IMR/IBR disputes. Such non-IMR... include, but are not limited to:

(D) an assertion by the medical treatment provider that the ... objection to the amount of the bill because the defendant al... prescribed by Labor Code sections 4603.2 or 4603.3 or by the... Administrative Director;

© DaisyBill 2018

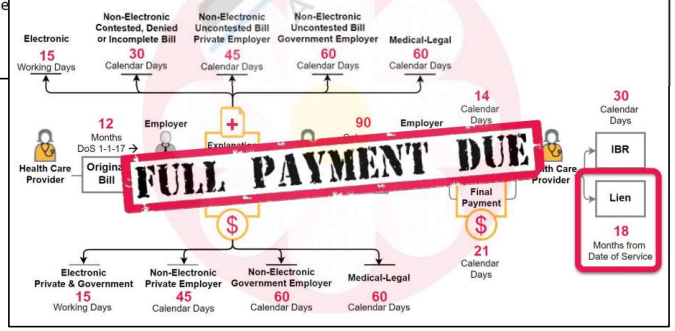
Breach of Duty = Lien



§10451.2.9 (c)(1)(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;

- #1 FAQ

Claims Administrator Breach of Duty Waives Any Objection to the Amount of Bill



Noncompliant Processing by Claims Administrator = Breach of Duty

DaisyBill Webinar on EORs and Payments - 101-3.pdf

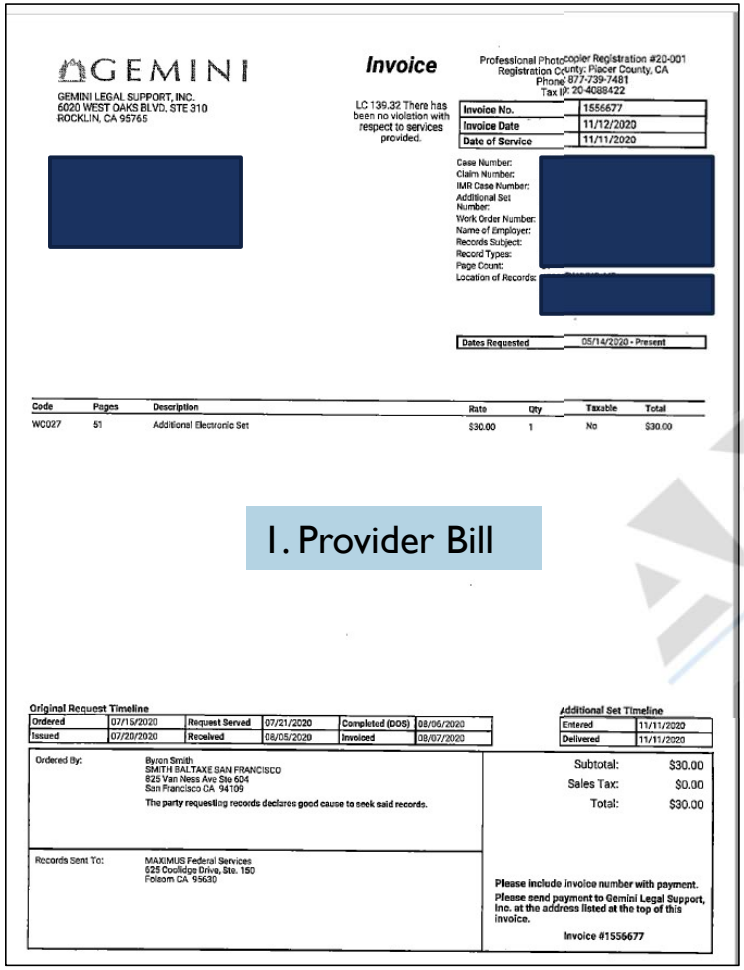
WHAT HAPPENS WHEN THE PROVIDER DISPUTES THE EOR?

EXAMPLE 1 & 2

EXAMPLE 1 – THE $30 COPY SERVICE BILL

RECORDS SUBMITTED TO MAXIMUS ON BEHALF OF THE INJURED WORKER

EXAMPLE – COPY SERVICE BILL



GEMINI

GEMINI LEGAL SUPPORT, INC.
6020 WEST OAKS BLVD, STE 310
ROCKLIN, CA 95765

[redacted]

Invoice

Professional Photocopier Registration #20-001
Registration County: Placer County, CA
Phone: 877-739-7481
Tax ID: 20-4088422

LC 139.32 There has been no violation with respect to services provided.

Invoice No.	1556677
Invoice Date	11/12/2020
Date of Service	11/11/2020

Case Number:
Claim Number:
IMR Case Number:
Additional Set Number:
Work Order Number:
Name of Employer:
Records Subject:
Record Types:
Page Count:
Location of Records:

[redacted]

Dates Requested	05/14/2020 - Present

Code	Pages	Description	Rate	Qty	Taxable	Total
WC027	51	Additional Electronic Set	$30.00	1	No	$30.00

Original Request Timeline

Ordered	07/15/2020	Request Served	07/21/2020	Completed (DOS)	08/06/2020
Issued	07/20/2020	Received	08/05/2020	Invoiced	08/07/2020

Additional Set Timeline

Entered	11/11/2020
Delivered	11/11/2020

Ordered By: Byron Smith
SMITH BALTAXE SAN FRANCISCO
825 Van Ness Ave Ste 604
San Francisco CA 94109
The party requesting records declares good cause to seek said records.

Subtotal: $30.00
Sales Tax: $0.00
Total: $30.00

Records Sent To: MAXIMUS Federal Services
625 Coolidge Drive, Ste. 150
Folsom CA 95630

Please include invoice number with payment.
Please send payment to Gemini Legal Support, Inc. at the address listed at the top of this invoice.
Invoice #1556677

1. Provider Bill

Gemini Legal Support billed for records sent to Maximus.

1. Is the claims administrator's response compliant and timely?
2. Is this Medical-Legal?
3. Is this a complete bill?
4. Was the service reasonable and necessary?

2. Claims Administrator's Objection

Dear Gemini:

Please be advised that I am in receipt of your invoice #1556676 and #155667, which are both for $30.C

Please be advised that that I am objecting to your charges because we are continuing to file and serve on the ordering party: Byron Smith, at Smith Baltaxe San Francisco.

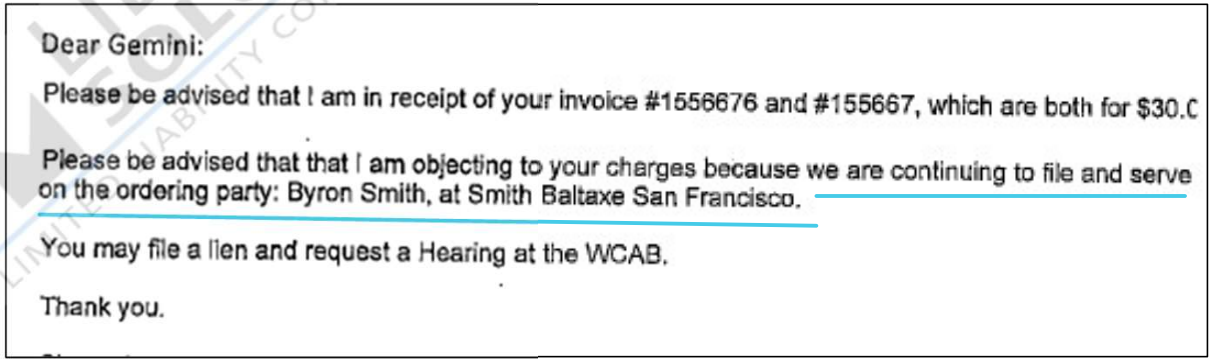
You may file a lien and request a Hearing at the WCAB.

Thank you.

EXAMPLE 1 – IS THE CLAIMS ADMINISTRATOR'S RESPONSE COMPLIANT AND TIMELY?

Answer: TIMELY BUT NOT COMPLIANT

- The date of service was 11/11/2020. Bill received 11/19/2020. Objection dated 11/19/2020. Within 30 days = Timely
- The response did include:
  - the reason for the denial
- The response did not include
  - A statement of items or procedures billed, and the amounts requested
  - The amount paid ($0.00)
  - Information on who to contact with the time limits to raise any objection and required SBR/IBR language



Dear Gemini:

Please be advised that I am in receipt of your invoice #1556676 and #155667, which are both for $30.0

Please be advised that that I am objecting to your charges because we are continuing to file and serve on the ordering party: Byron Smith, at Smith Baltaxe San Francisco.

You may file a lien and request a Hearing at the WCAB.

Thank you.

EXAMPLE 1 – IS THIS A MEDICAL-LEGAL SERVICE?

Answer: YES

- The applicant attorney submitted a request for Independent Medical Review on UR denied or modified treatment.
- It is considered a medical-legal service because it involves a dispute in regard to treatment.
- The injured worker is allowed to send records to Maximus
- The claims administrator MUST send records to Maximus, however they only have to send the previous six months of medical reporting

EOR Note

To early to tell if this should be paid within 60 days or objected to within 30. Claims Admin needs to complete a review of the bill, service, and make the decision.

EXAMPLE 1 – IS THIS A COMPLETE BILL?

Answer: NO

- Gemini only submitted an invoice and a proof of service
- At this point the bill can be considered incomplete and objected to with a request for additional information

EOR Note

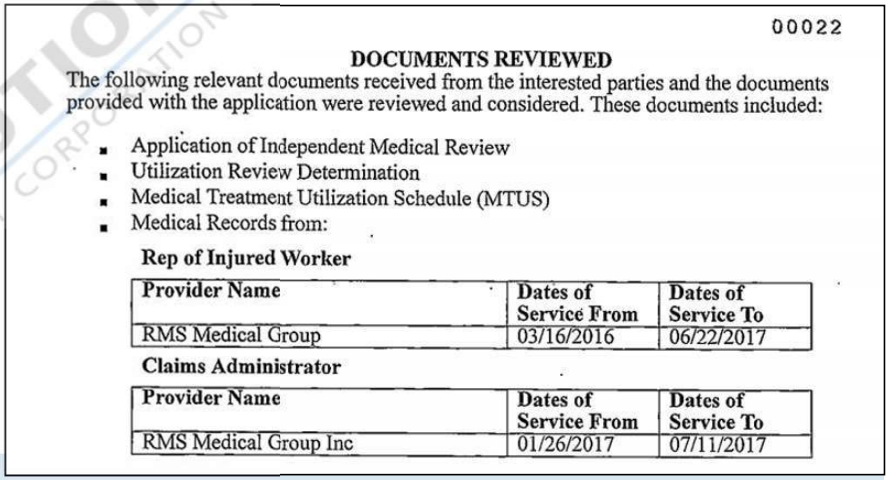
An explanation of review that states an itemization is incomplete shall also state all additional information required to make a decision. Possible requests for additional information could include:

1. the order form from applicant attorney
2. the name(s) and date(s) of the reports from RMS Medical sent to Maximus.
3. Proof the records were sent to Maximus (IMR Determination Letter)

EXAMPLE 1 – WAS THE SERVICE REASONABLE AND NECESSARY?

Answer: DEBATABLE

- The request was for narcotic medication. It was denied by UR.
- The CA submitted 6 months of medical records from RMS Medical Group
- The Injured Worker (AA through Gemini) submitted ALL the medical reports from RMS Medical Group



00022

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:

Rep of Injured Worker

Provider Name	Dates of Service From	Dates of Service To
RMS Medical Group	03/16/2016	06/22/2017

Claims Administrator

Provider Name	Dates of Service From	Dates of Service To
RMS Medical Group Inc	01/26/2017	07/11/2017

EOR Note

You could argue the services were not reasonable or necessary based on the type of medication requested and Jeffrey the fact that IMR upheld the determination and referenced the Drug Formulary. In this case the determination was straight forward. There was no need to submit more than 6 months of medical records from RMS Medical Group. The language on the EOR would need to be as specific as possible and could also include contact information from a UR contact who could explain this to the provider.

TIPS FOR COPY SERVICE REVIEWS

- Approach these reviews with a cost benefit analysis, Copy Service disputes can be extremely time consuming and costly. The bills are typically $180, $30, or $5.
- Be proactive not reactive
  - Take the time to review the charges
    - Are they valid medical-legal?
    - Are they reasonable?
    - Are they for related to IMR disputes? This is a business decision, UR either starts sending everything which is costly, or you pay the $30?
  - Communicate with the provider and request any documentation that may change your mind and make you consider paying the bill
- If you are not going to pay the bill, provide a compliant timely EOR

November 19, 2020

Gemini Legal Support, Inc
6020 West Oaks Blvd., Ste. 310
Rocklin, CA 95765

OBJECTION TO INVOICE 1556676

RE: Employee: [redacted]
Employer:
Date of Injury:
Claim Number:

Dear Gemini:

Please be advised that I am in receipt of your invoice #1556676 in the amount of $30. Please be advised that I am objecting to your charges.

Explanation of Review

Date Invoice Received: 11/19/2020

Date of Service	Code Billed	Description	Amount Billed	Amount Allowed	Reason Code
11/11/2020	WC027	Additional Electronic Set	$30.00	$0.00	1, 2

1. Per Labor Code §4621(a) med-legal expenses must be reasonably, actually, and necessarily incurred. We are unable to determine if the documents submitted were necessary.
2. Resubmit with the order form from applicant attorney and include the name(s) and date(s) of the reports from Jefrey Yung, MD sent to Maximus.

- Pursuant to CCR § 9794 (f)(1) you may object to the denial of this medical-legal expense issued under this subdivision by notifying the claims administrator in writing of your objection within ninety (90) days of the service of this explanation of review.
- If you do 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.

My contact information is below.

COMPLIANT EOR

This objection complies with all six requirements of **Labor Code 4603.3 (a)**

1) It includes the date of service, code billed, and amount requested by the provider
2) It includes the amount paid = $0.00
3) It includes the basis for the denial of the item (unable to determine reasonableness of service and incomplete bill)
4) It requests specific additional information required to make a decision
5) It includes information on who to contact
6) It includes the timeframe to object and process for objecting

INTERPRETING & DME SIMILAR SITUATION

- Interpreters have an established fee schedule, however if the provider is arguing they are due their market rate that is not subject to IBR. They will have to file a lien.
- Certain DME dispensed is proprietary (the company makes the devices) and doesn't have an applicable fee schedule. They will have to file a lien.
- These liens will be valid if they timely requested a SBR on the approved form, even if they don't request IBR after receipt of final EOR determination.

EXAMPLE 2 – THE $500,000 SURGERY BILL

APPROVED THROUGH UTILIZATION REVIEW

EXAMPLE – HOSPITAL BILL

- Facts to keep in mind:
  - The surgery was approved by UR on 01/21/2019. The provider had until 5/21/2019 to complete the procedure.
  - The patient was unable to have the procedure within the certified timeframe. On 5/30/2019 the provider contacted UR and asked for an extension.
  - The UR Coordinator for the Claims Administrator updated the existing UR Certification Letter and overrode the certified dates. The UR Certification included the surgery, DME, and one night inpatient stay through 6/7/2019.
  - The provider scheduled the surgery on 6/7/2019, the patient ended up having to stay three days and required additional services not on the original authorization letter.
  - The provider did not request concurrent UR for the additional days or services
  - When the CA received the bill, their bill review software could not match up a UR Certification because the discharge date was after 6/7/2019

EXPLANATION OF REVIEW

Srvce Dates:06-07-2019 To 06-12-2019

Received:08-30-2019
Reviewed:09-13-2019

DX:M48.062 SPINAL STENOSIS, LUMBAR REGION WITHOUT NEUROGENIC CLAUD
M47.817 SPONDYLS W/O MYELOPATHY OR RADICULOPATHY, LUMBOSACR REGION
M47.816 SPONDYLOSIS W/O MYELOPATHY OR RADICULOPATHY, LUMBAR REGION
I10 ESSENTIAL (PRIMARY) HYPERTENSION
G89.29 OTHER CHRONIC PAIN
I25.10 ATHSCL HEART DISEASE OF NATIVE CORONARY ARTERY W/O ANG PCTRS
F41.8 OTHER SPECIFIED ANXIETY DISORDERS

Date	Service & Description	Mods	Qty	Pd Qty	Charge	Reduction	Allowance	Reasons
06-07-2019	120 ROOM-BOARD/SEMI CRC's: G70		5	5	42670.00	42670.00	.00	G70
06-07-2019	250 PHARMACY CRC's: G70		324	324	23091.70	23091.70	.00	G70
06-07-2019	258 IV SOLUTIONS CRC's: G70		6	6	1157.00	1157.00	.00	G70
06-07-2019	272 STERILE SUPPLY CRC's: G70		44	44	25825.73	25825.73	.00	G70
06-07-2019	274 PROSTH/ORTH DEV CRC's: G70		2	2	6131.41	6131.41	.00	G70
06-07-2019	278 SUPPLY/IMPLANTS CRC's: G70		25	25	201375.85	201375.85	.00	G70
06-07-2019	300 LAB CRC's: G70		10	10	4350.72	4350.72	.00	G70
06-07-2019	301 CHEMISTRY TESTS CRC's: G70		2	2	1289.88	1289.88	.00	G70
06-07-2019	305 HEMATOLOGY TESTS CRC's: G70		6	6	1581.04	1581.04	.00	G70
06-07-2019	307 UROLOGY TESTS CRC's: G70		1	1	256.16	256.16	.00	G70
06-07-2019	360 OR SERVICES CRC's: G70		292	292	155306.22	155306.22	.00	G70
06-07-2019	370 ANESTHESIA CRC's: G70		292	292	54552.76	54552.76	.00	G70
06-07-2019	420 PHYSICAL THERP CRC's: G70		3	3	1209.02	1209.02	.00	G70
06-07-2019	424 PHYS THERP EVAL CRC's: G70		2	2	2437.16	2437.16	.00	G70
06-07-2019	710 RECOVERY ROOM CRC's: G70		42	42	12309.80	12309.80	.00	G70
06-07-2019	920 OTHER DX SVCS CPC's: G70		1	1	10780.80	10780.80	.00	G70
06-07-2019	922 EMG CRC's: G70		3	3	5603.04	5603.04	.00	G70
06-12-2019	120 ROOM-BOARD/SEMI CRC's: G70		1	0	.00	.00	.00	G70
				Totals:	549928.29	549928.29	.00	

G70 This charge is denied as the service was not authorized during the Utilization Review process. If you disagree please contact our Utilization Review vendor [redacted]

Is this a timely and compliant EOR?

EXAMPLE 2 – COMPLIANT EOR?

Answer: YES!!!!!

This objection complies with all requirements of **Labor Code 4603.3 (a)**

1) It includes the date of service, code billed, and amount requested by the provider
2) It includes the amount paid = $0.00
3) It includes the basis for the denial of the item (Services not authorized during the Utilization Review process)
4) It includes information on who to contact (UR vendor management)
5) It includes the timeframe to object and process for objecting

….wait…….wasn't the surgery authorized through UR, the reason code said it wasn't does that change things?

We will revisit this later

IMPORTANCE OF A COMPLIANT TIMELY EOR

- LABOR CODE 4603.2 (E) STATES "If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3."
- SBR 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.

PROVIDER OPTIONS

- IF DISPUTE INVOLVES AMOUNT OF PAYMENT THE PROVIDER MUST REQUEST SBR WTIHIN 90 DAYS
- IF DISPUTE INVOLVES DENIAL OF PAYMENT AND DISAGREEMENT WITH COMPLIANT EXPLANATION OF REVIEW, THE PROVIDER CAN FILE A DOR (WITHIN 90 DAYS) AND RESOLVE THE ISSUE THROUGH AN ORDER OF THE APPEALS BOARD

FAILURE TO FOLLOW SBR/ PROCESS BARRS THE PROVIDER FROM FILING A LIEN!

SO PROVIDERS HAVE TO FILE SBR W/I 90 DAYS BUT DON'T HAVE TO FOLLOW THROUGH WITH AN IBR REQUEST?

- Exceptions apply! Think back to the Interpreting and DME exceptions for admitted non contested bills:
- If the medical service provided is not covered under a fee schedule adopted by the DWC, and there is no contract for reimbursement, then the matter is not eligible for IBR and the provider's only recourse is to file a lien.
- There is no need to file for IBR because the charge is not covered in the OMFS that can be paid through IBR.
- The only way to resolve these disputes is through the WCAB and will most likely require referral to Agreed Bill Review or Expert Witness Testimony
- Source - https://www.dir.ca.gov/dwc/FAQ/IBR-Lien-Both.html

DEFENDING THE SBR PROCESS

KEY DECISION – MEADOWBROOK INSURANCE COMPANY VS. WORKERS' COMPENSATION APPEALS BOARD (ACCEPTED CLAIM)

- The applicant was provided treatment and he required a Spanish interpreter for medical appointments.
- Interpreting was provided by DFS Interpreting.
- DFS Interpreting served bills on Defendant.
- Defendant reduced the bills and served DFS Interpreting with the appropriate EORs.
- DFS Interpreting sent an objection letter to Defendant but did not make a SBR request.
- DFS Interpreting filed a lien and then subsequently a DOR.
- The case proceeded to lien trial and Defendant argued DFS Interpreting was not entitled to any further payment because they did not comply with SBR.
- DFS Interpreting argued that their objection letter was sufficient and that they were not required to request SBR.
- The WCJ at lien trial found in favor of DFS Interpreting.
- Defendant filed a Petition for Reconsideration, which was denied, leaving a favorable result for DFS Interpreting.
- Defendant then filed a Writ of Review with the California State Court who found in favor of Defendant and found that all lien claimants have to comply with the SBR process.
- The California State Court is higher than the WCAB trial courts and higher than the Work Comp Appeals Board. A California State Court decision has greater weight than a Work Comp Appeals Board En Banc Decision.
- The California State Court's decision is now the law of the land and all lien claimants have to comply with the SBR process.

CLARIFICATION OF INTENT OF SB 863

Meadowbrook did two things:

1) established that there is an adopted fee schedule for Interpreting
2) Determined a provider must comply with SBR when disputing a compliant and timely Explanation of Review.

Page 5 of the decision, specifically states:

> "(e)(1) If the provider disputes the amount paid, the provider may request a second review within 90 days of service of the explanation of review or an order of the appeals board resolving the threshold issue as stated in the explanation of review pursuant to paragraph (5) of subdivision (a) of Section 4603.3. The request for a second review shall be submitted to the employer on a form prescribed by the administrative director and

STRAIGHTFORWARD RULES & DEADLINES AND CASE LAW= BILLING AND PAYMENT BLISS

BILLING AND PAYMENT REALITY

WE DID EVERYTHING RIGHT, WHY DID THE PROVIDER FILE A LIEN?

Never received your EOR

Your EOR was late

You didn't respond to our request for SBR

Your SBR response was late

Your reason code was a lie! I'm going to report you to the audit unit

My provider never agreed to a PPO discount!

Your EOR was not compliant!

It's easy to file a lien and WCAB Judges will make you negotiate!

Provider miraculously finds all their SBR requests that were sent to the payor even though the payor has NO RECORD of ever receiving them! Payor didn't send final determination in 14 days, Lien is Valid!

CHALLENGES PROVING THE PROVIDER RECEIVED A TIMELY EOR

IT COMES DOWN TO THE DATE OF SERVICE, LET THE HE SAID SHE SAID GAMES BEGIN

CCR 9792.5.5 defines date of service 4 ways

1. PROOF OF SERVICE

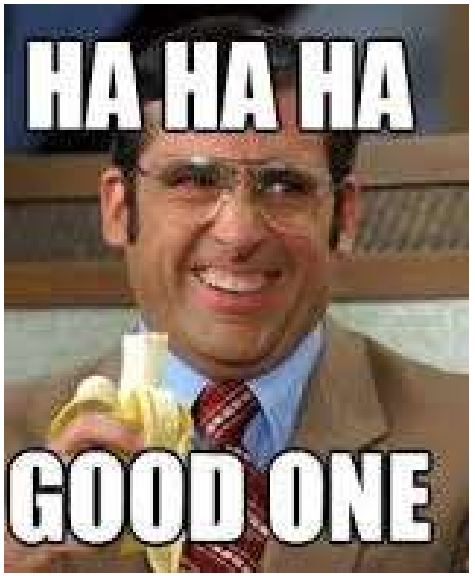
- A proof of service is the easiest way to show timely compliance, it is also not very practical
- AM Lien Solutions highly recommends sending your Explanation of Review with a Proof of Service for:
  - Large Hospital Bills
  - Difficult providers
  - Providers who balance bill
  - Bills repriced by contractual agreement vs OMFS
  - Interpreting bills where market rate is going to be an issue
  - Copy Service bills

2. CLAIMS ADMINISTRATOR PROOF OF RECEIPT

- Provider has 90 days to file SBR or request order from appeals board from date the administrator can prove the provider received the EOR
  - Payment made
    - You can use the date the check cleared
    - You will most likely need a declaration from someone in bill review describing the process of sending checks with an EOR
  - No Payment made
    - It is very difficult to prove the provider received an explanation of review if payment wasn't issued and you don't have documented proof (objection stating they received it and don't agree, request for reconsideration that does not use the SBR form)

3. 5 DAYS FROM THE DATE IT WAS MAILED

- **This one is easy**; just scan every single envelope you send out and keep it in the claims file! The Date of service would be (5) calendar days from USPS postmark stamped on the envelope in which the EOR was mailed.



4. DATE OF AN ORDER FROM WCAB

- Don't be surprised if providers start filing DOR's to dispute threshold issues on an explanation of review if they don't agree
- This is pretty much the only option they have to dispute nonpayment of their bills
- DOR's would be valid unless the reason they were not paid is a contested claim
- A WCAB Judge will decide whether the threshold issue is valid, if an issue to pay provider is ordered, payment needs to be made within 45 days (60 for government entities and ML service) and according to OMFS. P&I would not be due unless that is included in the WCJ Order.
- The provider would then follow the normal SBR/IBR process

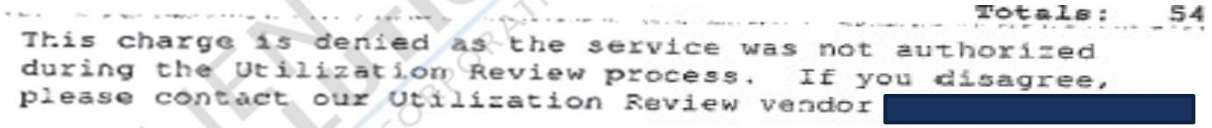
CONCLUSION ON DATE OF SERVICE

- Lien claimants have a valid argument that is not easy to overcome if the burden of the Date of Service falls on the payor
- Think about possible scenarios where sending a Proof of Service would eliminate large exposure

MORE PROVIDER ARGUMENTS

YOUR REASON CODE IS INVALID MAKING YOUR EOR INVALID?

- BACK TO EXAMPLE 2



- Few more details:
- The provider communicated with the TPA and resolved the UR issue. TPA argued not all the services were covered under the UR authorization and the dates of service extended past the dates of certification. The TPA issued timely payment in the amount of $72,292.26. Provider requested SBR for unpaid DME and provided the invoice needed to pay. TPA issued timely second EOR and payment of $1,431.27. Provider did not file IBR request as they were satisfied payment was issued by OMFS.
- File closed
- One year later, providers gets new collection company, and they file a lien in the amount of $14,473.17 claiming they were owed P&I because the reason code on the original EOR was not accurate and invalidated the timely objection

EXAMPLE 2 – WAS THE EOR INVALID?

- It cost $4,000 and took four lien conferences and two lien trials to convince the WCJ that the lien claimant filed an invalid lien, why was this so hard?
  - The EOR was timely and compliant.
  - It gave a specific reason, the services billed were not covered through Utilization Review.
  - Meadowbrook clarified that the provider had 90 days to request SBR OR request an order from the appeals board, by failing to do that they lost their claim to P&I
  - The issue was never submitted, and lien claimant reluctantly withdrew their lien, they didn't want to risk an adverse decision that would prevent them from trying this with other payors

MY PROVIDER NEVER AGREED TO A PPO/MPN DISCOUNT!

- Compliant EOR's need to include the PPO / MPN Name and ID Number – State License Number or Certificate Number
- If applying a PPO discount the contract number should be listed
- Examples below provided by DaisyBill

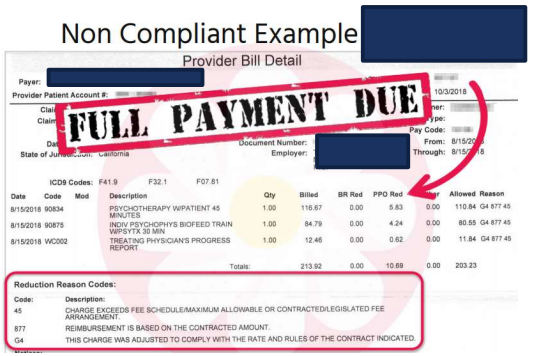
Compliant Example

Network: CorCare
Network Branch: CorCare II WC
Sub Network:
Contract: 09-BH99999

Date	Code	Units	POS	Bill Charges TOS	DXR	Reduction	Allowed Fees
09/13/2018	99214 GF	1	11	$149.32	1,2,3,4	$14.93	$134.39
09/13/2018	WC002 G4	1	11	$12.46	1,2,3,4	$1.25	$11.21
09/13/2018	95851 R79, G7	1	11	$28.90	1,2,3,4	$28.90	$0.00
				$190.68		$45.08	$145.60
							$145.60

Line Item Reason Codes and Descriptions
R79 CCI; Standards of Medical/ Surgical Practice
G4 This charge was adjusted to comply with the rate and rules of the contract indicated
G7 No separate payment was made because the value of the service is included within the value of another service performed on the

Non Compliant Example



Provider Bill Detail

FULL PAYMENT DUE

Date	Code	Mod	Description	Qty	Billed	BR Red	PPO Red	Allowed	Reason
8/15/2018	90834		PSYCHOTHERAPY W/PATIENT 45 MINUTES	1.00	116.67	0.00	5.83	110.84	G4 877 45
8/15/2018	90875		INDIV PSYCHOPHYS BIOFEED TRAIN W/PSYTX 30 MIN	1.00	84.79	0.00	4.24	80.55	G4 877 45
8/15/2018	WC002		TREATING PHYSICIAN'S PROGRESS REPORT	1.00	12.46	0.00	0.62	11.84	G4 877 45
			Totals:	213.92		0.00	10.69	0.00	203.23

Reduction Reason Codes:

Code:	Description:
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
877	REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.
G4	THIS CHARGE WAS ADJUSTED TO COMPLY WITH THE RATE AND RULES OF THE CONTRACT INDICATED.

TAKEAWAYS / Q&A

QUESTIONS & THANK YOU

- If you have any questions, please feel free to contact:

- Angelique Niles
- Client Services Director
- AM Lien Solutions
- Direct Line: 415-828-9744
- Email: aniles@amliensolutions.com

- www.amliensolutions.com

Workers' Comp Case Resolution

Expert, proactive, cost-efficient medical case management

Serving Northern and Southern California

- 24/7 Injury Triage
- Field & Telephonic Case Management
- OrthoTrak / PharmTrak
- Return-to-Work Programs
- Early Intervention Programs
- Catastrophic Injury
- Certified Interpreting Team
- Task / Limited Assignments
- Customized NCM Programs
- Ergonomic Evaluations
- In Service Training

Our Nurse Case Managers make the difference, helping your team to:

Resolve stalled cases
Reduce claim costs
Speed return to work
Improve communication flow
Problem-solve challenging cases

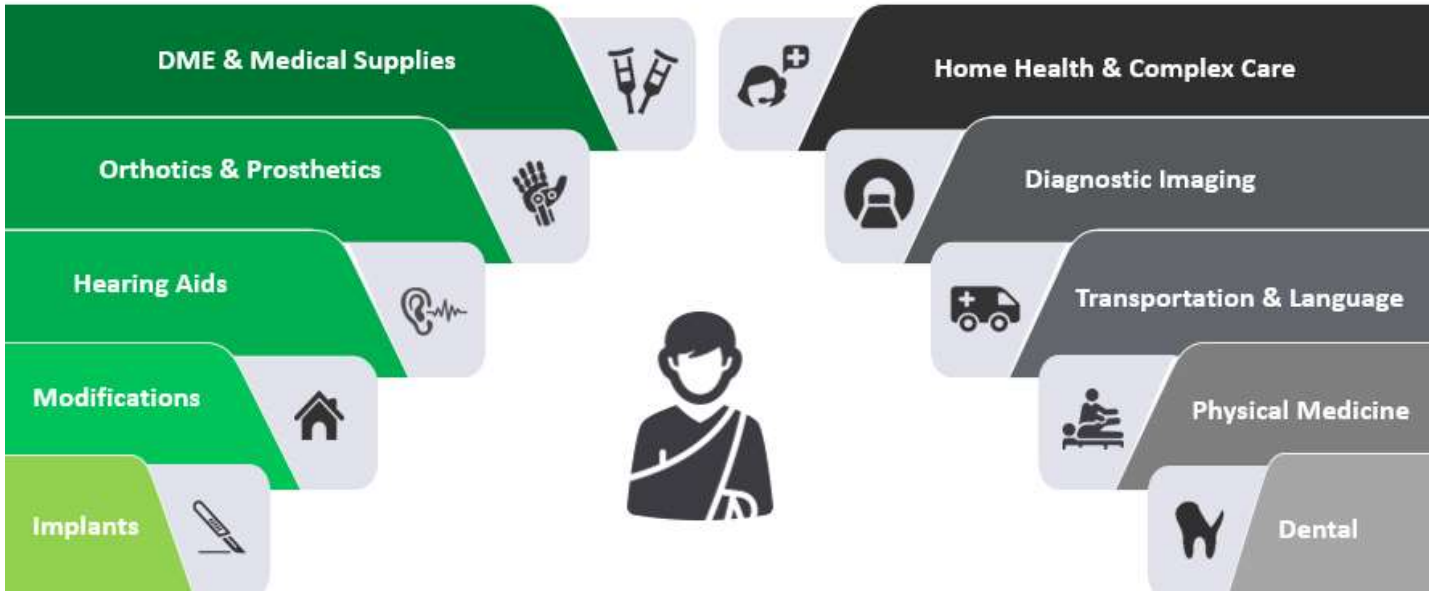
CCM
CHOICES CASE MANAGEMENT

For more information, or referrals:
(925) 516-3901
choicescm.com

The Right Choice for the Best Result

Brandon Olson
VP, Business Development
Brandon.Olson@orchidmedical.com

ORCHID medical®



866.888.6724 | referrals@orchidmedical.com | **ORCHID**medical.com