STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

NOTICE OF RULEMAKING AFTER EMERGENCY ADOPTION

Workers' Compensation – Independent Bill Review; Standardized Paper Billing and Payment; Electronic Billing and Payment

NOTICE IS HEREBY GIVEN that the Administrative Director of the Division of Workers' Compensation (hereinafter "Administrative Director"), pursuant to the authority vested in her by Labor Code Sections by Labor Code sections 59, 133, 4603.5, and 5307.3, has adopted regulations on an emergency basis to implement the provisions of Labor Code sections 4603.2, 4603.3, 4603.4, 4603.6, and 4622, as amended or enacted by Senate Bill 863 (Chapter 363, stats. of 2012, effective January 1, 2013).

The regulations amend Article 5.5.0 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9792.5.1 and 9792.5.3, and adopt Article 5.5.0 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9792.5.4, 9792.5.5. 9792.5.6. 9792.5.7, 9792.5.8, 9792.5.9, 9792.5.10, 9792.5.11, 9792.5.12, 9792.5.13, 9792.5.14, and 9792.5.15. The regulations further amend Article 5.6 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, sections 9793, 9794, and 9795. Together, the regulations implement, interpret, and make specific Labor Code sections 4603.2, 4603.3, 4603.4, 4603.6, and 4622. The regulations govern independent bill review, standardized paper billing and payment; and electronic billing and payment.

The emergency regulations listed below became effective on January 1, 2013, and will remain in effect for a period of 180 days from January 1, 2013. The purpose of this rulemaking is to adopt the emergency regulations on a permanent basis.

PROPOSED REGULATORY ACTION

Amend section 9792.5.1.	Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides
Amend section 9792.5.3.	Medical Treatment Bill Payment Rules
Adopt section 9792.5.4.	Second Review and Independent Bill Review – Definitions
Adopt section 9792.5.5.	Second Review of Medical Treatment Bill or Medical-Legal Bill
Adopt section 9792.5.6.	Provider's Request for Second Bill Review – Form
Adopt section 9792.5.7.	Requesting Independent Bill Review
Adopt section 9792.5.8.	Request for Independent Bill Review Form
Adopt section 9792.5.9.	Initial Review and Assignment of Request for Independent Bill Review to IBRO
Adopt section 9792.5.10.	Independent Bill Review - Document Filing
Adopt section 9792.5.11.	Withdrawal of Independent Bill Review
Adopt section 9792.5.12.	Independent Bill Review - Consolidation or Separation of Requests
Adopt section 9792.5.13.	Independent Bill Review – Review
Adopt section 9792.5.14.	Independent Bill Review – Determination
Adopt section 9792.5.15.	Independent Bill Review – Implementation of Determination and Appeal
Amend section 9793.	Definitions
Amend section 9794.	Reimbursement of Medical-Legal Expenses
Amend section 9795.	Reasonable Level of Fees for Medical-Legal Expenses, Follow-up Supplemental and Comprehensive Medical-Legal Evaluations and

Medical-Legal Testimony

TIME AND PLACE OF PUBLIC HEARING

A public hearing has been scheduled to permit all interested persons the opportunity to present statements or arguments, either orally or in writing, with respect to the subjects noted above. The hearing will be held at the following time and place:

Date: April 9, 2013
Time: 10:00 A.M. to 5:00 P.M., or until conclusion of business
Place: Elihu Harris State Office Building – Auditorium
1515 Clay Street
Oakland, California 94612

The State Office Building and its Auditorium are accessible to persons with mobility impairments. Alternate formats, assistive listening systems, sign language interpreters, or other type of reasonable accommodation to facilitate effective communication for persons with disabilities, are available upon request. Please contact the State Wide Disability Accommodation Coordinator, Kathleen Estrada, at 1-866-681-1459 (toll free), or through the California Relay Service by dialing 711 or 1-800-735-2929 (TTY/English) or 1-800-855-3000 (TTY/Spanish) as soon as possible to request assistance.

Please note that public comment will begin promptly at 10:00 a.m. and will conclude when the last speaker has finished his or her presentation or 5:00 p.m., whichever is earlier. If public comment concludes before the noon recess, no afternoon session will be held.

The Acting Administrative Director requests, but does not require, that any persons who make oral comments at the hearing also provide a written copy of their comments. Equal weight will be accorded to oral comments and written materials.

WRITTEN COMMENT PERIOD

Any interested person, or his or her authorized representative, may submit written comments relevant to the proposed regulatory action to the Department of Industrial Relations, Division of Workers' Compensation. The written comment period closes at **5:00 P.M., on April 9, 2013.** The Division of Workers' Compensation will consider only comments received at the Division by that time. Equal weight will be accorded to comments presented at the hearing and to other written comments received by 5 P.M. on that date by the Division.

Submit written comments concerning the proposed regulations prior to the close of the public comment period to:

Maureen Gray
Regulations Coordinator
Division of Workers' Compensation, Legal Unit
P.O. Box 420603
San Francisco, CA 94142

Written comments may be submitted by facsimile transmission (FAX), addressed to the above-named contact person at (510) 286-0687. Written comments may also be sent electronically (via e-mail) using the following e-mail address: dwcrules@dir.ca.gov.

Unless submitted prior to or at the public hearing, Ms. Gray must receive all written comments no later than **5:00 P.M., on April 9, 2013.**

AUTHORITY AND REFERENCE

The Acting Administrative Director is undertaking this regulatory action pursuant to the authority vested in her by Labor Code sections 59, 133, 4603.5, and 5307.3.

Reference is to Labor Code sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4603.6, 4620, 4621, 4622, 4625, 4628, and 5307.6.

INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW

Labor Code section 4603.6, as enacted in SB 863, establishes an independent bill review (IBR) process, which is new to the California workers' compensation system. Previously, disputes over the appropriate amount of payment for a medical treatment bill or a medical-legal bill were resolved through litigation before the WCAB.

Labor Code section 4603.2 sets forth the procedures and timelines for payment of a medical treatment bill. Bills for medical services rendered under Labor Code section 4600 are required to follow the mandates of this section. SB 863 first added subdivision (b)(1), which states the documents that are required to be submitted by named providers in order for a bill to be properly paid. The documents include an itemization of services provided and the charge for each service, a copy of all reports showing the services performed, the prescription or referral from the primary treating physician if the services were performed by a person other than the primary treating physician, and any evidence of authorization for the services that may have been received.

Labor Code section 4603.2(b)(2) now requires an employer or claims administrator to pay a medical treatment within 45 calendar days after receipt of a complete bill. An objection to the bill must be made within thirty 30 calendar days and must be accompanied by an explanation of review as described in new Labor Code section 4603.3. The explanation of review must contain:

- A statement of the items or procedures billed and the amounts requested by the provider to be paid.
- The amount paid.
- The basis for any adjustment, change or denial of the item or procedure billed.
- The additional information required to make a decision for an incomplete itemization;
- The reason for the denial of payment if it's not a fee dispute; and

Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing, including information on how the provider should raise an objection regarding the item paid or disputed and how to obtain an independent review of the medical bill under Labor Code section 4603.6.

Labor Code section 4603.2(b)(4) was expressly added to preclude the duplicate submission of medical treatment bills. Duplicate submissions do not require additional notification or objection by the claims administration.

Subdivision (e) was added to section 4603.2 to establish a second bill review procedure that must be followed before initiating IBR. Under this new process, the provider must generally request a second review within 90 days of receiving the explanation of review that reduced or denied the payment sought

in the initial bill. The request, on a form to be prescribed by the Administrative Director, must set for the reason and any additional information that would support the additional payment Under subdivision (e)(3), the claims administrator must respond with a final written determination on each of the disputed items or amounts in dispute within 14 days of a request for second review. The payment of any balance not in dispute must be made within 21 days of receipt of the request for second review. The claims administrator will not be liable to for any additional payments if the second review is not sought by the provider

Labor Code section 4622, the statute that sets forth the procedures and timelines for payment of a medical-legal bill, was amended by SB 863 to require that an explanation of review under Labor Code section 4603.3 be used to object to an initial bill. The bill also makes the second bill review procedure applicable to those bills as well as recourse to IBR under Labor Code section 4603.6 following the second review.

Labor Code section 4603.3 establishes the IBR process. If the only dispute between a provider and a claims administrator is the amount of payment and the second review that did not resolve the dispute, the provider may request IBR within 30 calendar days of service of the claims administrator's second review decision. If IBR is not requested, the bill will be deemed paid. If the dispute involves an issue other than the amount of payment, the time to commence IBR will not begin until that threshold issue is resolved.

IBR will be requested by the provider on a form prescribed by the Administrative Director. The request must include copies of the original billing itemization, any supporting documents that were furnished with the original billing, the explanation of review, the request for second review together with any supporting documentation submitted with that request, and the final written determination of the second review. The Administrative Director may require that the request be made electronically.

Subsection (c) of the new statute requires the provider to pay a fee when seeking review. The fee, which may vary depending on the number of items in the bill, must cover the reasonable estimated cost of IBR and administration of the program. If any additional payment is found owing from the claims administrator to the provider, the claims administrator must reimburse the provider for the fee in addition to the amount found owing.

Upon receipt of a request for IBR and the required fee, the Administrative Director, or the Administrative Director's designee, must assign the request to an independent bill reviewer within 30 days and notify the parties of the assignment. The reviewer may request additional documents from the parties if necessary. Within 60 days of assignment, the reviewer must make a written determination of any additional amounts to be paid to the provider and state the reasons for the determination. The determination, which shall be deemed an order of the Administrative Director, must be sent to Administrative Director and provided to both the claims administrator and the provider.

Under Labor Code section 4603.6(f), an IBR determination may be appealed to the WCAB within 20 days after service of the determination. The determination is presumed to be correct and can only be overturned on the basis of fraud, conflict of interest, or mistake of fact.

The proposed regulations will provide the public with clear guidelines for the mandated IBR process and set forth the obligations that health care providers and claims administrator must meet in order for the process to work in an efficient and effective manner. The regulations will ensure that billing disputes in the workers' compensation system will be resolved by conflict-free billing and payment experts rather than the lengthy and costly process of litigation.

The described regulations were adopted as emergency regulations, effective January 1, 2013. This rulemaking would make the regulations permanent. Changes to the text of the regulations that have been made after the adoption of the emergency regulations are shown in italics. These proposed

regulations implement, interpret, and make specific the above sections of the Labor Code and Government Code as follows:

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

- Based on Labor Code sections 4603.2 and 4603.4, subdivision (a) of the regulation is amended to revise the reference to the California Division of Workers' Compensation Medical Billing and Payment Guide to substitute "version 1.1" for "dated 2011." *Subdivision (c) incorporating by reference the guides, manuals and technical reports for paper and electronic billing is deleted in order to eliminate duplication.*

    - Medical Billing and Payment Guide (which is incorporated by reference) is amended.

        - The cover page is amended to delete the date "2011" and insert "Version 1.1".

        - The introduction page is amended to add Labor Code section 4603.3 as additional authority.

        - Based on Labor Code sections 4603.2 and 4603.4 Section One-Business Rules, 1.0 Standardized Billing/Electronic Billing Definitions, subdivision (b) "Authorized medical treatment," is amended to refer to treatment that has been "provided or prescribed by the treating physician" instead of "provided or authorized by the treating physician."

        - Based on Labor Code sections 4603.3 and 4603.4 Section One-Business Rules, 1.0 Standardized Billing/Electronic Billing Definitions, subdivision (m) is amended revise the definition of "explanation of review." Subdivision (p) is amended revise the definition of "itemization" of services. Subdivision (w) is amended to revise the definition of "supporting documentation."

        - Based on Labor Code section 4603.2 Section One-Business Rules, 2.0 Standardized Medical Treatment Billing Format, subdivision (a) is amended to allow a handwritten entry indicating a Request for Second Review. Subdivision (a)(4) is amended to make a technical correction in the reference to the National Council on Prescription Drug Programs paper WC/PC Universal Claim Form by deleting version "1.0 05/2008" (a prototype never put in production) and inserting version "1.1 -05/2009."

        - *Based on Labor Code section 4603.2 subdivision (b)(1), Section One-Business Rules, 3.0 Complete Bills, is amended to specify that an invoice or proof of documented paid costs is required supporting documentation for a bill when required by statute.* Also, subdivision (b)(11) is amended to expand the requirement to provide any evidence of authorization for services that may have been received so that the requirement applies to both paper and electronic, and applies to all providers, not just physicians.

        - Based on Labor Code section 4603.2 subdivision (b)(4), Section One-Business Rules, 5.0 Duplicate Bills, subdivision (a) is amended to prohibit the submission of a duplicate bill after an explanation of review has been provided. A cross reference to 6.0(b) is revised to reference sections 6.1 and 6.2 to conform to changes in Chapter 6. Also, a grammatical change is made.

        - Based on Labor Code sections 4603.2 and 4603.3, Section One-Business Rules,

6.0 Medical Treatment Billing and Payment Requirements for Non-electronically Submitted Bills is amended to add introductory language and provide that a claims administrator is not required to respond to a duplicate bill if an explanation of review has already been issued on the original bill. Also, the title of 6.0 is changed to more accurately reflect the contents of the section. Sections 6.1 and 6.2 are added to carry out the provisions regarding timeliness of payment on original bills. Section 6.3 is amended to delete language that is no longer accurate or that is duplicative (lien information and the statement that contested charges can be challenged before the Workers' Compensation Appeals Board.) Section 6.3 is amended to carry out the statutory provisions regarding the explanation of review on original bills that are contested, denied or considered incomplete. Section 6.4 is added to specify the penalties for failure to pay or dispute treatment bills. Section 6.5 is added to specify the timeframes responding to a Request for Second Review and for issuance of payment of any balance not in dispute after the second review.

- Based on Labor Code sections 4603.2, 4603.3 and 4603.4, Section One-Business Rules, 7.0 Medical Treatment Billing and Payments Requirements for Electronically submitted Bills is amended. Section 7.1 Timeframes (b)(1) is amended change the language from "treatment provided or authorized by the treating physician" to "treatment provided or prescribed by the treating physician." Section 7.2 Penalty is amended to specify "30 days" rather than "30 working days" to conform to the statutory change. *Section 7.3 Electronic Bill Attachments is amended so that subdivision (b) states what is required to be on the body of the attachment or inscribed on the face of the attachment.* Section 7.4 is added to provide timeframes for issuing an explanation of review and payment in response to a Request for Second Review. *The following sections are renumbered 7.5 and 7.6.*

- *Based on Labor Code sections 4603.2, 4603.3 and 4603.4, a new Section 8.0 Request for Second Review of a Paper or Electronic Bill is added to set forth the timeframe for requesting the second review and cross reference to section 9792.5.4 and the Companion Guide which contain further provisions regarding second review.*

- *Based on Labor Code section 4603.2, Appendix A, Standard Paper Forms, 1.0 CMS 1500 is amended to adopt an updated 1500 Health Insurance Claim Form Reference Instruction manual (and change log), and to specify the dates of applicability of the old and new instruction manual. The section is also amended to specify who must use the CMS 1500 form.*

- Based on Labor Code section 4603.2, Appendix A, Standard Paper Forms, 1.1 Field Table CMS 1500, Field 10d, California Workers' Compensation Instruction is amended to specify that the W3 – Level 1 Appeal is a Request for Second Review. *Field 14 instruction is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412.*

- *Based on Labor Code section 4603.2, Appendix A, Standard Paper Forms, 2.0 UB-04 is amended to adopt an updated Official UB-04 Data Specifications Manual and to specify the dates of applicability of the old and new manual. The section is also amended to specify who must use the UB-04 form.*

- 2.1 Field Table UB-04, Form Locator 18-28, the California Workers' Compensation Instruction is amended to specify that the W3 – Level 1 Appeal is a Request for Second Review. *Form locater 31-34a,b instruction is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412.*

- *Based on Labor Code section 4603.2, Appendix A, Standard Paper Forms, section 3.0 National Council for Prescription Drug Programs (NCPDP) Workers' Compensation/Property & Casualty Universal Claim Form is amended to adopt an updated NCPDP Manual Claim Forms Reference Implementation Guide and to specify the dates of applicability of the old and new guide. The section is also amended to specify that pharmacies must use the NCPDP WC/PC claim form.* Section 3.0 National Council for Prescription Drug Programs is amended to make a technical correction in the reference to the National Council on Prescription Drug Programs paper WC/PC Universal Claim Form by deleting version "1.0 05/2008" (a prototype never put in production) and inserting version "1.1 -05/2009*." The 3.1 Field Table NCPDP is amended to correct the heading to eliminate reference to the 2008 claim form. The Field 11 instruction is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412. Multiple changes are made in the table to conform the field references and NCPDP crosswalk references to the NCPDP guide. A new Field 68 "Prescription Origin Code" is added to the chart to conform to the NCPDP WC/PC UCF version 1.1. Subsequent fields are renumbered.*

- *Based on Labor Code section 4603.2, Appendix A, Standard Paper Forms, 4.0 ADA 2006 is amended to adopt an updated American Dental Association coding/claim form manual and to specify the dates of applicability of the old and new manual. The section is also amended to specify who must use the ADA claim form.* 4.1 Field Table ADA 2006 is amended to specify that a Request for Second Review will be identified by entering the words "Request for Second Review" in Field 1. *Field 46 is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412.*

- Based on Labor Code sections 4603.2, 4603.3 and 4603.4, Appendix B, Standard Explanation of Review is amended to specify that an explanation of review must be issued after review of an original bill and after conducting a second review. The language regarding Paper Explanation of Review is amended to clarify that the claims administrator must include relevant situational data elements. The section is also amended to specify that the claims administrator shall utilize additional narrative explanatory language where necessary to fully explain why the bill is adjusted, denied or considered incomplete.

- Based on Labor Code section 4603.2 Appendix B, Table 1.0 California DWC Bill Adjustment Reason Code/CARC/RARC Matrix Crosswalk, Code M2 is amended to add "Request for Second Review" to the explanatory message as it currently refers to "Appeal/Reconsideration" which is equivalent to the Request for Second Review under the statutory amendments. "Request for Second Review" is added to message codes M5 and M6. *Amendments are made to Table 1.0 to add language to the "Issue" and "DWC Explanatory Message" columns for many of the DWC Bill Adjustment Reason Codes. The table is also amended to correct a RARC that has changed numbers and to correct RARC language. A conforming*

correction is also made to 2.0 Matrix List in CARC Order.

- Based on Labor Code sections 4603.2 and 4603.3, Appendix B, Table 3.0 Data Item No. 8 and No. 9 are amended to conform the language regarding whom to contact regarding billing disputes. The Table 3.0 is amended to add a new required Data Item No.54 to give information regarding provider remedies, including time limit and method to dispute payment and request second review, and time limit and method to request independent bill review.

- *Based on Labor Code sections 4603.2 and 4603.4, Section Two, Transmission Standards, is amended to add a new 2.5 Communication Requesting Claims Status and Response adopting the ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277) and errata.*

- *Throughout the document, the source to obtain the electronic transaction standards (other than pharmaceutical standard) is changed from the Data Interchange Standards Association to the Accredited Standards Committee (ASC) X12.*

- Based on Labor Code sections 4603.2 and 4603.4, subdivision (b) of the regulation is amended to revise the reference to the California Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide to substitute "version 1.1" for "dated 2012."

  - Electronic Medical Billing and Payment Companion Guide (which is incorporated by reference) is amended.

    - The cover page is amended to delete the date "2012" and insert "Version 1.2" (*changed from Version 1.1).*

    - *Throughout the document, the source to obtain the electronic transaction standards (other than pharmaceutical standard) is changed from the Data Interchange Standards Association to the Accredited Standards Committee (ASC) X12. Also, throughout the document changes are made in the identification of loops, segments, and data elements. For each of the chapters regarding ASC X12 standards language is added to clarify that the Companion Guide is an additional source of information but does not replace the ASC X12 Type 3 Technical Reports.*

    - *In the Preface, in the Documentation Change Control section, the table is amended to reference rulemaking documents and website as the source of information on the changes made to the document.*

    - *The list of Accredited Standards Committee (ASC X12) technical reports is amended to add the ASC X12N/005010X212 Health Care Claim Status Request and Response (276/277) and errata. The 005010X212 is also added to the 2.2 summary list of national standard formats adopted for optional use and to 2.2.1 California Prescribed and Optional Formats where it is incorporated by reference into a new section "(5) Communication Requesting Claims Status and Response [Optional]".*

    - *In Chapter 2, section 2.4.1 language is added specifying that trading partners will exchange identification numbers to be reported based on the applicable transaction format requirements and superseded language is deleted. Section 2.4.4 is amended to clarify that in California workers' compensation billing the employee is identified by specified data elements and specifies how to submit*

the employee's identification number (social security number.) In 2.4.7 language is added that shows an example of how a PR-2 (primary treating physician's progress report) would be identified, using the ASC X12 report type code 09. Language is added in new sections 2.71, 2.72, and 2.73 for date sent/invoice date, date received, and paid date. In 2.8, duplicative language regarding code set utilization is deleted.

- Based on Labor Code section 4603.2, the heading of Chapter 2, Section 2.11 is amended to include the "Request for Second Review."

- Based on Labor Code section 4603.2, Chapter 2, Section 2.11.1 Claim Resubmission Code the words "second review" are added to modify "request for reconsideration." *Section 2.11.1 is also amended to provide clearer instruction on how to submit the National Uniform Billing Committee condition codes.*

- Based on Labor Code sections 4603.2 and 4603.4, Chapter 2, Section 2.11.2 is amended to specify the manner of indicating a duplicate bill in the electronic 005010X224 dental transmission. The duplicate bill transaction examples are corrected and the "Original Reference Number" is changed to "Payer Claim control Number." The section is amended to add language stating that the claims administrator is not required to respond to a duplicate bill if the 0050X221 has already issued on the original bill.

- Section 2.11.4 is amended to insert the phrase "Request for Second Review" in the heading and in the description of the W3 – 1st Level Appeal. The phrase "Second Review" is added in several places so that the regulation uses the term "Reconsideration/Second Review." The section is amended to delete language related to "subsequent reconsideration bill transactions."

- Based on Labor Code section 4603.2, Chapter 3, the table in Section 3.3.1 ASC X12N/005010X222 Health Care Claim: Professional (837) is amended for Loop 2300, the HI segment Condition Information by adding the "request for second review" to the California Workers' Compensation Instructions. *Chapter 3 is also amended to replace language in 3.2 Trading Partner Agreement with language more aligned with the IAIABC model companion guide. In Table 3.3.1 amendments are made to conform to the requirements of the ASC X12. Also, in Table 3.3.1 2300 DTP is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412. Loop 2300 PWK06 is amended to provide clearer information regarding attachment control number. A new Loop 2300 K301 segment instruction is added to provide a jurisdiction state code in conformity with the IAIABC model. The Table is amended to provide 2300 HI instruction for request for second review of bill.*

- Based on Labor Code section 4603.2, Chapter 4, the table in Section 4.3.1 ASC X12N/005010X223 Health Care Claim: Institutional (837) is amended for Loop 2300, the HI segment Condition Information by adding the "request for second review" to the California Workers' Compensation Instructions. *In Table 4.3.1 amendments are made to conform to the requirements of the ASC X12. Also, in Table 4.3.1 Loop 2300 PWK06 segment is amended to provide clearer information regarding attachment control number. Loop 2300 HI01 segment is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412. A new Loop 2300 K301 segment instruction is added to provide a jurisdiction state code in conformity*

with the IAIABC model. The Table is amended to provide 2300 HI instruction for request for second review of bill.

- *Chapter 5, Dental Claims is amended to conform to ASC X12 requirements including deletion of duplicative material. Loop 2300 DTP segment is amended to revise the date to be entered for cumulative injury or occupational disease to conform to Labor Code section 5412. A new Loop 2300 K301 segment instruction is added to provide a jurisdiction state code in conformity with the IAIABC model.*

- Based on Labor Code section 4603.2, Chapter 6, *Section 6.10 deletes duplicative language and adds clarifying language regarding the California workers' compensation instructions.* Section 6.11 is added to specify that the trading partner agreement may include business rules to establish a method for identifying pharmacy second review transmissions, or may use the DWC Form SBR-1.

- *Chapter 7 introductory language is added to explain the role of the Companion Guide, and superseded language is deleted. Section 7.4.1 Claim Adjustment Reason Codes 191, 214, 221, W1 is amended for accuracy and clarity, making additions and deletions to the language.* Based on Labor Code sections 4603.2, 4603.3 and 4603.6, Chapter 7, Section 7.6 Claim Level California Jurisdictional EOR Statement ID Qualifier is amended to delete language referring to seeking review of contested charges by filing a lien at the Workers' Compensation Appeals Board and to insert language referring to the process and timelines for making a request for second review or a request for independent bill review. *The Table 7.8.1 ASC X12N/005010X221 Health Care Claim Payment/Advice containing instructions for California workers' compensation application is amended to conform to ASC X 12 requirements.*

- *Chapter 9 introductory language is amended to clarify the cross reference.* Based on Labor Code sections 4603.2, 4603.3 and 4603.6, Chapter 9, Section 9.4.4 ASC X12N/005010X221 Health Care Claim Payment/Advice (835) is amended to identify the 835 as the explanation of review. Chapter 9, sections 9.2, 9.2.1, 9.3.1 are amended to change code qualifier "U" to "WQ" correct an error, as "U" indicates a rejection and "WQ" indicates acceptance for further bill processing. *Section 9.1 and 9.2 remove the word "clean" from the phrase "clean bill" used in the title of those sections. Section 9.2.1 "Claim Found" deletes language that is duplicative of the ASC X12 TR3 Section 9.4.1, 9.4.2, and 9.4.3 regarding acknowledgments are deleted and replaced with new language. A new section 9.4.2 is added to provide clarification regarding use of the ASC X12N/005010X213 Request for Additional Information (277). A new section 9.4.4 is added to provide clarification regarding use of the ASC X12N/005010X213 Health Care Claim Statuts Request and Response (276/277).*

- Based on Labor Code sections 4603.2 and 4603.3, Appendix A Glossary of Terms is amended to modify the definition of "EOR" to include both paper and electronic forms of explanation of review*. Other changes are made to improve the accuracy of the glossary.*

- *Appendix B – Code Set References is deleted. Appendix D Security Rule is re-lettered as Appendix B.*

- Based on Labor Code section 4603.2, Subdivision (h) is amended to make a technical correction in the reference to the National Council on Prescription Drug Programs paper WC/PC Universal Claim Form by deleting version "1.0 05/2008" (a prototype never put into production) and inserting version "1.1 -05/2009."

Section 9792.5.3 Medical Treatment Bill Payment Rules.

- Based on Labor Code section 4603.3 which mandates the adoption of rules to require the issuance of an explanation of review upon payment, adjustment, or denial of a complete or incomplete medical bill, reference to Labor Code section 4603.3 is added to this section which governs payment and communication by a claims administrator.

Section 9792.5.4. Second Review and Independent Bill Review – Definitions.

- Based on the amendments to Labor Code sections 4603.2 and 4622, and the enactment of sections 4603.3 and 4603.6, this section provides definitions for key terms regarding the second bill review process and IBR. The definitions are added to ensure that the terms meaning, as used in the regulations, will be clear to the regulated public.

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

- This section sets for the procedures and timelines for the second bill review process, as it relates to medical treatment bills and medical legal bills for services rendered on or after January 1, 2013. Subdivision (b) provides the timeline for filing the request, which is based on 90 days from the date of service of the explanation of review or 90 days of the date of service of an order of the Workers' Compensation Appeal Board resolving any threshold issues that would preclude a provider's right to receive compensation for the submitted bill.

- Subdivision (c) addresses the manner in which a second bill review request can be made, which encompasses medical treatment billing on standardized forms, medical-legal billing, and electronic billing. The provider can use either the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6, or the standardized or electronic bill as modified by the necessary code. For electronic pharmacy bills, the method to identify a request for second review may be addressed in the trading partner agreement.

- Subdivision (d) indicates the required contents of the second bill review request. The request, which is limited to the original dates of service and the same itemized services rendered as the original bill, must include; the date of the explanation of review and identifying information; the item and amount in dispute; the additional payment requested and the reason for the request; and any additional information that was either requested or in support of the request.

- Subdivision (f) provides the timeframe for the claims administrator to respond the second bill review request with a final written determination and the consequences – a 15% increase – for a failure to pay any undisputed amounts.

- Subdivision (g) expressly provides that if a provider still contests the amount of payment following the second review, IBR may be sought to resolve the dispute.

Section 9792.5.6. Request for Second Review of Bill – Form.

- This section contains the form for requesting a second review of a medical treatment bill or a medical-legal bill. The form contains identifying information and those elements required by Labor Code section 4603.2(e).

Section 9792.5.7. Requesting Independent Bill Review.

- This section contains the procedure and timeframes for the IBR process. Subdivision (a) sets forth the scope of the billing dispute that can be determined by IBR. For a bill for medical treatment services, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, one date of service, and one billing code under the applicable fee schedule adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11 covering one range of effective dates. For a bill for medical-legal expenses, a dispute over the amount of payment billed by a single provider involving one injured employee, one claims administrator, and one medical-legal evaluation including supplemental reports based on that same evaluation.

- Subdivision (b) provides that a dispute subject to IBR is limited to the amount of payment owed to the provider under a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11. IBR shall not include a determination of reasonableness of a fee or the selection of an analogous billing code, unless allowed by an existing fee schedule.

- Subdivision (c) sets forth the timeline for a provider to request IBR. The deadline is generally 30 days from the date of service of the final written determination of the second bill review or the date of resolution of any threshold issue that would preclude a provider's right to receive compensation for medical treatment services provided in accordance with Labor Code section 4600 or for medical-legal expenses defined in Labor Code section 9720.

- Subdivision (d) sets forth the manner in which to request IBR, which can be either online through the Division's website, or by utilizing the Request for Independent Bill Review form, DWC Form IBR-1, located in section 9792.5.8. In addition to the form, the subdivision states that the fee of $335.00 must accompany the request.

- Subdivision (d) further lists the documents, mandated by Labor Code section 4603.6(b) that the provider must submit in order to conduct IBR. The provider may ask for the consolidation of two or more disputes that would constitute separate requests for IBR.

- Subdivision (f) provides that the provider shall serve all documents on the claims administrator. Any document that was previously provided to the claims administrator or originated from the claims administrator need not be served by the provider if a written description of the document

Section 9792.5.8. Request for Independent Bill Review, DWC Form IBR-1.

- This section contains the form for requesting IBR. The form contains identifying information regarding the parties and identifying information regarding the billing dispute.

Section 9792.5.9. Initial Review and Assignment of Request for Independent Bill Review to IBRO.

- This section contains the procedure for identifying those IBR requests that are ineligible for review and assignment of those for which a determination shall issue.

- Subdivision (a) allows the Administrative Director to determine ineligible IBR requests based on the information contained in the request form. The Administrative Director shall consider timeliness, whether the fee was paid, or whether the treatment for which payment is sought was authorized, or whether the dispute is covered under an existing fee schedule.

- *Subdivision (a)(4) is amended to allow the Administrative Director to consider the date of service and whether a second bill review was completed. The provision in the emergency regulation effective January 1, 2013 allowing the Administrative Director to consider other, unspecified reasons has been deleted.*

- Should a request appear eligible, subdivision (b) requires the Administrative Director to notify the parties of the filing and allow the claims administrator to submit any documentation indicating that the provider's request is ineligible for IBR.

- Upon receipt of documents from the claims administrator, the Administrative Director shall issue a determination finding the request for IBR to be ineligible or else assign the request to an independent bill review organization (IBRO) for review. If the request is found ineligible, the provider will be reimbursed the amount of $270.00. The IBRO shall notify the parties of the assignment and assign the case to conflict-free bill reviewer. If the bill reviewer is found to have prohibiting interest as set forth in Labor Code section 139.5(c), the dispute shall be reassigned to another bill reviewer.

Section 9792.5.10. Independent Bill Review - Document Filing.

- This section contains the procedure for the reviewer assigned by the IBRO to review the dispute to request additional documents from the parties. Subdivision (b) sets forth the timeframe in which the parties must provide and serve the requested documents (within 35 days of the request, if the request is made by mail, or 32 days of the request, if the request is made electronically).

Section 9792.5.11. Withdrawal of Independent Bill Review.

- This section contains the procedure for the provider to withdraw the request for IBR if, before a determination on the amount of payment owed, the provider and claims administrator settle their dispute regarding the amount of payment of the bill. If the provider and claims administrator settle their dispute, they shall make a written joint request for withdrawal and serve it on the independent bill reviewer.

- If a request for IBR is withdrawn, the provider shall not be reimbursed the fee provided with the initial request.

Section 9792.5.12. Independent Bill Review - Consolidation or Separation of Requests.

- An IBR request can either be consolidated with other requests for a single determination or separated – disaggregated – into multiple requests. This section contains the procedures for consolidation or disaggregation.

- Subdivision (b) provides definitions for key terms regarding IBR consolidation and disaggregation. The definitions are added to ensure that the terms meaning, as used in this section, will be clear to the regulated public. *Subdivision (b)(3) has been added to define "pattern and practice" as ongoing conduct by a claims administrator that is reasonably distinguishable from an isolated event.*

- Subdivision (c) provides that two or more IBR requests by a single provider may be aggregated if the Administrative Director or the IBRO determines that the requests involve common issues of law and fact or the delivery of similar or related services.

- Under subdivision (c)(1) IBR requests by a single provider involving multiple dates of medical

treatment services may be consolidated and treated as one single IBR request if the requests involve one injured employee, one claims administrator, and one billing code under an applicable fee schedule adopted by the Administrative Director, or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, and the total amount in dispute does not exceed $4,000.00.

- Under subdivision (c)(2), an IBR request by a single provider involving multiple billing codes under applicable fee schedules adopted by the Administrative Director or, if applicable, under a contract for reimbursement rates under Labor Code section 5307.11, may be consolidated with no limit on the total dollar amount in dispute and treated as one request if the request involves one injured employee, one claims administrator, and one date of medical treatment service.

- Under subdivision (c)(3), upon a showing of good cause and after consultation with the Administrative Director, the IBRO may allow the consolidation of IBR requests by a single provider that show a possible pattern and practice of underpayment by a claims administrator for specific billing codes. Such consolidation requests must involve multiple injured employees, one claim administrator, one billing code, one or multiple dates of service, and aggregated amounts in dispute up to $4,000.00 or individual amounts in dispute less than $50.00 each.

- If a request for IBR also requests consolidation, the provider, in addition to providing the filing fee, must specify all of the IBR requests sought to be consolidated with a description of how the requests involve common issues of law and fact or delivery of similar or related services.

- The decision to grant or deny consolidation shall be immediately communicated in writing by the IBRO.

- Conversely, under subdivision (f)(1) the IBRO may disaggregate into separate independent bill review requests a single request that does not meet the consolidation standards set forth in subdivision (c). For any IBR request subject to disaggregated, the same fee shall be charged for each additional IBR request as charged for one IBR request.

- Under subdivision (f)(2), if an IBR request is separated by the IBRO, the IBRO must immediately provide notice in writing to the provider and claims administrator stating the reasons for separation, and shall inform the Provider of the additional fee or fees required to perform the independent bill review. The failure to provide the additional fee or fees shall subject the request to a determination of ineligibility.

Section 9792.5.13. Independent Bill Review – Review.

- This section provides the standards under which IBR is conducted to determine the additional amounts, if any that are to be paid to the provider. The bill reviewer must apply, as applicable, the Official Medical Fee Schedule (OMFS), found at California Code of Regulations, title 8, sections 9789.10 to 9792.5.3, the Medical-Legal Fee Schedule (M/L Fee Schedule), found at sections 9793-9795 and 9795.1 to 9795.4, or a contract for reimbursement rates under Labor Code section 5307.11.

- The bill reviewer must apply the OMFS, the M/L Fee Schedule, and, if applicable, the contract for reimbursement rates under Labor Code section 5307.11, as if the bill is being reviewed for the first time.

Section 9792.5.14. Independent Bill Review – Determination.

- This section implements Labor Code section 4603.6(e) and (f) by setting forth the manner in which an IBR decision is made. Under subdivision (a), the bill reviewer must, within 60 days of

the assignment, issue a written determination, in plain language, if any additional amount of money is owed the provider under the IBR request. The determination shall state the reasons for the determination and the information received and relied upon in reaching the determination.

- Under subdivision (b), if any additional amount of money is found owed to the provider, the determination must order the claims administrator to reimburse the provider the amount of the filing fee in addition to any additional payments for services found owing.

- The determination, which is deemed to be the determination of the Administrative Director and be binding on all parties, must be served on the provider, the claims administrator and the Administrative Director.

Section 9792.5.15. Independent Bill Review – Implementation of Determination and Appeal.

- Subdivision (a) applies Labor Code section 4603.6(h)'s mandate as to how and when final IBR determinations are implemented; the claims administrator must pay additional amounts determined owed per the timely payment requirements set forth in Labor Code sections 4603.2 and 4603.4.

- *Subdivision (b) provides that an IBR determination may be appealed to the Workers' Compensation Appeals Board. Provisions in the emergency regulations effective January 1, 2013 regarding the WCAB's appeal procedures and scope of review regarding IBR determinations have been deleted from this section.*

- Subdivision (c) implements Labor Code section 4603.6(g) by providing the procedure for reassigning an IBR review should the WCAB reverse and remand the final IBR determination.

Section 9793. Definitions.

- This section of the Medical-Legal Expense regulations (commending at section 9790) is amended to provide definitions for key terms regarding comprehensive medical evaluations, the Independent Medical Review (IMR) process, the second bill review process, and IBR.

- Subdivision (e) is amended to conform to Labor Code section 4061 and 4062's mandate that disputes over the necessity of medical treatment will be decided by IMR under Labor Code sections 4610.5 and 4610.6. *The dates and conditions set forth in the subdivision under which a Qualified Medical Evaluator (QME) can conduct an evaluation of a disputed medical fact have been corrected to reflect the effective dates of IMR.*

- Subdivision (f) is added to include the definition of "explanation of review" as described in Labor Code section 4603.3.

- Re-lettered subdivision (m) is amended to allow for the factual correction procedure set forth in Labor Code section 4061(d).

Section 9794. Reimbursement of Medical-Legal Expenses.

- This section is amended to reflect the addition of the second bill review process for disputes regarding the amount of payment on a medical-legal bill.

- *Subdivision (c) provides that claims administrator must use an explanation of review when contesting all or any part of a bill for medical-legal expense. With the explanation of review the claims administrator must advise the provider that they may seek a second review by the*

claims administrator of the reduction of billing of the medical-legal expense. The explanation of review must also include statements that the second review process is a prerequisite to seeking independent bill review provided in Labor Code section 4603.6, and that the failure of a physician to seek request a second review shall deem a bill satisfied and neither the employer nor the employee shall be liable for any additional payment.

- *Subdivision (d), which has been added subsequent to the emergency regulations that were effective January 1, 2013, provides that if the provider disputes the amount of payment made by the claims administrator on a bill for medical-legal expenses following the receipt of an explanation of review, the provider must request a second bill review under section 9792.5.5. The following subsections have been re-lettered to accommodate this addition.*

- *Subdivision (e) provides that if after completion of the second review process the provider still contests the amount paid for the medical-legal expense, the provider must request IBR.*

- Under subdivision (f), if a claims administrator denies liability for the medical-legal expense for any reasons other than the amount to be paid pursuant to the Medical-Legal fee schedule, the denial shall set forth the legal, medical, or factual basis for the decision in the explanation of review which must also advise the physician of their right to file a written objection with the claims administrator. If the physician does not submit a written objection, then neither the employer nor the employee shall be liable for the amount of the expense was denied.

- Under subdivision (g), if the claims administrator receives a written objection to the denial of the medical-legal expense, the claims administrator shall file a petition to review of the denial of medical–legal expense and a declaration of readiness to proceed with the WCAB.

Section 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

- This section, which sets forth the billing codes for the Medical-Legal Fee Schedule, is amended to reflect Labor Code section 4061 and 4062's mandate that disputes over the necessity of medical treatment will be decided by IMR under Labor Code sections 4610.5 and 4610.6. *Correspondingly, the complexity factors under Code ML 103 have been amended to delete enhanced fees for addressing a discovered causation issue and the issue of medical monitoring following a toxic exposure. The dates and conditions set forth in the complexity factors under Code ML 103, under which a Qualified Medical Evaluator (QME) can conduct an evaluation of a disputed medical fact have been corrected to reflect the effective dates of IMR.*

Objective and Anticipated Benefits of the Proposed Regulations:

The objective of the proposed emergency regulations is to establish an independent bill review program, a system where disputes over the amount of payment made on a medical treatment bill or a bill for medical-legal expenses are ultimately made by conflict-free payment and billing experts applying fee schedules adopted by the Administrative Director of DWC. Unquantifiable benefits will result from the deterrence of frivolous disputes on the part of either providers or payers and from the swift resolution of legitimate billing disputes. Eventual savings for California employers from the reduction in lien litigation are estimated to be similar to the $106 million that the WCIRB attributed to the lien filing fee. (WCIRB Evaluation of the Cost Impact of Senate Bill No. 863, Updated October 12, 2012.) Local government employers will likely experience savings of approximately $15 million annually based on the reduction in lien litigation while the state may experience savings of approximately $4 million beginning Fiscal Year 2013-14 for the same reason.

Determination of Inconsistency/Incompatibility with Existing State Regulations:

The Acting Administrative Director has determined that this proposed regulation is not inconsistent or incompatible with existing regulations. After conducting a review for any regulations that would relate to or affect this area, the Acting Administrative Director has concluded that these are the only valid regulations that implement the statutory mandate to transfer the dispute resolution procedure for disputes over the amount of payment on a bill for medical treatment services or medical-legal expenses away from the now lengthy and costly WCAB lien procedures to an efficient review process before an independent bill reviewer assigned independent review organization designated by the Administrative Director.

Duplication of Labor Code Provisions:

The proposed regulations repeat or rephrase various provisions of Labor Code sections 4603.2, 4603.6, and 4622, as amended or added by Senate Bill 863. Duplication is necessary for the purpose of clarity in that statutes establish comprehensive and detailed procedures for the second bill review and independent bill review programs. Rather than simply delegating to the Division authority to establish such programs, the Labor Code provisions specify the documents that must be filed or submitted by the parties, the timelines for filing, the nature of the review that will be conducted, and the required elements in a decision. Since these programs are entirely new to workers' compensation in this state, duplication is beneficial so that affected parties can analyze and review program procedures and the timeframes for exercising statutory rights in one set of documents.

DISCLOSURES REGARDING THE PROPOSED REGULATORY ACTION

The Acting Administrative Director has made the following initial determinations:

- Mandate on local agencies and school districts: None

- Cost or savings to any state agency: It is estimated that the proposed regulations will result in a savings of $4 million beginning Fiscal Year 2013-2014. The Division may also experience unquantifiable savings based on a reduced number of litigated cases before the WCAB involving medical billing disputes.

- Cost to any local agency or school district which must be reimbursed in accordance with Government Code sections 17500 through 17630: None

- Other nondiscretionary cost or savings imposed on local agencies: It is estimated that the proposed regulations will result in a savings of $15 million annually for local government.

- Cost or savings in federal funding to the state: None

- Cost impacts on a representative private person or business: Most of the affected businesses are medical providers – such as physicians – and for these businesses the annual ongoing costs to comply with the IBR regulations will be approximately $1,200 to $1,500 per year. The measurable increase in cost for medical providers will be partially offset by more rapid and accurate payment of accounts receivable, however those offsetting savings cannot be adequately estimated.

- Statewide adverse economic impact directly affecting businesses and individuals: Although the proposed action will directly affect businesses statewide, including small businesses, and individuals, the Acting Administrative Director concludes that the adverse economic impact,

including the ability of California businesses to compete with business in the other states, will not be significant.

- Significant effect on housing costs: None.

Results of the Economic Impact Analysis/Assessment

The Acting Administrative Director concludes that it is (1) unlikely that the proposal will create any jobs within the State of California, outside of those created by the independent review organization, (2) unlikely that the proposal will eliminate any jobs within the State of California, (3) unlikely that the proposal will create any new businesses with the State of California, (4) unlikely that the proposal will eliminate any existing businesses with the State of California, and (5) unlikely that the proposal would cause the expansion of the business currently doing business within the State of California.

Benefits of the Proposed Action: The proposed regulations will create a more efficient, less costly way of resolving disputes over the amount of payment made on either a bill for medical treatment services or a bill for medical-legal expenses. Under the existing system, a medical provider in the workers' compensation system who objects to the payment made by a claims administrator on a medical bill had no recourse but to initiate litigation by filing a lien with the WCAB. The second bill review and IBR process set forth in the regulations will first allow the parties to resolve any differences that may have resulted through an error or initial lack of information. Then, should the provider still find the payment inadequate following the second review, the regulations would allow the provider to seek IMR, where a bias-free medical billing and payment expert, using fee scheduled adopted by the Division, would issue a determination resolving the dispute. The regulations have been drafted to streamline the IBR process while allowing the parties due process. Based on lien litigation before the WCAB, it is estimated that California employers may save $106 million based on the expeditious and efficient IBR process.

Small Business Determination: The Acting Administrative Director has determined that the proposed regulations affect small business. Annual ongoing costs for small business to comply with the IBR regulations will be approximately $1,200 to $1,500 per year. Most of the affected small businesses are medical providers – such as physicians – with fewer than 100 employees. The measurable increase in cost for medical providers will be partially offset by more rapid and accurate payment of accounts receivable, however those offsetting savings cannot be adequately estimated

CONSIDERATION OF ALTERNATIVES

In accordance with Government Code section 11346.5(a)(13), the Acting Administrative Director must determine that no reasonable alternative considered or that has otherwise been identified and brought to the Acting Administrative Director's attention would be more effective in carrying out the purpose for which the actions are proposed, would be as effective and less burdensome to affected private persons than the proposed actions, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The Acting Administrative Director invites interested persons to present reasonable alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

PUBLIC DISCUSSIONS OF PROPOSED REGULATIONS

The text of the draft proposed regulations was made available for pre-regulatory public comment from December 3 – 7, 2012 through the Division's Internet website (the "DWC Forum").

AVAILABILITY OF INITIAL STATEMENT OF REASONS, TEXT OF PROPOSED REGULATIONS, RULEMAKING FILE AND DOCUMENTS SUPPORTING THE RULEMAKING FILE / INTERNET ACCESS

An Initial Statement of Reasons and the text of the proposed regulations in plain English have been prepared and are available from the contact person named in this notice. The entire rulemaking file will be made available for inspection and copying at the address indicated below.

As of the date of this Notice, the rulemaking file consists of the Notice, the Initial Statement of Reasons, proposed text of the regulations, pre-rulemaking comments and the Economic Impact Statement (Form STD 399). Also included are studies and documents relied upon in drafting the proposed regulations, and documents incorporated by reference.

In addition, the Notice, Initial Statement of Reasons, and proposed text of the regulations being proposed may be accessed and downloaded from the Division's website at www.dir.ca.gov. To access them, click on the "Proposed Regulations – Rulemaking" link and scroll down the list of rulemaking proceedings to find the Independent Medical Review link.

Any interested person may inspect a copy or direct questions about the proposed regulations and any supplemental information contained in the rulemaking file. The rulemaking file will be available for inspection at the Department of Industrial Relations, Division of Workers' Compensation, 1515 Clay Street, 17th Floor, Oakland, California 94612, between 9:00 A.M. and 4:30 P.M., Monday through Friday. Copies of the proposed regulations, Initial Statement of Reasons and any information contained in the rulemaking file may be requested in writing to the contact person.

CONTACT PERSON FOR GENERAL QUESTIONS

Non-substantive inquiries concerning this action, such as requests to be added to the mailing list for rulemaking notices, requests for copies of the text of the proposed regulations, the Initial Statement of Reasons, and any supplemental information contained in the rulemaking file may be requested in writing at the same address. The contact person is:

Maureen Gray
Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142
E-mail: mgray@dir.ca.gov

The telephone number of the contact person is (510) 286-7100.

CONTACT PERSON FOR SUBSTANTIVE QUESTIONS

In the event the contact person above is unavailable, or for questions regarding the substance of the proposed regulations, inquiries should be directed to:

George Parisotto
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142

E-mail: gparisotto@dir.ca.gov

The telephone number of this contact person is (510) 286-7100.

FORMAT OF REGULATORY TEXT.

Text of Emergency Regulations Effective January 1, 2013:

Deletions from the original codified regulatory text made by the emergency regulatory text effective January 1, 2013, are indicated by single strike-through, thus: ~~deleted language~~.

Additions to the original codified regulatory text made by the emergency regulatory text effective January 1, 2013, are indicated by single underlining, thus: added language.

Additional Proposed Text Noticed for 45-Day Comment Period:

Additions to the original codified regulatory text and emergency regulatory text noticed for the 45-day comment period are indicated by double underlining: added language.

Newly proposed deletions from the original codified regulatory text and emergency regulatory text noticed for the 45-day comment period are indicated by double strike-through: ~~deleted language~~ or ~~deleted language~~.

AVAILABILITY OF CHANGES FOLLOWING PUBLIC HEARING

If the Acting Administrative Director makes changes to the proposed regulations as a result of the public hearing and public comment received, the modified text with changes clearly shown will be made available for public comment for at least 15 days prior to the date on which the regulations are adopted.

AVAILABILITY OF THE FINAL STATEMENT OF REASONS

Upon its completion, the final Statement of Reasons will be available and copies may be requested from the contact person named in this notice or may be accessed on the Division's website at www.dir.ca.gov.

AUTOMATIC MAILING

A copy of this Notice, the Initial Statement of Reasons, and the text of the regulations, will automatically be sent to those interested persons on the Acting Administrative Director's mailing list.

If adopted, the regulations as amended will appear in California Code of Regulations, title 8, commencing with section 9792.5.1. The text of the final regulations also may be available through the website of the Office of Administrative Law at www.oal.ca.gov.