2018 Independent Bill Review (IBR) Report: Analysis of 2013-2017 Application Filings

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Introduction

In September 2012, Governor Brown signed into legislation Senate Bill (SB) 863. This reform of the workers' compensation system in California included Independent Bill Review (IBR), which went into effect January 1, 2013. IBR is an efficient, nonjudicial process for resolving medical treatment and medical-legal billing disputes in which the medical provider disagrees with the amount paid by a claims administrator on a properly documented bill after a second review (CCR § 9792.5).

In a Second Bill Review (SBR), the medical provider seeks reconsideration of the denial or adjustment of the billed charges for the medical services or goods, or medical-legal services, given to the injured worker. IBR cannot be requested until after the claims administrator issues a decision following a second review requested in a timely fashion, with which the medical provider disagrees.

Prior to SB 863, a medical provider engaged in a billing dispute with a claims administrator was limited to filing a lien with the Workers' Compensation Appeal Board in order to determine entitlement to the amount initially billed. SB 863 established SBR and IBR to decide billing disputes expediently, in which the only issue is the amount to be paid for the medical service provided. If the medical service is covered by a fee schedule adopted by the Division of Workers' Compensation (DWC), then SBR and IBR must be used to resolve the dispute.

A medical provider may request IBR within thirty (30) days after service of the second review decision. Upon referral by the administrative director, the Independent Bill Review Organization (IBRO) notifies the parties of the assignment and provides them with an IBR case or identification number. The IBRO assigns an independent bill reviewer to examine all documents submitted, apply the appropriate fee schedule, and issue a written determination within sixty (60) days of the assignment to IBR.

For the IBRO to consider the disputed billing, the medical service or good (or medical-legal service) must be included in a fee schedule adopted by the DWC. The Official Medical Fee Schedule (OMFS) sets forth rates for ambulance fees, durable medical equipment, inpatient and outpatient hospital services, surgical centers, laboratories, pharmaceuticals, and physician services. The DWC also maintains contracts for reimbursement rates, along with regulations for medical-legal evaluations.

The report that follows examines the IBR program activity from its implementation, capturing all applicant filings through December 31, 2017, including determinations for cases started in 2017 that were resolved in the first quarter of calendar year 2018.

Methodology

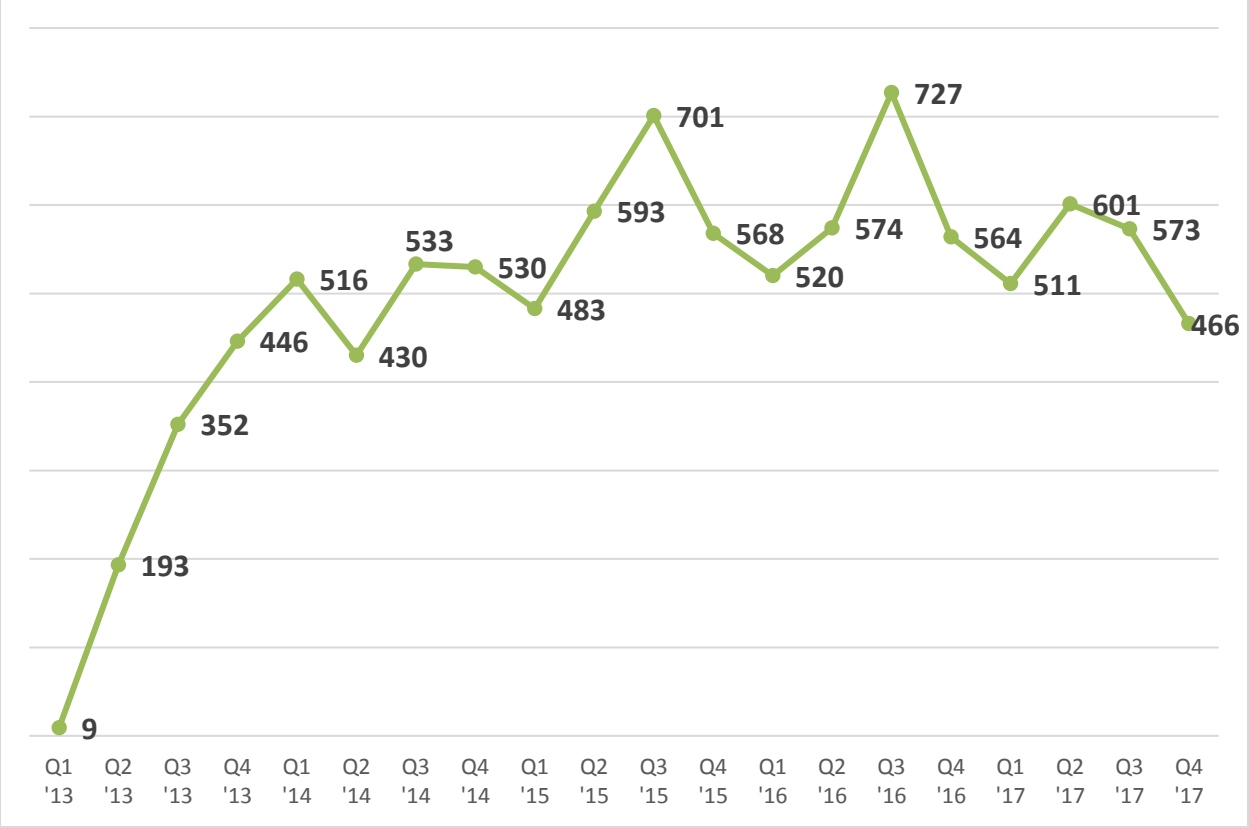
Maximus Federal Services, the IBRO, provides the DWC with data extracted from its proprietary software. This data corresponds with information contained in the Final Determination Letters (FDLs) that are received by the filing party. Anonymized copies are available on the DWC website for all decisions within 30 days of the FDL issuance (https://www.dir.ca.gov/dwc/IBR/IBR-Decisions/IBR_Decisions.asp).

Results

IBR Applications Received

During the first few months of the program, the IBRO received only a handful of applications. In the second quarter, filings increased and then accelerated throughout the remainder of 2013. In 2014, 2,009 applications were filed. The number of filings in 2015 and 2016 was nearly identical: 2,345 in 2015 and 2,385 in 2016. In 2017, filings decreased approximately 10 percent from the peaks in previous years, to 2,151.

Figure 1: IBR Applications Received by Quarter, 2013-2017



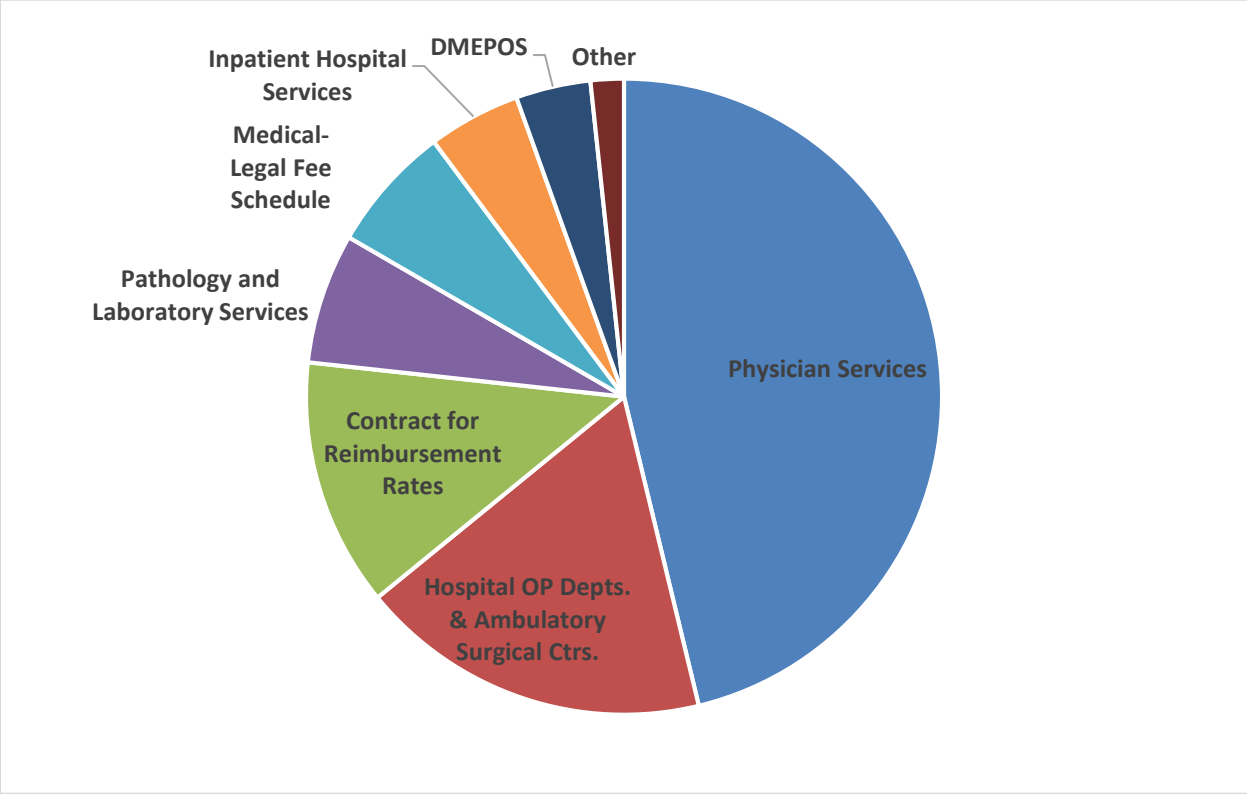
N = 9,890 IBR applications received January 2013–December 2017.
Source: DWC.

Fee Schedule

The disputed billing must be covered by a fee schedule adopted by the DWC: medical services in the Official Medical Fee Schedule, evaluations under the Medical-Legal Fee Schedule, or set forth in a contract for reimbursement (LC § 5307.11).

In the first five years following IBR's implementation, almost half the challenged billings (46.2%) related to Physician Services, including visits, consultations, and nonsurgical procedures. The second-highest number of review requests was for services at hospital outpatient departments and ambulatory surgical centers (17.9%). Disputes with contracts for reimbursement rates were the third highest (12.6%).

Figure 2: IBR Fee Schedule, 2013-2017



Notes: *N* = 11,902 listed fee schedule review requests from 9,890 IBR applications received January 2013–December 2017. Some IBR cases contain multiple fee schedule review requests. DMEPOS refers to Durable Medical Equipment, Prosthetics, Orthotics, Supplies.
Source: DWC.

Table 1: IBR Fee Schedule, 2013-2017

Applicable Fee Schedule	2013	2014	2015	2016	2017	Total	Percent
Physician Services	619	1,056	1,366	1,331	1,129	5,501	46.2%
Hospital Outpatient Departments/Ambulatory Surgical Centers	128	312	481	679	530	2,130	17.9%
Contract for Reimbursement Rates	16	282	353	541	309	1,501	12.6%
Pathology and Laboratory Services	101	239	199	174	76	789	6.6%
Medical-Legal Fee Schedule	98	154	207	168	140	767	6.4%
Inpatient Hospital Services	59	126	152	131	92	560	4.7%
Durable Medical Equipment, Prosthetics, Orthotics, Supplies	56	87	71	68	171	453	3.8%
Pharmaceutical	59	59	41	10	7	176	1.5%
Interpreter	1	4	3	5	2	15	0.1%
Ambulance Services	1	3	2	2	2	10	0.1%
Total	1,138	2,322	2,875	3,109	2,458	11,902	100%

Notes: *N* = 11,902 listed fee schedule review requests from 9,890 IBR applications received January 2013–December 2017. Some IBR cases contain multiple fee schedule review requests.
Source: DWC.

Procedure Codes

In addition to indicating the applicable fee schedule, IBR applicants must state the billing code of the services or goods whose payment is in dispute. Most often, this is a billing code using Current Procedural Terminology (CPT) published by the American Medical Association (AMA). Some codes represent non-physician services, such as durable medical equipment and certain pharmaceuticals (HCPCS)*, while others are specific to the California Code of Regulations, including progress reports by treating physicians and medical-legal evaluations performed by Qualified Medical Evaluators (QMEs).

Table 2 describes the twenty billing codes and related descriptions for services or goods that were listed most often in the IBR application filings from 2013 to 2017.

*Healthcare Common Procedure Coding System, developed by the Centers for Medicare and Medicaid.

Table 2: Top 20 Procedure Codes, 2013-2017

Code	Description	Total
CPT 97799	Unlisted physical medicine/rehabilitation service	713
CPT 99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history, a detailed examination, and medical decision making of moderate complexity	381
ML-104	Comprehensive medical-legal evaluation with extraordinary circumstances	378
WC002	Treating physician's progress report (PR-2 or narrative equivalent in accordance with §9785)	362
E1399	Durable medical equipment, miscellaneous	335
CPT 99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history, a comprehensive examination, and medical decision making of high complexity	309
CPT 82486	Chromotolotogy, qualitative; Column (e.g., gas liquid or HPLC), analyte not elsewhere specified	306
HCPCS J3490	Unclassified drugs	270
CPT 97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility	264
CPT 99358	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care	247
CPT 83925	Opiate(s), drug and metabolites, each procedure	244
CPT 99070	Supplies and materials (except spectacles), provided by the physician or other qualified health-care professional and above those usually included with the office visit or other services rendered	222
CPT 82145	Amphetamine or methamphetamine	217
CPT 99199	Unlisted special service, procedure or report	208
CPT 96101	Psychological testing, per hour of the psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	201
HCPCS G0431	Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class	195
CPT 97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction, one or more regions, each 15 minutes)	193
CPT 99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	191
WC007	Consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director; consultation reports requested by the Qualified Medical Evaluator or Agreed Medical Evaluator in the context of a medical-legal evaluation	174
CPT 99205	Office or other outpatient visit for the evaluation and management of an established patient, which requires these three key components: a comprehensive history, a comprehensive evaluation, and medical decision making of a high complexity	167

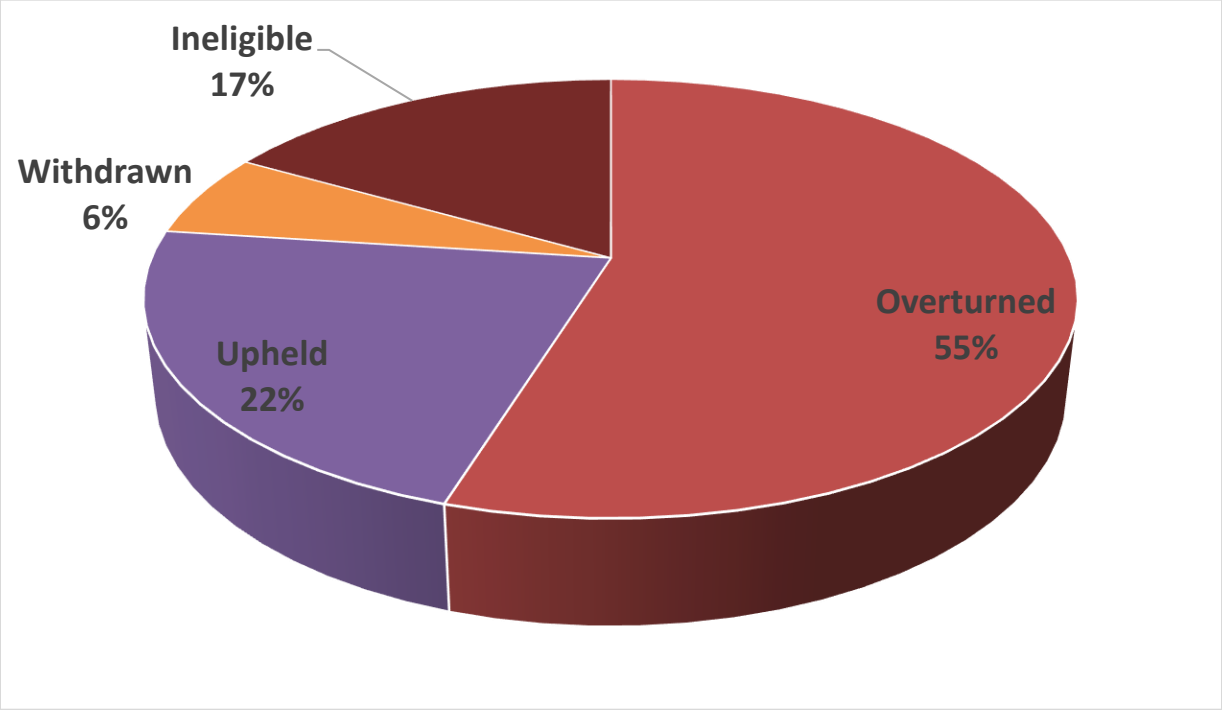
Notes: N = 5,517 of 19,137 listed procedure code billing appeals from 9,890 IBR applications received January 2013–December 2017. Some IBR cases contain multiple procedure code billing appeals.
Source: DWC.

Case Dispositions

Approximately one of every six IBR applications is determined to be ineligible for review. Ineligibility factors include untimely requests, requests made prior to completion of a second review, and requests made without payment of the required fee.

Among the filings that receive a review and a case determination, 71.1 percent are "overturned," meaning the IBRO determined that additional reimbursement is warranted. The claims administrator's determination is reversed, so the provider is due reimbursement for the review cost, along with the amount for review of the billing and fee schedule.

Figure 3: IBR Case Dispositions for Applications Filed from 2013 to 2017



N = 9,890 IBR case decisions issued June 2013–March 2018.
Source: DWC.

Table 3: IBR Case Dispositions by Year, Applications Filed from 2013 to 2017

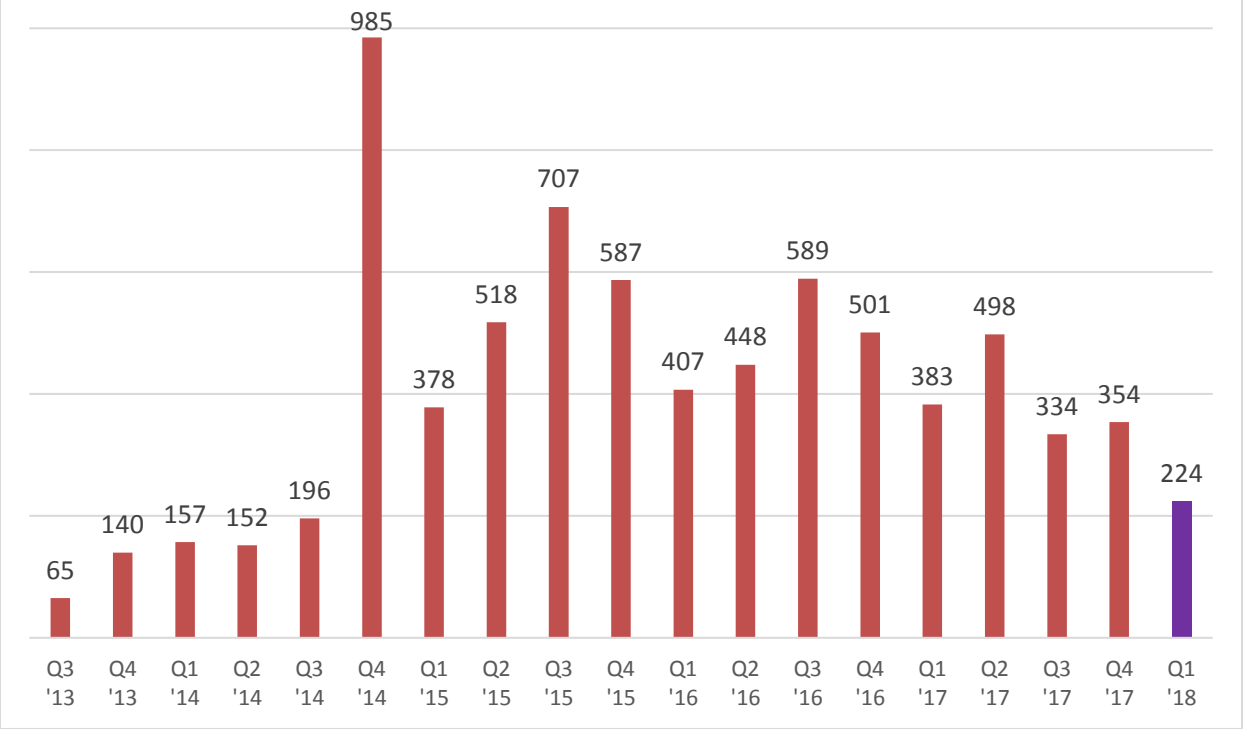
Disposition	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	Total	Percent
Overturned	432	949	1,435	1,485	1,121	**5,422**	55%
Upheld	273	458	444	509	515	**2,199**	22%
Withdrawn	62	120	157	110	162	**611**	6%
Ineligible	233	482	309	281	353	**1,658**	17%
Total	*1,000*	*2,009*	*2,345*	*2,385*	*2,151*	***9,890***	100%

N = 9,890 IBR case decisions issued June 2013–March 2018.
Source: DWC.

Case Decisions Issued

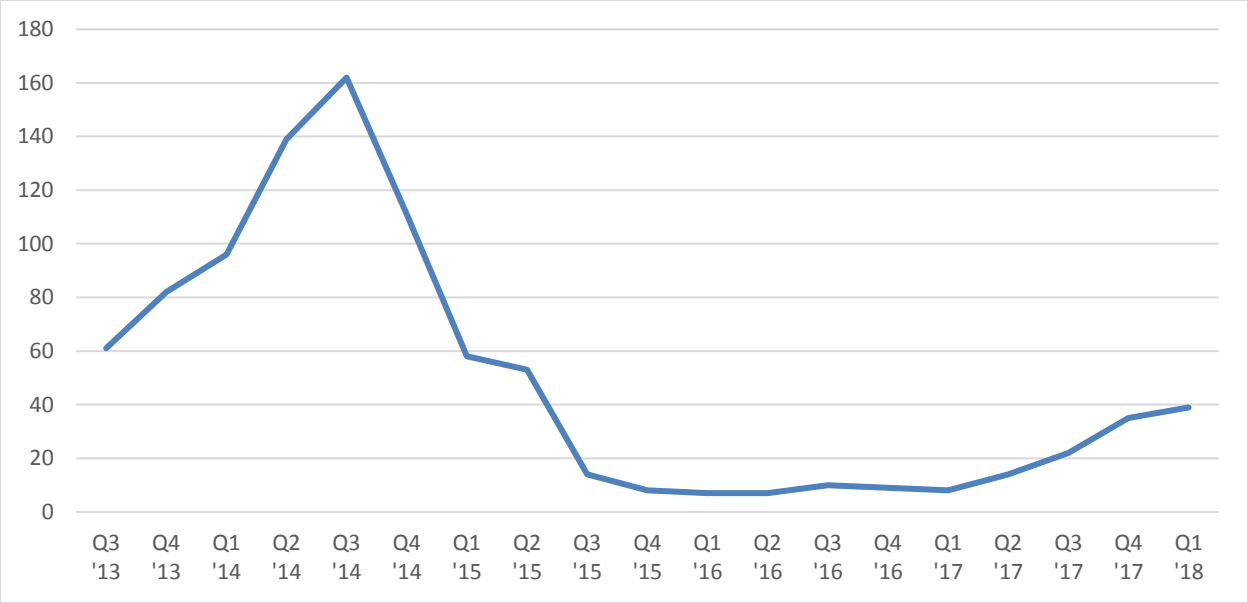
In the second half of 2013 and the first half of 2014, the IBRO issued FDLs at a rate of approximately 40 to 45 per month. During this period, the IBRO elevated its recruitment and attainment of highly qualified specialists needed to address the complexity and detail involved in analyzing billing disputes, developed its software capabilities to increase efficiency in the review process, and expanded outreach efforts with professional organizations in promoting the program. These efforts were responsible for eliminating the backlog that had developed through the steady activity of IBR application filings and helped return the vast majority of cases to compliance with statutory requirements by the beginning of 2015. In 2016 and 2017 combined, all but eight determinations were issued within the required time frame.

Figure 4: IBR Case Decisions Issued per Quarter for Applications Filed from 2013 to 2017



N = 9,890 IBR case decisions issued June 2013–March 2018.
*Two case decisions issued in June 2013 are included in the total for the third quarter of 2013.
**Total for the first quarter of 2018 includes only decisions on cases in which IBR application was filed in 2017.
Source: DWC.

Figure 5: Average Number of Days from Date of Assignment to Decision Date



N = 9,890 IBR case decisions issued June 2013–March 2018.
Source: DWC.

Additional Reimbursement

Overturned IBR case decisions for applications filed in 2013-2017 resulted in reimbursement to the providers totaling **$12,277,568**. This amount includes the repayment of filing fees for those cases. When IBR was introduced, the filing fee was $335. Effective April 1, 2014, this fee was reduced to $250 and then further decreased to $195 on January 1, 2015.

For calendar year 2017, the most recent year in this study, the IBRO determined that $2,635,074 in billing was due to the providers at the time of the decision. Although 1,112 overturned cases were issued in 2017, the compensable reimbursement for 37 overturned cases is not included in this total. In these cases, the claims administrator submitted supplemental payment to the provider while the IBR was in process. They were still charged $195, based on the determination of the bill review.

In the 1,075 overturned cases where additional payment was warranted, reimbursement amounts range from less than $1 to more than $100,000 per case, based on the services provided in the injured workers' treatment plan.

Of the twenty largest billing appeals awarded in 2017, the majority were for surgeries and other inpatient stays, such as rehabilitation services.

Table 4: Highest Amounts Awarded by IBR to Providers, 2017

Case Number	Fee Sched.	Diagnosis-Related Group	Provider Billed	Plan Allowed	Dispute Amount	WC Allowed Amount	Due to Provider
CB17-0000120	IP	DRG 559	$168,227	$19,801	$136,040	$155,841	$136,040
CB16-0002279	IP	DRG 454	$225,137	–	$99,421	$99,421	$99,421
CB17-0000299	OP	[various]	$91,500	$5,110	$80,791	$82,350	$77,240
CB17-0000799	IP	DRG 560	$85,128	$12,932	$72,196	$85,128	$72,196
CB17-0001383	IP	DRG 560	$132,844	$35,910	$63,723	$99,633	$63,723
CB17-0001204	IP	DRG 945	$65,534	$12,734	$52,800	$65,534	$52,800
CB17-0001317	IP	DRG 946	$55,369	$13,512	$41,858	$55,369	$41,858
CB17-0000018	IP	DRG 457	$1,026,599	$96,093	$40,831	$136,923	$40,831
CB17-0000385	IP	DRG 945	$44,398	–	$39,958	$39,958	$39,958
CB17-0000152	IP	[various]	$49,193	$5,937	$38,337	$44,280	$38,337
CB17-0001374	IP	DRG 949	$61,460	$11,398	$37,770	$49,168	$37,770
CB17-0001606	OP	[various]	$11,440	$11,326	$34,312	$45,638	$34,312
CB17-0001781	OP	[various]	$36,744	$2,883	$32,024	$34,907	$32,024
CB16-0002341	OP	[various]	$169,794	–	$30,689	$30,689	$30,689
CB16-0002211	IP	DRG 470	$93,527	–	$26,208	$26,208	$26,208
CB17-0001147	IP	DRG 454	$193,416	$84,947	$25,736	$110,683	$25,736
CB17-0000967	OP	[various]	$188,254	–	$25,000	$25,000	$25,000
CB17-0001342	IP	DRG 904	$24,246	$23,761	$24,452	$48,219	$24,452
CB17-0000850	OP	[various]	$29,451	$2,891	$23,615	$26,506	$23,615
CB17-0001170	IP	DRG 856	$274,007	$57,589	$23,036	$80,625	$23,036

IP = Inpatient Hospital Services OP = Hospital Outpatient Departments and Ambulatory Service Centers
CC/MCC = Complication or Comorbidity/Major Complication or Comorbidity

Diagnosis-Related Group: A statistical system of classifying any inpatient stay into groups for the purpose of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement.

454 Combined anterior/posterior spinal fusion w CC
457 Spinal fusion exc. cervical w spinal curvature/malignancy/infection or ext. fusions (9+) w CC
470 Major joint replacement or reattachment of lower extremity w/o MCC
559 Aftercare, musculoskeletal system & connective tissue w MCC
560 Aftercare, musculoskeletal system & connective tissue w CC
856 Postoperative or post-traumatic infections w O.R. procedure w MCC
904 Skin grafts for injuries w CC/MCC
945 Rehabilitation w CC/MCC
946 Rehabilitation w/o CC/MCC
949 Aftercare w CC/MCC

Conclusion

Now in its sixth year, IBR continues to provide an effective process for resolving billing disputes for payment of medical and medical-legal services in the workers' compensation system. The IBRO continues to receive approximately 200 applications per month, similar to the activity of the program in much of its first five years.

IBR case decisions must be issued within sixty (60) days of their assignment to an IBRO reviewer. After the initial volume issues were resolved, the monthly averages range from 7 to 39 days. With few exceptions, all cases are resolved within 60 days.

Seven of every ten IBR cases that complete the determination process are found to be owed additional payment. Providers received $12.3 million in reimbursement for services in 2013-2017, including the filing fee. Billing for physician services are most often submitted for review and most often overturned. The highest amounts for reimbursement are for inpatient hospital services and ambulatory surgical centers.

Fee schedules for interpreters and home health care are pending adoption by the DWC. This is anticipated to increase IBR program activity. As with all adjustments to the fee schedules, the DWC intends to reassess allocation of resources to the IBR program.

Appendix: The IBR Process