The request for second review shall be made as follows:

(1) For a non-electronic medical treatment bill, the second review shall be requested on either:

(A) The initially reviewed bill submitted on a CMS 1500 or UB04, as modified by this subdivision. The second review bill shall be marked using the National Uniform Billing Committee (NUBC)

Condition Code Qualifier “BG” followed by NUBC Condition Code “W3”

in the field designated for that information to indicate a request for second review, or, for the ADA Dental Claim Form 2006, or ADA Dental Claim Form (2012), the words “Request for Second Review” will be marked in Field 1, or for the NCPDP WC/PC Claim Form, the words “Request for Second Review” may be written on the form.

(B) The Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6. The DWC Form SBR-1 shall be the first page of the request for second review submitted by the provider.

(2) For an electronic medical treatment bills for professional, institutional or dental services, the request for second review shall be submitted on the correct electronic standard format, utilizing the National Uniform Billing Committee (NUBC) Condition Code Qualifier “BG” followed by NUBC Condition Code “W3” as specified in the Division of Workers' Compensation Electronic Medical Billing and Payment Companion Guide.

(3) For an electronic pharmacy bill that used either the NCPDP Telecommunications D.0 or the NCPDP Batch Standard Implementation Guide 1.2, the method for identifying a request for second review may be addressed in the trading partner agreement, or the second review may be requested on the DWC Form SBR-1.

(4) For medical-legal bills, the second review shall be requested on the Request for Second Bill Review form, DWC Form SBR-1, set forth at section 9792.5.6.

(d) The request for second review shall include:

1. The original dates of service and the same itemized services rendered as the original bill. No new dates of service or additional billing codes may be included.

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(2) In addition to the bill as modified in this subdivision, the second review request shall include, as applicable, the following:

1. The date of the explanation of review and the claim number or other unique identifying number provided on the explanation of review.
2. The item and amount in dispute.
3. The additional payment requested and the reason therefor.

(D) The additional information provided in response to a request in the first explanation of review or any other additional information provided in support of the additional payment requested.

(e) If the only dispute is the amount of payment and the provider does not request a second review within the timeframes set forth in subdivision (b), the bill shall be deemed satisfied and neither the claims administrator nor the employee shall be liable for any further payment.

(e) If the only dispute is the amount of payment and the provider does not request a second review within the timeframes set forth in subdivision (b), the bill shall be deemed satisfied and neither the claims administrator nor the employee shall be liable for any further payment.

(f) A claims administrator may respond to a request for second bill review that does not comply with the requirements of subdivision (d). Any response to such a request is not subject to the requirements of subdivisions (g) and (h) of this section.

(g) Within 14 days of receipt of a request for second review that complies with the requirements of subdivision (d), the claims administrator shall respond to the provider with a final written determination on each of the items or amounts in dispute by issuing an explanation of review. The determination shall contain all the information that is required to be set forth in an explanation of review under Labor Code section 4603.3, including an explanation of the time limit to raise any further objection regarding the amount paid for services and how to obtain independent bill review under Labor Code section 4603.6. The 14 day time limit for responding to a request for second review may be extended by mutual written agreement between the provider and the claims administrator.

(h) Based on the results of the second review, payment of any balance no longer in dispute, or payment of any additional amount determined to be payable, shall be made within 21 days of receipt of the request for second review. The 21-day time limit for payment may be extended by mutual written agreement between the provider and the claims administrator.

(i) If the provider further contests the amount paid after receipt of the final written determination following a second review, the provider shall request an independent bill review pursuant to this Article.

Note: Authority cited: Sections 133, 4603.6, 5307.3 and 5307.6, Labor Code. Reference: Sections 4060, 4061, 4061.5, 4062, 4600, 4603.2, 4603.3, 4603.4, 4620, 4621, 4622, 4625, 4628 and 5307.6, Labor Code.

HISTORY

1. New section filed 12-31-2012 as an emergency; operative 1-1-2013 pursuant to Government Code section 11346.1(d) (Register 2013, No. 1). A Certificate of Compliance must be transmitted to OAL by 7-1-2013 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 7-1-2013 as an emergency; operative 7-1-2013 (Register 2013, No. 27). A Certificate of Compliance must be transmitted to OAL by 9-30-2013 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 9-30-2013 as an emergency; operative 10-1-2013 (Register 2013, No. 40). A

Certificate of Compliance must be transmitted to OAL by 12-30-2013 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 9-30-2013 order, including amendment of section, transmitted to OAL 12-30-2013 and filed 2-12-2014; amendments effective 2-12-2014 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 7).

5. Editorial correction of subsections (b)(1)(A)-(B) (Register 2014, No. 9).