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

NOTICE OF MODIFICATION TO TEXT OF PROPOSED REGULATIONS AND FORMS AND NOTICE OF ADDITION OF DOCUMENTS TO THE RULEMAKING FILE

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

TITLE 8, CALIFORNIA CODE OF REGULATIONS,
ARTICLES 5.5.0 AND 5.6 OF CHAPTER 4.5, SUBCHAPTER 1

NOTICE IS HEREBY GIVEN, pursuant to Government Code section 11346.8(c) that the Acting Administrative Director of the Division of Workers' Compensation, proposes to modify the text of the following proposed amendments to Title 8, California Code of Regulations:

Section 9792.5.1.	Medical Billing and Payment Guide; Electronic Medical Billing and Payment Companion Guide; Various Implementation Guides
Section 9792.5.4.	Second Review and Independent Bill Review – Definitions
Section 9792.5.5.	Second Review of Medical Treatment Bill or Medical-Legal Bill
Section 9792.5.6.	Provider's Request for Second Bill Review – Form
Section 9792.5.7.	Requesting Independent Bill Review
Section 9792.5.8.	Request for Independent Bill Review Form
Section 9792.5.9.	Initial Review and Assignment of Request for Independent Bill Review to IBRO
Section 9792.5.10.	Independent Bill Review - Document Filing
Section 9792.5.11.	Withdrawal of Independent Bill Review
Section 9792.5.12.	Independent Bill Review - Consolidation or Separation of Requests
Section 9792.5.13.	Independent Bill Review – Review
Section 9792.5.15.	Independent Bill Review – Implementation of Determination and Appeal
Section 9793.	Definitions

PRESENTATION OF WRITTEN COMMENTS AND DEADLINE FOR SUBMISSION OF WRITTEN COMMENTS

Members of the public are invited to present written comments regarding this proposed modification and documents added to the rulemaking file. **Only comments concerning the proposed modification to the text of the regulations, documents**

incorporated by reference, and documents added to the rulemaking file will be considered and responded to in the Final Statement of Reasons.

Written comments should be addressed to:

Maureen Gray, Regulations Coordinator
Department of Industrial Relations
Division of Workers' Compensation
Post Office Box 420603
San Francisco, CA 94142

The Division's contact person must receive all written comments concerning the proposed modifications to the regulations no later than 5:00 p.m. on October 23, 2013.

Written comments may be submitted by facsimile transmission (FAX), addressed to the 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

Due to the inherent risks of non-delivery by facsimile transmission, the Acting Administrative Director suggests, but does not require, that a copy of any comments transmitted by facsimile transmission also be submitted by regular mail.

Comments sent to other e-mail addresses or facsimile numbers will not be accepted. Comments sent by e-mail or facsimile are subject to the deadline set forth above for written comments.

AVAILABILITY OF TEXT OF REGULATIONS AND RULEMAKING FILE

Copies of the original text, the modified text with modifications clearly indicated and the entire rulemaking file, are currently available for public review during normal business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays, at the offices of the Division of Workers' Compensation. The Division is located at 1515 Clay Street, 17th Floor, Oakland, California. Please contact the Division's regulations coordinator, Ms. Maureen Gray, at (510) 286-7100 to arrange to inspect the rulemaking file.

NOTICE OF ADDITION OF REFERENCE MATERIAL TO RULEMAKING FILE

Pursuant to the requirements of Government Code section 11347.1, the Division of Workers' Compensation is providing notice that reference materials which the agency has relied upon in proposing the modifications to the proposed regulations have been added to the rulemaking file. The documents are available for public inspection and comment during the written comment period, see "Presentation of Written Comments and Deadline for Submission of Written Comments" set forth above. The Division will respond to comments regarding the documents in the Final Statement of Reasons. The

documents may be inspected as part of the rulemaking file; see “Availability of Text of Regulations and Rulemaking File” above for the place and time the documents will be available and the name and phone number of the contact person.

Documents added to the rulemaking file after close of the 45-day comment period:

Documents Incorporated by Reference

- CMS 1500 Health Insurance Claim Form (version 02/12)
- NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, June 2013 Version 1.1 06/13
- National Uniform Billing Committee Official UB-04 Data Specification Manual 2014, Version 8.0, July 2013
- NCPDP Manual Claim Forms Reference Implementation Guide Version 1.1, March 2012, except for pages 13-35 relating to the Universal Claim Form
- CDT 2014: Dental Procedure Codes
- ADA Dental Claim Form 2012

ICD-10-CM

- 2014 Code Descriptions in Tabular Order [ZIP, 1MB]
- 2014 Code Tables and Index [ZIP, 16MB]
- 2014 ICD-10-CM Duplicate Code Numbers [ZIP, 64KB]
- 2014 General Equivalence Mappings (GEMs) – Diagnosis Codes and Guide [ZIP, 623KB]
- 2014 ICD-10-CM Present On Admission (POA) Exempt List [ZIP, 4MB]

ICD-10-PCS

- 2014 Official ICD-10-PCS Coding Guidelines [PDF, 71KB]
- 2014 Version – What’s New [PDF, 39KB]
- 2014 Code Tables and Index [ZIP, 5MB]
- 2014 PCS Long and Abbreviated Titles [ZIP, 1MB]
- 2014 Development of the ICD-10 Procedure Coding System (ICD-10-PCS) [PDF, 245KB]
- 2014 ICD-10-PCS Reference Manual [ZIP, 709KB]
- 2014 Addendum [ZIP, 64KB]
- PCS Slides for 2014 [ZIP, 689KB]
- 2014 General Equivalence Mappings (GEMs) – Procedure Codes and Guide [ZIP, 721KB]

Documents Relied Upon

- 1500 Health Insurance Claim Form Change Log 6/17/2013
- NUCC 02/12 1500 Claim Form Map to X12 Health Care Claim: Professional (837)
- ADA Dental Claim Form (2012 © American Dental Association) Completion

Instructions

- Federal Register, Vol. 74, No. 11, January 16, 2009, page 3328 et seq. Final Rule: HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards To Adopt ICD–10–CM and ICD–10–PCS
- Federal Register, Vol. 77, No. 172, September 5, 2012, page 54664 et seq. Final Rule: Administrative Simplification: Adoptions of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data code Sets
- CMS ICD-10 Transition Focus on Non-Covered Entities September 2012

FORMAT OF PROPOSED MODIFICATIONS

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: ~~deleted language~~.

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

Additional Proposed Text Noticed for 45-Day Comment Period:

Deletions from the emergency regulatory text noticed for the 45-day comment period are indicated by strike-through underlining: ~~deleted language~~.

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 noticed for the 45-day comment period are indicated by double strike-through: ~~deleted language.~~

For sections that were not included in the adoption of the emergency regulatory text, deletions and additions from the original codified regulatory text are indicated by single strike-through and single underlining, respectively.

Proposed Text Noticed for This 15-Day Comment Period on Modified Text:

The proposed text is indicated by bold underlining, thus: **added language**. Deletions are indicated by bold strikeout, thus: **~~deleted language~~**.

SUMMARY OF PROPOSED CHANGES

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

Electronic Medical Billing and Payment Companion Guide (incorporated by reference)

Amendments were made throughout the document to improve reference to the electronic ASC X12 transaction standards by conforming to standard nomenclature by adding the applicable addenda version (either “A1” or “A2”):

ASC X12N/005010X222 Health Care Claim: Professional (837)	ASC X12N/005010X222A1
ASC X12N/005010X223 Health Care Claim: Institutional (837)	ASC X12N/005010X223A2
ASC X12N/005010X224 Health Care Claim: Dental (837)	ASC X12N/005010X224A2
ASC X12N/005010X231 Implementation Acknowledgment (999)	ASC X12N/005010X231A1
ASC X12N/005010X221 Health Care Claim Payment/Advice (835)	ASC X12N/005010X221A1

Preface: Amend to provide a placeholder for the Change Control Table to insert new web links for the public to access the rulemaking documents that will reflect all changes adopted.

Table of Contents: Changed the headings relating to “Clean Bill” to “Complete Bill” to conform to text.

Section 2.4.7: Amend to require only the unique attachment indicator number on documentation related to an electronic bill in order to streamline process and improve consistency with the provisions in the Medical Billing and Payment Guide. Amend to add cross reference to the Medical Billing and Payment Guide Section 7.3 relating to electronic bill attachments.

Chapter 9 Companion Guide Acknowledgments: Amend throughout chapter to replace “clean bill” with “complete bill”.

Section 9.2: Amend in two places to refer to an “otherwise complete” bill.

Medical Billing and Payment Guide (incorporated by reference)

Amendments were made throughout the document to improve reference to the electronic ASC X12 transaction standards by conforming to standard nomenclature by adding the applicable addenda version (either “A1” or “A2”):

ASC X12N/005010X222 Health Care Claim: Professional (837)	ASC X12N/005010X222A1

ASC X12N/005010X223 Health Care Claim: Institutional (837)	ASC X12N/005010X223A2
ASC X12N/005010X224 Health Care Claim: Dental (837)	ASC X12N/005010X224A2
ASC X12N/005010X231 Implementation Acknowledgment (999)	ASC X12N/005010X231A1
ASC X12N/005010X221 Health Care Claim Payment/Advice (835)	ASC X12N/005010X221A1

Section One – Business Rules, 1.0 Standardized Billing/Electronic Billing Definitions:
1.0(z)(2): Amend to modify the definition of the "CDT Codes".
1.0(z)(7): Amend to add definitions of ICD-10-CM and ICD-10-PCS. Amend to re-number remaining definitions.

Section One – Business Rules, 2.0 Standardized Medical Treatment Billing Format:
2.0(a)(1): Amend to add the "(08/05)" version number to the CMS 1500 form definition.
2.0(a)(1): Amend to add a definition for the new CMS 1500 form: "Form CMS-1500 (02/12)"
2.0(a)(3): Amend to clarify the title of the dental claim form and to add a definition for the new dental claim form: "American Dental Association Dental Claim Form, Version 2012".

Section One – Business Rules, 3.0 Complete Bills:
3.0(a)(2): Amend to specify that a complete bill includes use of the correct ICD code as specified in Section 3.1.0 – 3.2.1.
3.0(b)(12): Amend regarding supporting documentation for a claim to provide rules specific to pharmacy claims in order to comply with statutory changes made by Senate Bill 146 (Statutes of 2013, Chapter 129.)
3.1.0, 3.1.1, and 3.2.1: Adopt new sections to incorporate by reference the International Classification of Diseases 10th Revision Clinical Modification (ICD-10-CM) and related documents, to incorporate by reference the International Classification of Diseases 10th Revision Procedure Coding System (ICD-10-PCS) and related documents, to specify the effective dates for usage of the ICD-10, and to inform the public of where to obtain the documents.

Section One – Business Rules, 6.5 Timeframes: Treatment Bills that are Submitted as a Request for Second Review: Amend to specify that the time frames for responding to a request for second review and for making a payment may be extended by mutual written agreement. Add a cross reference to the California Code of Regulations.

Section One – Business Rules, 7.3 Electronic Bill Attachments:
7.3(b): Amend to delete requirement to include specified information on the attachments, and retain only the "unique attachment indicator number" as an item required on the body or face of the attachment.
7.3(b): Amend to meld (c) into (b).
7.3(d): Amend to re-number as "(c)".
7.3(e): Amend to re-number as "(d)". Amend to delete a list of attachment types and to add language providing that attachment types are specified in 005010X222A1, 005010X223A2, and 005010X224A2 and in the Appendix B of the California Electronic Medical Billing and Payment Guide: Jurisdictional Report Type Codes.

Section One – Business Rules, 7.4 Timeframes: Treatment Bills that are Submitted as a Request for Second Review:
Amend to specify that the time frames for responding to a request for second review and for making a payment may be extended by mutual written agreement. Add a cross reference to the California Code of Regulations.

Appendices for Section One: Appendix A. Standard Paper Forms
1.0 CMS 1500: Amend to incorporate by reference new CMS 1500 Claim Form (version 02/12) and to adopt the new 1500 Health Insurance Claim Form Reference Instruction Manual For Form Version 02/12, Version 1.1 06/13. Amend to specify the dates for usage of the new form and instruction manual. Delete language in order to reorganize section to provide the form and manual versions in a table format for greater clarity. Amend to update information about where to obtain the CMS 1500 form and manual.
1.1 Field Table CMS 1500: Amend to specify the version (08/05) and the effective date.
1.1 Field Table CMS 1500 Field 19: Amend to add language clarifying that Field 19 may be left blank if supporting documentation is sent in the same envelope/package with the bill.
1.2: Adopt a new Field Table CMS 1500 (02/12) to specify data requirements (required, situational, optional, not applicable) for the data fields of the new CMS 1500 form, and to provide California workers' compensation-specific instructions where needed. Also specifies dates of usage.
2.0 UB-04: Amend to incorporate by reference new National Uniform Billing Committee Official UB-04 Data Specifications Manual. Amend to specify the dates for usage of the new specifications manual. Delete language in order to reorganize section to provide the form and manual versions in a table format for greater clarity.
2.1 Field Table UB-04: Amend to add language to the California Workers' Compensation Instructions for Form Locator 66 and 67 to cross reference to Section One – Business Rules, 3.1.0 – 3.2.1 for dates of usage of ICD-9 or ICD-10 codes.
3.0 National Council for Prescription Drug Programs "NCPDP" Workers' Compensation/Property & Casualty Universal Claim Form ("WC/PC UCF"): Amend to incorporate by reference new NCPDP Manual Claims Form Reference Implementation Guide and specify effective date. Delete language in order to reorganize section to provide the form and manual versions in a table format for greater clarity. Amend to update information about where to obtain the NCPDP WC/PC Claim Form and implementation guide.
3.1 Field Table NCPDP:
Field 76 Product Strength: Amend to re-number as "77". Amend to specify that the data field is optional rather than required.
4.0 ADA 2006: Amend to delete "2006" and add "Dental Claim Form" to the section title. Amend to incorporate by reference new American Dental Association Dental Claim Form and dental coding book. Delete language in order to reorganize section to provide the form and manual versions in a table format for greater clarity.
4.1 Field Table ADA 2006: Amend to add "Dental Claim Form" to the title.
4.2 Field Table ADA Dental Claim Form 2012: Adopt a new Field Table to specify data requirements (required, situational, optional, not applicable) for the data fields of the new ADA Dental Form 2012, and to provide California workers' compensation-specific

instructions where needed.

Appendices for Section One: Appendix B. Standard Explanation of Review:
Added language stating that when a bill is paid in full or in part, the EOR also serves as a remittance advice. Added “remittance advice” in the title and subtitles for paper and electronic EORs. Amended language regarding Paper Explanation of Review to correct two references to “fields”, and changed the word “Field” to “Data Items”.
3.0 Table for Paper Explanation of Review: Amended to add clarifying language to Data Items 39 and 51 (DWC Bill Adjustment Reason Codes and explanatory language) to specify that the situational data is required if an adjustment is made to the bill, if there is a denial of billed charges, or there is a need to communicate the messages represented in the codes.

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

Preface: Amend to provide that the section is applicable to medical treatment services and goods rendered under Labor Code section 4600, or medical-legal expenses incurred under Labor Code section 4620, on or after January 1, 2013.

(a)(1): Amend to specify that “amount of payment” includes the amount of money paid by the claims administrator for medical treatment services or goods rendered by a provider in accordance with Labor Code section 4600 that were authorized by Labor Code section 4610, and for which there exists an applicable fee schedule adopted by the Administrative Director for those category of services, including but not limited to those found at sections 9789.10 to 9789.111, or for which a contract for reimbursement rates exists under Labor Code section 5307.11.

(a)(2): Amend to specify that “amount of payment” includes the amount of money paid by the claims administrator for medical-legal expenses, as defined by Labor Code section 4620, where the payment is determined in accordance with sections 9793-9795 and 9795.1-9795.4.

(i): Amend to include a health care facility as defined in Section One of the California Division of Workers’ Compensation Medical Billing and Payment Guide as incorporated by reference in section 9792.5.1, within the definition of provider. Further amend to provide that a provider may use a billing agent, a person or entity that has contracted with the provider to process bill under article 5.5.0, for services or goods rendered by the provider, to request a second bill review or independent bill review.

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

(a): Deletion of comma after reference to section 4603.2.

(c)(1): Amend to change “bills” to “bill”; provide that the second review shall be

requested on the forms listed under subdivision (c)(1)(A) or (c)(1)(B).

(c)(1)(A): Amend to clarify that the second review bill shall be modified with the appropriate second review code. Amend to clarify reference to the American Dental Association Dental Claim Form (2006) and to add reference to the new ADA Dental Claim Form (2012).

(c)(1)(B): Substitute “the” for “requested on the.”

(c)(2): Amend to singular electronic medical treatment bill.

(d)(1): Amend to provide that no additional billing codes may be included with a second bill review.

(f): Addition of subdivision to provide that 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).

(f): Re-letter former subdivision (f) as subdivision (g). Amend to specify that the 14-day response requirement applies to a request for a second bill review that complies with subdivision (d). Relocate former subdivision (f)(1) into text of new subdivision (g).

(f)(1) and (f)(2): Deleted.

(g): Re-letter former subdivision (g) as subdivision (h). Amend to provide that 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.

(h): Re-letter former subdivision (h) as subdivision (i).

4. Section 9792.5.6. Provider’s Request for Second Bill Review – Form

The following amendments are proposed for the Provider’s Request for Second Bill Review, DWC Form SBR-1:

a. Employee Information
    1. Delete Social Security Number.
    2. Relocate Claim Number and add Employer Name.
b. Provider Information
    1. Delete separate fields for City, State, and Zip Code.

c. Claims Administrator Information
    1. Delete separate fields for City, State, and Zip Code
    2. Delete E-Mail Address and Employer Name.
d. Bill Information
    1. Delete row for Was Bill Authorized?
    2. Substitute “items” for “goods” in row beginning with “List of disputed….”
    3. Substitute “procedure” for “treatment” in second column.
    4. Add column for “Procedure/Service/Item Authorized?”
    5. Deletion of “Additional” and Information” in last column and following row.
e. Signature
    1. Add “Provider.”
f. Instructions
    1. Bill Information is amended to conform to form changes.

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5. Section 9792.5.7. Requesting Independent Bill Review

(a)(1): Amend to provide that an independent bill review shall resolve, for a bill for medical treatment services, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, and either one date of service, and one billing code, or one hospital stay, 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.

(a)(2): Amend to specify that an independent bill review shall resolve, for a bill for medical-legal expenses, a dispute over the amount of payment for services billed by a single provider involving one injured employee, one claims administrator, and one comprehensive, follow-up, or supplemental medical legal evaluation report as defined in section 9794..

(c): Amend to specify that a request for independent bill review must be made within 30 calendar days of the stated conditions.

(d)(2): Amend to provide that the provider shall include the listed documents with the application for independent bill review, which shall be indexed and arranged so that each category of documents can be separately identified:

6. Section 9792.5.8. Request for Independent Bill Review Form

The following amendments are proposed for the Provider’s Request for Second Bill Review, DWC Form SBR-1:

a. Employee Information
    1. Delete Social Security Number.
    2. Relocate Claim Number and add Employer Name.
b. Provider Information

1. Under “Provider Type,” add “Other Practitioner – specify” box.
2. Add row for “Provider Specialty.”

c. Claims Administrator Information
1. Delete Employer Name.

d. Bill Information
1. Under “Applicable Fee Schedule(s),” add “Other – specify” box” and Insert “or” before Contract for Reimbursement Rates.”
2. Substitute “Decision” for “Outcome.”
3. Substitute “Procedure” for “Treatment.”
4. Insert “Reduction or” prior to “Denial of Full Payment.”

e. Consolidation
1. Add “Procedure” and “Item” to third line to read: “Procedure/Service/Item….”
2. Substitute “Procedure” for “Treatment.”
3. Insert “Reduction or” prior to “Denial of Full Payment.”

f. Documents to Accompany Request
1. Add “Must by Indexed and Separated” to heading line.
2. Add “Concurrently send a copy of this request to the Claims Administrator.”

g. Instructions
1. Form Instructions, is amended to conform to above form changes.
2. Delete “please” as it occurs.
3. Under last bullet point, substitute “must” for “should” and add “You must index and arrange the documents so that each category of documents can be separately identified.” Substitute “concurrently sent to” for “served on.”
4. Under “Fee,” substitute “must” for “should”
5. Under “How to Apply by Mail,” add the last sentence “Concurrently send a copy of this request and supporting documents to the Claims Administrator.”

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

(a)(2): Amend to clarify that the Administrative Director shall consider as a factor for eligibility the date the medical treatment services or goods were rendered or the medical-legal expenses incurred.

(a)(3): Include as an additional consideration whether the second request for review of the bill under section 9792.5.5 was timely requested by the provider.

(a)(4): Include as an additional consideration whether the second review of the bill under section 9792.5.5 was timely completed by the claims administrator.
(a)(3)-(6): The former subdivisions are re-numbered as (a)(5) through (8). The word “not” is deleted from new subdivision (a)(6).

(b): Amend to provide that the notification required by the subdivision be made within

fifteen (15) days of the eligibility determination.

(b)(3): Amend to provide that the claims administrator, in submitting documentation challenging the request for independent bill review, may dispute both eligibility of the request under subdivision (a) of the section and the provider's reason for requesting independent bill review.

(c): Amend to provide the documents filed by the claims administrator must be concurrently served on the provider.

(f): Amend to delete reference to subdivision (a).

8. Section 9792.5.10. Independent Bill Review - Document Filing

(b): Amend to specify that the documents requested under subdivision (a) must be received within be received 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. The subdivision is further amended to provide that the filing party shall concurrently serve the non-filing party with the documents requested by the independent bill reviewer.

9. Section 9792.5.11. Withdrawal of Independent Bill Review

Amend to expressly provide that the provider may withdraw their request for independent bill review at any time prior to the issuance of a final determination on the amount of payment owed under section 9792.5.14.

(a): The existing subdivision is deleted and replaced with a provision providing that if the request is withdrawn prior to its assignment to an Independent Bill Review Organization for an independent bill review under section 9792.5.9(f), the provider shall be reimbursed the amount of $270.00 from the fee provided with the request under section 9792.5.7(d).

(b): Amend to provide that if the request is withdrawn subsequent to its assignment to an IBRO for an independent bill review under section 9792.5.9(f), the provider shall not be reimbursed the fee provided with the request under section 9792.5.7(d).

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

(b)(3): The first sentence is amended to read "After consultation with the Administrative Director, the IBRO may allow the consolidation of requests for independent bill review by a single provider showing a possible pattern and practice of underpayment by a claims administrator for specific billing codes."

11. Section 9792.5.13. Independent Bill Review – Review

(d): Amend to add the sentence: “The independent bill review shall also apply as necessary all billing, payment, and coding rules adopted under this Article.

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

(b)(1): Amend to substitute “bill” for “medical.”

13. Section 9793. Definitions

(c)(2): Correct citation to subdivision (h).

(e): Punctuation changes in definition of “disputed medical fact” for clarity.