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Reply to Philadelphia

June 27, 2006

Eileen Wunsch, Chief
Health Care Services Review Division
Bureau of Workers' Compensation
Department of Labor and Industry
Chapter 127 Regulations -- Comments
P.O. Box 15121
Harrisburg, PA 17105

Re: AAHAM Comments - Chapter 127 Regulations

Dear Ms. Wunsch:

Please be advised that I am counsel to the Philadelphia Chapter of the America Association of Healthcare Administrative Management ("AAHAM"). AAHAM represents a broad-based constituency of healthcare administrative professionals. The Philadelphia Chapter's 135 members work in all of the major hospitals and healthcare providers in the metropolitan area. I am writing to provide you with AAHAM's comments on the proposed regulations that the Bureau published on June 10, 2006 at 36 Pa.Bull. 2913 - 2944.

Of great concern to AAHAM is the Bureau's proposed amendment to § 127.201(b)-(c) to the effect that, if a provider does not bill an insurer within "90 days from the first date of treatment reflected on the bill," the "provider may not seek payment from the insurer or employee." The threshold issue posed by this change is whether the Bureau has statutory authority to impose a billing deadline. In this regard, it should be noted that, when the legislature enacted the cost containment provisions of Act 44, it specifically considered the applicable time limits. It is therefore significant that the legislation has no reference to timely billing. The only pertinent time provision relates to the deadline by which Fee Review Applications must be filed. 77 Pa.Cons.Stat. § 531(5). This omission means that the Bureau has no statutory authority to impose a timely billing requirement and that the Bureau's attempt to do so constitutes administrative fiat. See Pennsylvania Human Relations Commission v. Uniontown Area School District, 455 Pa. 52, 313 A.2d 156 (1973) (regula-

tion is invalid if inconsistent with legislative intent or beyond the scope of statutory authority).

Assuming, *arguendo*, that the Bureau has authority to establish a billing deadline, the proposed rule is seriously flawed. The employee who has a 91 day inpatient stay demonstrates one aspect of the problem created by this rule. Even if the hospital submits its bill to the insurer immediately after the patient is discharged, the proposed rule would deem it to be untimely because the hospital billed more than 90 days from the first date of treatment. Interim billing is not an adequate solution to this situation. Most hospitals do not submit interim bills for stays of only 90 days. Moreover, since cost outliers and day outliers cannot be calculated until the patient has been discharged, insurers have no way of paying interim bills. For this reason, interim bills would serve no purpose.

Another problem with the proposed timely billing rule is that, despite due diligence, providers may not know that they have treated a patient for a work-related condition within 90 days. For instance, I recently had a case in which, when the patient was admitted, he told the hospital that his health insurer should be billed. The hospital did so and received payment from the health insurer. Several months later, the health insurer retracted its payment, asserting that the condition for which the patient was treated was work-related. The proposed rule would have prevented the hospital from thereafter submitting its bill to the workers' compensation insurer, even though, until the health insurer retracted its payment, the hospital had no reason to suspect that the patient's condition was work-related. Further, Section 127.201(d) of the proposed rule would bar the provider from billing the patient, despite the fact that he was at fault for providing the hospital with incorrect information about his insurance.

Even if a provider knows that a patient's condition is work-related, it is sometimes difficult for the provider to identify the responsible insurer. Where there are issues of statutory employment or borrowed servants, the identity of the employer (and its insurer) may not be resolved until the conclusion of a lengthy legal proceeding. For this and other reasons, within the 90 day billing window, even the employee may not have sufficient information for the provider to submit its bill (i.e. claim number, date of injury, employer's name, insurer's name, insurer's address). And, sometimes, lacking a statutory duty, employers are reluctant to disclose this information to providers. While it may be possible to obtain the name of the insurer from the Bureau if the name of the employer is known to the provider,[1] because that insurance information is not available online or by

1. Of course, the employer's name may not be known to the provider. As noted above, this is especially true in cases of statutory employment or borrowed servants, where the patient's actual employer is not necessarily the same as the nominal employer.

telephone,[2] the process can take several weeks, rendering it difficult to comply with the proposed 90 day rule.

The foregoing mandates the conclusion that, if there is to be a timely billing requirement, it should not begin on the date of first treatment. Rather, it should start when the provider receives a Notice of Compensation Payable, a Notice of Temporary Compensation Payable, or, in cases of disputed liability, an order from a Workers' Compensation Judge showing that the patient was treated for a compensable injury. Only after the provider has these documents can the provider properly be charged with knowledge that a workers' compensation claim has been reported, that the injury has been deemed to be compensable, of the nature of the work-related injury, and of the identity of the insurer to which the bill should be submitted. It necessarily follows that the timely billing clock should not begin to run until the provider receives this information.

In addition, AAHAM submits that the proposed 90 day deadline is *sui generis* and unreasonable. I know of no other insurance that imposes such a short billing period. Medicare, for instance, allows between 15 and 27 months (See 42 U.S.C. § 424.44); Pennsylvania Medical Assistance permits at least 180 days (See 55 Pa.Admin.Code § 1101.68); and, many health insurers allow at least one (1) year. Moreover, virtually all of these payers have exceptions to their timely billing rules. For example, Medical Assistance will pay a bill submitted more than 180 days after the service if the provider billed another payer first. 55 Pa.Admin.Code § 1101.68(c)(2). In contrast, the proposed rule permits no exceptions.[3]

As a result of the more reasonable deadlines imposed by most governmental plans and private health insurers, providers' billing offices are not prepared to comply with a 90 day deadline that is unique to Pennsylvania workers' compensation. Further, I can conceive of no reason why workers' compensation should impose a significantly shorter deadline than that of almost all other payers.

Another area of concern to AAHAM is the proposal to establish a "usual and customary charge" database that will be used to calculate the reimbursement to certified burn units and Level I and II trauma centers that render care for an immediately life-threatening or urgent injury. While the current regulations contemplate that reimbursement under the trauma and burn exceptions will be made at "[t]he charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided," 34 Pa.Admin.Code § 127.3, until now, the Bureau has recognized that an accurate database of charges does not exist. The commercially

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2. In some states, this information is readily available. New Jersey, for instance, places its database of employers and insurers on the Internet. See www.njcrib.com/pcov/policycoverage.asp.

3. Indeed, as written, the proposed regulation would seemingly bar a provider from billing more than 90 days after the first date of treatment, even if the insurer initially denies liability. This scenario confirms the conclusion that, the timely billing period should be tolled until the provider is notified that the insurer has admitted liability or that a workers' compensation judge has entered an order deeming the insurer to be liable.

available databases are flawed by data that is as much as two (2) years old and an inability to identify comparable hospitals within a relevant geographic area.[4] While the task of compiling an adequate database would seem to be Herculean, AAHAM has no objection to the Bureau doing so. AAHAM fears, however, that the devil may be in the details. The proposed regulations shed no light on how this database will be compiled and offer no assurance that the database will accurately reflect charges made by comparable hospitals. Accordingly, AAHAM asks that the regulations clarify the Bureau's proposed methodology and assure that the new usual and customary charge database will not eviscerate Act 44's trauma and burn exceptions.

Two issues are raised by Section 127.211(c)'s provision that an employer may not seek payment from an employee for a "reported work injury until the provider has received an EOR from the insurer denying that the treatment is related to the work injury or denying liability for a work injury." First, the proposed regulation assumes that providers have some way of knowing whether the condition for which a patient has been treated is a work injury and that it has been reported. In fact, this information is not available readily to providers unless insurers choose disclose it. The proposed regulations, however, do not require that insurers release this information to providers. Absent any such mandate, it is unreasonable to impute this knowledge to providers.

Moreover, proposed Section 127.211(c) prevents a provider from billing the patient when an insurer fails to promptly send an Explanation of Reimbursement ("EOR"). The fact that Section 127.211(d) provides that an insurer's failure to timely issue an EOR constitutes a violation of the Act offers little relief to a provider who has an unpaid bill since the provider must rely on the Bureau to take enforcement action against the insurer. During that potentially lengthy proceeding, the proposed regulations would unfairly prevent the provider from seeking payment from the patient. Further, if the Bureau decides not take enforcement action, the provider's bill will never be paid.

A better rule would be that a provider may not bill the patient until 45 days after the provider has submitted a bill to the workers' compensation insurer. This would allow insurers ample opportunity to pay or deny the claim. Where the insurer does neither and the patient is billed, the patient may file an appropriate petition to compel action by the insurer. Absent the ability of a provider to bill the patient, the patient has no incentive to take action against the insurer and, as a result, the provider's bill will likely remain unpaid.

With regard to the Fee Review process, I note that Section 127.259(a) deletes the provision that Fee Review Hearings are *de novo*. While it does not appear that the Bureau intended a substantive change, the omission of the *de novo* language could be construed to suggest that the hearing officer should give deference to the administrative decision. To clarify that this was not intended, the proposed regulations should retain the express statement that Fee Review Hearings

4. The biases in databases of this type are the subject of class action litigation in First State Orthopaedics, et al. v. Concentra, Inc., et al., U.S.D.C. E.D. Pa. C.A. No. 05-cv-04951.

are *de novo*.[5]

Two of the definitional changes are problematic. First, "Charge master" is defined as a list of a "cost-based reimbursable providers' rates of reimbursement." Since providers are reimbursed different amounts by different payers, the "rate of reimbursement" to which this definition refers is unclear. Moreover, since a cost-based provider's reimbursement is supposed to use the provider's actual charge to calculate the Act 44 payment, the provider's rate of reimbursement by other payers is not relevant. See e.g. proposed Section 127.117(b) (provider's *actual charge* shall be multiplied by cost-to-charge ratio to determine reimbursement). AAHAM therefore suggests that the Bureau retain the current regulation's definition of charge master ("[a] provider's listing of current charges").

Second, the definition of "Provider under review" explains that "[w]hen treatment is provided or ordered by a provider whose activities are subject to direction or supervising by another provider, the directing or supervising provider shall be to the provider under review." The effect of this provision is that, when UR is conducted, providers who are excluded by this definition will not be given notice of the UR and will not have an opportunity to participate in the UR. See Proposed Section 127.806(b). Since those providers will nevertheless be bound by the URO's determination, this can result in an unconstitutional deprivation of the non-participating provider's right to payment (a property right) without due process of law. See e.g. Lyness v. Pennsylvania State Board of Medicine, 529 Pa. 535, 542 605 A.2d 1204, 1207 (1992). To cure this constitutional infirmity, "provider under review" should be defined as any provider whose care is being reviewed by a URO.

Section 127.209a deems any entity (other than insurers and self-insurers) that "engages in calculating reimbursement or paying medical bills" to be "engaged in the business of adjusting or serving injury cases." As a result, all such entities are required by 77 Pa.Cons.Stat. § 997(c) to register with the Department of Labor and Industry and file reports. To the extent that proposed Section 127.209a expressly reaches entities retained by providers to reprice bills, AAHAM submits that it casts an improperly wide net. The purpose of Section 997(c) is to give the Bureau jurisdiction over entities that have de facto responsibility for paying claims, even if they are not insurers or self-insurers. In this way, the Bureau can exercise authority over these entities and take steps to see that claims are being paid correctly. In contrast, an entity retained by a provider has no input into an insurer's decision to pay a claim. Since the adjustment and servicing of claims are functions that belong exclusively to payers, Section 997(c) has no application. To nevertheless define providers' repricers as engaging in the adjustment or servicing of claims is sophistry. Thus, the Bureau's effort to bring entities that contract with payers into the ambit of Section 997(c) constitutes an act that exceeds its statutory authority.

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5. In addition there appears to be an editorial error in Section 127.252(a). The proposed regulation says that a provider must file a Fee Review Application "30 days following the insurer's receipt of the first notification of a disputed treatment" and that "the insurer shall be deemed to have received notification of disputed treatment 3 days after the notification is deposited in the United States Mail." Presumably, both of the references the "insurer" should be to the "provider."

Thank you affording AAHAM this opportunity to comment on the important issues raised by the proposed regulations.

Very truly yours,

Howard R. Maadoff

cc: Phila. AAHAM Board
Thomas A. Peifer

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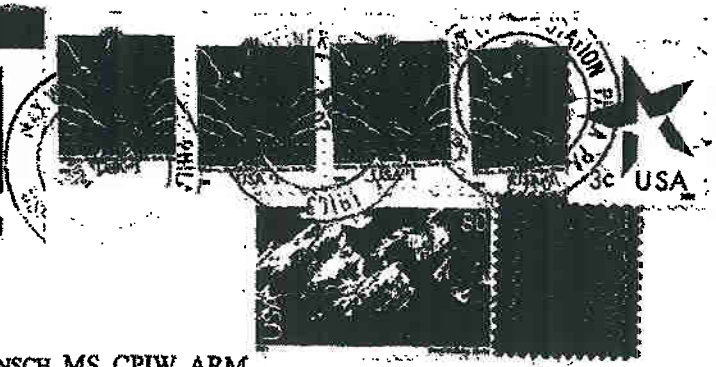

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