ORIGINAL: 2542

Gelnett, Wanda B.

From: LI, BWC-Administrative Division [RA-LI-BWC-Administra@state.pa.us]
Sent: Wednesday, July 05, 2006 8:31 AM
To: Wunsch, Eileen; Kupchinsky, John; Howell, Thomas P. (GC-LI); Kuzma, Thomas J. (GC-LI)
Subject: Comments on Regs from Karla

-----Original Message-----
From: Diana Lorine [mailto:dlorine@lrcdisability.com]
Sent: Thursday, June 29, 2006 4:37 PM
To: RA-LI-BWC-Administra@state.pa.us
Subject: Questions Rules and Regs

Attached are questions regarding the Proposed Medical Cost Containment Rules and Regulations in advance of the July 10 public meeting in Philadelphia.

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Questions for the Public Meetings on the Bureau of Workers' Compensation's Proposed Medical Cost Containment Regulations.

1. Section 127.801 says the "Department will operate a UR process"—new wording.

*What is meant by this change?

2. Section 127.803

*Since wording no longer says "random assignment" to UROs does this mean there will be a change in the way URs are assigned?

3. Section 127.806 Again, no mention of "random assignment"

*How does the Bureau intend to assign URs?

4. Section 127-807 relating to requests for UR reassignment

*How is this going to differ from the current practice?

5. Section 127.808 regarding the Bureau identifying situations that constitute a conflict of interest.

*Will the RUO continue to be able to identify specifics under the general circumstances that Bureau identifies?

6. Section 127.811 relating to UR of "entire course of treatment"- the Department writes that "any inconsistencies between reviewers will be resolved through consultation of the involved reviewers".

*This consultation of the "involved reviewers" could be seen as reviewers influencing others' opinions.

*How can an independent opinion be insured in this case?

*Another problem, depending on the timelines to complete a review, the Reviewers' reports may be completed at different times. This would not allow for discussion before completion of their reports.

*Who is to determine if and what an "inconsistency" entails?

7. Section 127.821 relating to "pre certification"

*What is the distinction between "pre certification" and "prospective" review?

*If by adding "pre certification" is the Bureau requiring that a URO pre-approve a treatment/procedure? If so, is this not getting into the area of approving for payment of treatment? If so, this would be addressing issues the URO is neither permitted to address under the "Act" or would a URO be qualified to "precert" treatment.

*Why is the assignment of the UR Request to a UR"interlocutory"? Was it meant to say "Determination".

*Was there a typo and was the second UR to mean URO?

8. Section 127.851 relating to requesting & providing medical records: The proposed time is 15 days for a UR Request and 7 days for a Recertification/redetermination for the Provider to forward records.

*Note that in a significant number of UR Requests the insurer has incorrectly listed contact information (address and phone number) for the Provider under Review. This decreased timeline would be even more of a problem with the shortened collection period. As a URO we are concerned about the records collection process with this shortened timeline.

9. Section 127.852 relating to scope of review of URO: UROs shall decide the extent to which treatment subject to ..... will remain reasonable and necessary "in the future". Section 127.864 defines the time frame "not to exceed 180 days"

*Is it meant that a URO "shall decide the extent to which treatment subject to concurrent or prospective review will remain reasonable and necessary" to be defined as 180 days?

10 . Section 127.856 states that the insurer may submit "peer-reviewed, independently funded studies and articles and reliable medical literature which are relevant to the reasonableness and necessity of the treatment under review to the URO".

*Not all such submissions are quality research. Does the Department intend

that the URO pass on all submissions of studies submitted by the insurer to the Reviewer if that study is questionable?

*Since the practice of medicine is an ever changing art/science, who will insure that the articles are the most recent on the subject? Does the author of the article need to be of like license and specialty of the Provider under Review?

*Does the claimant have opportunity to submit his/her article/studies in rebuttal?

Section 127.861 requires the URO to issue a Determination that treatment is unreasonable and unnecessary if the Provider under Review does not submit records within 15 days.

*Is there no provision with this change for the URO to proceed with a review if the employee submits an Employee Statement?.

* The Bureau has advised UROs up to this point to proceed with a review if we receive no medical records but we receive an Employee Statement. Is this to be changed?

*Will the employee have no opportunity under this provision to submit a statement?

11. Section 127.862 relating to requests for UR deadline for UR Determination. Proposed rules state that a "request for UR shall be deemed complete upon the UROs receipt of the medical records or 18 days from the date of notice of the assignment, whichever is earlier" As proposed, the deadline for completion of the UR Determination can fall within the timeline that the Provider Under Review has to timely submit records. For example: NOA is dated 6/2/06. URO has up to 6/7/06 to send request for records. If URO postmarks request for records on 6/7/06, the PUR has up to 15 days (6/22/06) to send records. If PUR postmarks records on 6/22/06 and URO receives them on 6/23/06 they would be considered timely. However, in this case, by providing that the request be deemed complete "upon the earlier" of receipt of medical records OR 18 days from NOA, the 18 days from the NOA is earlier than the postmark and receipt date of the provider's records. The request for UR would then be deemed complete BEFORE the legitimate time that the PUR has to submit records. In addition, the shortened timeframe to render a Determination (20 days for a UR request and 10 days for a recertification or

redetermination) will not give the Reviewer adequate time to contact the PUR if requested and then adequately review the material, research, and to research guidelines for treatment. Additionally, in the case of the UR of the "entire course of treatment" this time period would not allow for adequate resolution of inconsistencies between reviewers.

12. Section 127.863 relating to assignment of UR request to reviewer. The "Act", Section 306 f.1, Section 6 (i) the provision is for "utilization Review of all treatment rendered by a provider licensed in the same profession and having the same or similar specialty (emphasis added) as that of the provider of treatment under review."

* Is it the intent of this proposed Rule to limit who can be a potential reviewer for a specific case? it has been our experience that a provider with a Board Certification/Specialty may be providing services that do not usually fall within that Board Certification/Specialty and thus the URO is obliged to assign to a Reviewer of that Board Certification when the Reviewer should actually be in the same "practice" for that procedure/treatment under review. For example, a Gynecologist who was providing hot packs and ultra sound treatments was not providing the type of treatment normally provided by a Gynecologist. Therefore, the appropriate Reviewer should have been one who is of "like license" (MD/DO) but who is providing similar treatment (practice). However, under this case, the URO was required to assign to a Gynecologist.

13. Section 127.1051 relating to the authorization of UROs/PROs. The "Act" clearly states that "The department shall authorize utilization review organizations to perform utilization review under this act". Section 127.1051 states that "The Bureau may authorize UROs/PROs to perform reviews under this chapter through an award of contracts under 62 Pa C.S. (relating to Commonweath Procurement Code). The Bureau will award contracts on a competitive sealed basis in accordance with the Commonwealth Procurement Code".

First, the Bureau of Procurement is "responsible for purchasing or contracting for equipment and supplies for the Commonwealth. (emphasis added) The Bureau is the

purchasing coordinator and exercises control over the acquisition of supplies and services, and awards contracts to suppliers." Under Part 1-"Chapter 4-Contract Use, Need and Authorization" of Pa C. S. 62 Procurement Code, it is clearly defined when contracts may be used and what satisfies the need for a Commonwealth contract. Under Parts A and B of Chapter 4, the Department does not meet the "Need, Use, and Authorization" conditions to authorize UROs under the "Act".

If the Department's intent is to "authorize" UROs/PROs by means of an awarded "contract" via RFP, it appears that the Bureau/Department is acting as a "purchasing agent" for insurers/employers (see Part 1 "Policy Guidelines" for Act 57 of the Commonwealth Procurement Code 62-Section 101). This would mean that the Department/Bureau intends to pay for Utilization Reviews on behalf of insurers, despite the "Act" stating specifically in Section 306 (f.1)(6) iii, "The employer or insurer shall pay the cost of the Utilization Review".

*Is it the Bureau's intent to begin paying for Utilization Reviews on behalf of private insurers/employers?

*If the Bureau/Department intends to issue an RFP and begin paying for Utilization Reviews on behalf of private insurers/employers, what is the reason and what would be the criteria for the Bureau to eliminate and not award contracts to UROs that are qualified and meet the minimum requirements?

*Is it the Bureau's intent to set fixed prices for Utilization Reviews under this RFP proposal?

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July 6, 2006

MS. Eileen Wunsch
Chief, Health Care Services Review Division
Bureau of Workers' Compensation
Department of Labor and Industry
Chapter 127 Regulations-Comments
PO Box 15121
Harrisburg, PA 17105-5121

Dear Ms. Wunsch:

These comments are made with reference to the **Proposed Rule Making (34 PA, Code CH 127) Medical Cost Containment.**

It would appear that the Department of Labor and Industry is proposing changes to the Rules and Regulations of the Medical Cost Containment Section of the "Act" which would appear to conflict with, rather than interpret or clarify, the provisions of the PA Workers' Compensation Act (Act). These changes, particularly those in regard to the Utilization Review process, would be to the detriment of injured workers in the Commonwealth of Pennsylvania; would limit access to medical care; would increase costs to employers; would give excessive control of the Utilization Process to the Bureau of Workers' Compensation, thus loosing the impartiality of the current system, and are overall in direct conflict with the intent of the "Act" and the intended Legislation.

Section 127.805a, relating to medical treatment prior to acceptance of a claim and providing a means for review of medical treatment prior to acceptance of a claim is contrary to current case law.

In Section 127.811 relating to UR of "entire course of treatment"- the Department writes that "any inconsistencies between reviewers will be resolved through consultation of the involved reviewers". This consultation of the "involved reviewers" could be seen as reviewers influencing others' opinions. An "independent" opinion can not be insured in this case. Another problem, depending on the timelines to complete a review, the reviewers' reports may be completed at different times. This would not allow for discussion before completion of their reports. Additionally, who is to determine if and what an "inconsistency" entails?

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Section 127.821 relating to "precertification". This precertification is "in response to a rquest for a prospective UR" and requires the provider of possible treatment to go through hoops within a timeline to provide reasons why treatment is necessary. Through fault of his/her own, the injured worker may be denied this treatment because the provider did not get the information to the insured on the "Department-designated form" within 10 days (perhaps a delay in mailing, a busy medical practice). The insurer then is required to respond that it is willing to pay or that it declines to pay, citing its reasons. There is no requirement for the insurer to provide the medical criteria for the denial (other than unrelated or denial of liability). Thereafter, the injured worker has treatment further delayed while waiting for a full Utilization Review. This adds time delay and could have been accomplished with a Prospective Review and its timelines.

Section 127.842 relating to "redetermination". This sounds very much like the "Reconsideration" process in the original legislation. During the last Legislative changes to the "Act" the "Reconsideration" portion of Utilization Reviews was eliminated because it became impossible for the Bureau to collect the funds which it paid the URO on behalf of the claimant/defendant. Additionally, "redetermination" is requiring the Utilization Review Organization to determine if the "employee's medical condition has changed and the treatment is now reasonable and necessary". This is a decision for the final fact finder, the Workers' Compensation Judge, and not a URO Reviewer who has not seen or examined the injured worker to determine if, in fact, there is a change in medical condition. It was not the intent of the Legislature to have a URO determine changes in medical condition.

In Section 127.851 the proposed time is 15 days for a UR Request and 7 days for a Recertification/redetermination for the Provider to forward records. Note that in a significant number of UR Requests the insurer has incorrectly listed contact information (address and phone number) for the Provider under Review. This decreased timeline would be even more of a problem with the shortened collection period. This places providers and employees at a disadvantage. As a URO we are concerned about insuring fairness of the records collection process.

Section 127.856 states that the insurer may submit "peer-reviewed, independently funded studies and articles and reliable medical literature which are relevant to the reasonableness and necessity of the treatment under review to the URO". Note that not all such submissions are quality research. Does the Department intend that the URO pass on all submissions of studies to the Reviewer if that study is questionable? Since the practice of medicine is an ever changing art/science, who will insure that the articles are the most recent on the subject? Does the author of the article need to be of like license and specialty of the Provider Under Review? Also, there is no opportunity for the claimant to submit his/her article/studies in rebuttal

Proposed Rules Comments

Section 127.861 requires the URO to issue a Determination that treatment is unreasonable and unnecessary if the Provider under Review does not submit records within 15 days. There is no provision with this change for the URO to proceed with a review if the employee submits an Employee Statement. The Bureau has advised UROs to this point to proceed with a review if we receive no medical records but we receive an Employee Statement. This Sections stands in conflict with the Bureau's own guidelines.

The "Act" clearly states that a "utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request". In apparent conflict with the "Act" this proposed Rule requires the URO to complete the Review within 20 days. These timelines are also making the process more burdensome on the URO and the Reviewer. Qualified Reviewers are difficult to retain and, if they are held to even tighter timelines that the current time frame, it is feared that many Reviewers will no longer perform Reviews and those who do will likely increase their fees to make up for the additional time constraints. This would make the UR process more costly.

As above, Section 127.862 relating to requests for UR deadline for UR Determination. Proposed rules state that a "request for UR shall be deemed complete upon the UROs receipt of the medical records or 18 days from the date of notice of the assignment, whichever is earlier" As proposed, the deadline for completion of the UR Determination can fall within the timeline that the Provider Under Review has to timely submit records. For example: Notice of Assignment (NOA) is dated 6/2/06. URO has up to 6/7/06 to send request for records. If URO postmarks request for records on 6/7/06, the Provider Under Review (PUR) has up to 15 days (6/22/06) to send records. If PUR postmarks records on 6/22/06 and URO receives them on 6/23/06 they would be considered timely. However, in this case, by providing that the request be deemed complete "upon the earlier" of receipt of medical records OR 18 days from NOA, the 18 days from the NOA is earlier than the postmark and receipt date of the provider's records. The request for UR would then be deemed complete BEFORE the legitimate time that the PUR has to submit records. In addition, the shortened timeframe to render a Determination (20 days for a UR request and 10 days for a recertification or redetermination) will not give the Reviewer adequate time to contact the PUR if requested and then adequately review the material, research, and to research guidelines for treatment. Additionally, in the case of the UR of the "entire course of treatment" this time period would not allow for adequate resolution of inconsistencies between reviewers.

Section 127.863 relating to assignment of UR request to reviewer. The "Act", Section 306 f.1, Section 6 (i) the provision is for "Utilization Review of all treatment rendered by a health care provider licensed in the same profession and having the same or similarspecialty (emphasis added) as that of the provider of treatment under review."Currently, the Rules & Regulations define same or similar specialty as matching

the PUR's ABMS or AOA Board Certification. The wording of 127.863 mentions "same licenses and specialties" but does not actually describe if this is a change in the current interpretation by the Bureau. Again, it appears that the proposed Rule is in conflict with the Act by limiting who can be a potential reviewer for a specific case. It is noted by this URO that if the Department wishes to change this via Legislation, it has been our experience that a provider with a "Board Certification" may be providing services that do not usually fall within that Board Certification and thus the URO is obliged to assign to a Reviewer of that Board Certification when the Reviewer should actually be in the same "practice" for that procedure/treatment under review. For example, a Gynecologist who was providing hot packs and ultra sound treatments was not providing the type of treatment normally provided by a Gynecologist. Therefore, the appropriate Reviewer should have been one who is of "like license" (MD/DO) but who is providing similar treatment (practice). However, under this case, the URO was required to assign to a Gynecologist.

Section 127.864 relating to duties of reviewers – generally the Bureau proposes adding a requirement that reviewers specifically note the time frame within which treatment may continue to be reasonable and necessary and set this time frame not to exceed 180 days. This is in conflict with current Case Law. It also puts additional burden on the provider and the injured worker to seek approval every 180 days for continued treatment, which can delay necessary treatment, negatively affect recovery and return to work, and add expense to the insurer to pay for the review (see 127.1051 for comments on who is to pay for reviews). If an insurer believes that treatment is going on too long, they have the option of filing a Utilization Review. There seems no need to burden the provider and injured worker with the need to prove treatment that has already been determined to be reasonable and necessary. This also places responsibility on the Reviewer to give a specific timeline for treatment when, in fact, individuals respond differently to treatment, even when there are reasonable expectations for outcomes.

Section 127.905 relating to petition for review—transmission of records, requires UROs to forward medical records obtained for its review to the WCJ to rule on a petition and further provides for the URO to forward the UR Report and requires that the URO verify the authenticity and completeness of the record. To this point in time, the URO has been notified that a Petition has been filed and to which WCJ the case has been assigned. The URO is advised that, if the WCJ requests the records, we are to supply them. Since this is a deNovo hearing, records may not be admissible. This requirement by this proposed Rule seems to add an additional expense to the Bureau to reimburse the URO for records to be copied and sent to a WCJ when, if fact, these records may not be admissible.

Section 127.1051 relating to the authorization of UROs/PROs. Again, it appears that the Department is proposing Rules in conflict with the "Act". The "Act" clearly states that "The department shall authorize (emphasis added) utilization review organizations to perform utilization review under this act". Section 127.1051 states that "The Bureau may authorize (emphasis added) UROs/PROs to perform reviews under this chapter through an award of contracts under 62 Pa C.S. (relating to Commonweath Procurement Code). The Bureau will award contracts on a competitive sealed basis in accordance with the Commonwealth Procurement Code".

First, the Bureau of Procurement is "responsible for purchasing or contracting for equipment and supplies for the Commonwealth. (emphasis added) The Bureau is the purchasing coordinator and exercises control over the acquisition of supplies and services, and awards contracts to suppliers." Under Part 1-"Chapter 4-Contract Use, Need and Authorization" of Pa C. S. 62 Procurement Code, it is clearly defined when contracts may be used and what satisfies the need for a Commonwealth contract. Under Parts A and B of Chapter 4, the Department does not meet the "Need, Use, and Authorization" conditions to authorize UROs under the "Act".

If the Department's intent is to "authorize" UROs/PROs by means of an awarded "contract" via RFP, it appears that the Bureau/Department is planning to act as a "purchasing agent" for insurers/employers (see Part 1 "Policy Guidelines" for Act 57 of the Commonwealth Procurement Code 62-Section 101). This would mean that the Department/Bureau intends to pay for Utilization Reviews on behalf of insurers, despite the "Act" stating specifically in Section 306 (f.1)(6) iii, "The employer or insurer shall pay the cost of the Utilization Review".

The Proposed Rulemaking states that the RFP "issued by the Bureau will set forth the specific minimum requirements that an offeror's proposal must address". It also states that "The Bureau is not required to award a contract to every offeror that submits a proposal that meets the minimum requirements offered by the RFP". The Bureau stating that it "is not required to award a contract to every offeror that submits a proposal that meets the minimum requirements" indicates that the Bureau will arbitrarily and selectively eliminate qualified UROs from being "awarded a contract" or be "authorized" to perform Utilization Reviews

This entire Section in regard to the Bureau "awarding contracts" and issuing "RFP"s, flies in the face of the intent of the Act. The URO process was developed by the Legislature to give all parties, insurers/employers, employees, and providers an unbiased (randomly assigning URs) venue to address reasonableness and necessity of treatment. The Bureau, with the proposed language, appears to be attempting to control the URO process by awarding contracts. If the Bureau (Department) uses the Procurement Code as

it was intended, it would require the Bureau to pay for the service (Utilization Review). It would seem that the Bureau is attempting to price fix the process by requiring "bidding", and by selecting UROs, not on their ability to meet the minimum requirements established or their history of providing an excellent service, but on some arbitrary selection process, thus limiting the insurers/employers, employer, and providers to only a few UROs, selected and controlled by the Bureau. This Section also does not require that the UROs "awarded" a contract to perform Utilization Reviews will be assigned URs. It implies that the Bureau will control who is assigned URs. This, again, flies in the face of the intent of the Legislation and would imply that the Bureau would prefer that the UROs act in the manner of the PRO under Act 6 of the Motor Vehicle Financial Responsibility Act, where Peer Review Organizations are beholding to the insurers who assign them cases and tend to have findings that are biased toward the insurer. The Bureau is attempting, under the Section, to control costs and outcomes and to eliminate UROs. It should be noted that approximately six (6) years ago there were nearly four (4) times the number of Utilization Review Organizations currently authorized by the Bureau to perform URs. This seems a clear indication that the Bureau wants to reduce the numbers of qualified organizations and control the process. The more the UROs are limited in number, the more biased the outcomes will be.

Respectfully submitted,

Diana L. Lorine

Diana L. Lorine, RN, CDMS, CCM
President

Cc: John Kupchinski, Bureau Director
Honorable Andrew Dinniman, Senator
Honorable Carole Rubley, House of Representatives
Independent Regulatory Review Commission

Gelnett, Wanda B.

From: LI, BWC-Administrative Division [RA-LI-BWC-Administra@state.pa.us]
Sent: Friday, July 07, 2006 8:00 AM
To: Wunsch, Eileen; Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: Comments on Regs. from Karla

-----Original Message-----
From: Diana Lorine [mailto:dlorine@lrcdisability.com]
Sent: Thursday, July 06, 2006 1:26 PM
To: RA-LI-BWC-Administra@state.pa.us
Subject: Proposed Rules Comments

Attached please find my comments on the proposed Rules regarding Medical Cost Containment. Please also accept this as my request to speak at the July 11, 2006 meeting in Philadelphia

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