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July 6, 2006

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Ms. 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: **COMMENTS AND OBJECTIONS TO PROPOSED RULEMAKING**
Department of Labor and Industry Medical Cost Containment Regulations
WorkWell Physical Medicine, Inc.

Dear Ms. Wunsch:

This law firm represents WorkWell Physical Medicine, Inc. ("WorkWell"). Please treat this correspondence as WorkWell's comments and objections to the Department of Labor and Industry's Proposed Rulemaking relating to Medical Cost Containment regulations published at 34 Pa. Code Ch. 127. The Proposed Rulemaking was published at 36 *Pa. Bulletin* 2913 (June 10, 2006). Each issue and objection will be addressed separately.

LIST OF DESIGNATED PROVIDERS: THE SINGLE POINT OF CONTACT PROHIBITION IS INCONSISTENT WITH THE ACT AND LEGISLATIVE INTENT

The Proposed Rulemaking would create a new prohibition not justified by the Workers' Compensation Act ("the Act") by effectively eviscerating WorkWell's unique List management single point of contact function. The Proposed Rulemaking states as follows:

> (b) The employer shall **prominently** include the names, addresses, telephone numbers and area of medical specialties of **each of the** designated providers on the list. **The employer may not require the employee to report to a single point of contact before receiving treatment from a provider on the list.**

34 Pa. Code § 127.752(b) (proposed); 36 *Pa. Bulletin* 2935 (6/10/06).

The Proposed Rulemaking also states:

> (e) **If the list references a single point of contact or referral for more than one provider on the list, all providers associated with the single point of contact or referral shall be considered a single provider under subsection (a).**

34 Pa. Code § 127.752(e) (proposed); 36 *Pa. Bulletin* 2935 (6/10/06) (emphasis in original).

WorkWell provides a variety of management services on behalf of Pennsylvania businesses. WorkWell assists businesses in developing their List of Designated Providers ("the List"). WorkWell establishes a single point of contact on the list for the *injured worker's* benefit. WorkWell helps injured workers to secure fast scheduling of appointments for a variety of medical care and conditions following work-related injuries. WorkWell facilitates immediate patient access to medically necessary care; coordinates care with physicians and injured workers for follow up care; provides case management services; provides quality assurance analysis; and performs a variety of other functions that are directly linked to *ensuring injured workers receive the full gamut of medically necessary medical care, diagnostic tests, rehabilitation or any other service to resolve the work related injury.*

WorkWell's program has achieved high satisfaction ratings from both businesses and injured workers. WorkWell has scores of extremely satisfied clients, many of which include Fortune 500 companies with a major employment presence in Pennsylvania. WorkWell facilitates efficient and safe return of injured workers to the work place. Not a single union complaint or grievance has ever been filed concerning WorkWell's quality management protocols. *Not a single union or other employee complaint or grievance has ever been filed concerning WorkWell's single point of contact on the list it develops for businesses.* WorkWell's quality management protocol, including the single point of contact, fosters both the intent and purpose of the legislative reforms enacted in 1993 and 1995.

Section 306(f)(1)(i) of the Act states, in part, with regard to the List, as follows:

> Provided an employer establishes a list of at least six designated health care providers, *no more than four of whom may be a coordinated care organization* and *no fewer than three of whom shall be physicians*, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled *by the employer or the employer's insurer* unless employment, ownership or control is disclosed on the list.

77 P.S. § 531(1)(i) (emphasis added).

The General Assembly amended § 531(1)(i) in 1993 to allow employers more flexibility to assert control over injured workers' access to providers on the employer's List. The time restriction was expanded from 30 days to 90 days. The legislative purpose and intent of the § 531(1)(i) List amendment was to control costs and give employers greater authority than existed under prior law. The legislative intent to expand employer control over the employer's list development imposed only three restrictions:

- Between one and four COOs may be included on the List, but no more;

- At least three physicians, defined by the Statutory Construction Act as medical doctors and doctors of osteopathic medicine (1 Pa.C.S. § 1991) must be included on the List, but the employer may include on the List as many MDs or DOs as it desires; and

- The employer must disclose to employees if any physician or provider on the List is employed, owned or controlled by the employer itself or the employer's insurer.

These are the only three exceptions to the employer's broad authority to establish a List. Under the Statutory Construction principle *exclusio unius alterius*, a list of specific exceptions must be construed to include only those items on the list; there are no other exceptions that can be implied or inferred. 1 Pa.C.S. § 1924 ("exception

expressed in a statute shall be construed to exclude all others"). Accordingly, under prevailing Statutory Construction principles, the Department or the Bureau cannot promulgate a regulation that includes more restrictions on the employer's right to develop the List than the three articulated in the statute.

The Proposed Rulemaking at both § 127.752(b) and § 127.752(e) would create restrictions on the employer's right to develop the List that are not authorized by the three limited exceptions and would, therefore, violate the statute and legislative intent. Nothing in the exceptions articulated under § 531(1)(i) prevents or prohibits the employer from establishing a single point of contact before the injured worker receives treatment from the provider on the List. Nothing in the three exceptions articulated in § 531(1)(i) justifies the regulation at subsection (e) under which a single point of contact (that facilitates *injured workers access to care* and does not eliminate the injured worker's choice to access physicians on the List) changes 6 providers into a single provider. The proposed regulation unlawfully eradicates all of the physicians "associated" (whatever that means) with the single point of contact and requires the employer to virtually double the list it has already developed, since its List of 6 would only count as a List of 1. Accordingly, the single point of contact prohibition under subsection (b) and the reduction of the List from 6 to 1 (for all providers "associated" with the single point of contact) do not fall within the finite List of three exceptions created by the Legislature. The Department has no authority to create additional statutory exceptions beyond the existing three in § 531(1)(i). Therefore, the proposed prohibitions on the single point of contact on the List are beyond the scope of delegated authority, are unconstitutional, and must be stricken in their entirety in the final rulemaking.

Two other points of construction justify WorkWell's objection. First, subsection (b) makes it unlawful for an employer to have a single point of contact on the List. But, subsection (e) authorizes the single point of contact, yet shrinks every provider associated with the single point of contact to a single provider on the List. The single point of contact is illegal under subsection (b) but lawful under subsection (e), albeit with a penalty. This demonstrates the Department's arbitrary and unlawful approach to these provisions. Second, the term "associated" in subsection (e) is extremely vague. How can anyone conceivably understand the breadth and scope of potential relationships that fall within the rubric of "associated" in order to understand which bundle of providers no longer stand alone, but are combined into a single provider? These drafting anomalies demonstrate the arbitrary and unlawful nature of subsections (b) and (e). Each provision in its entirety must be stricken from the final rulemaking.

The final objection to the unlawful List restriction in the proposed regulation is based on public policy. We are acutely aware of the employee freedom of choice principle

having served as co-counsel[1] in the Supreme Court's landmark decision in Martin v. WCAB (Emmaus Bakery), 539 Pa. 442, 652 A.2d 1301 (1995), in which the Supreme Court held that an employee retains the freedom to choose a type of practitioner (in the Martin case, a doctor of chiropractic) of the healing arts needed when none of those members of a particular profession are included on the list designated by the employer. Martin, 652 A.2d at 1303. In Martin, we aggressively and successfully argued all the way to the Supreme Court that an employee who suffers a neuromuscular skeletal injury for which chiropractic care is appropriate must retain the freedom of choice to access chiropractic care if the employer *fails to include* any chiropractors on the list. Martin continues to be viable, and stands for the proposition that the employee freedom of choice precept remains inviolate where the employer fails to act by including a particular profession on the list.

WorkWell's development of a single point of contact has absolutely nothing to do with the employer failing to act triggering the Martin freedom of choice rule. Even under Martin, if the employer creates a single point of contact and one MD, one DO, one chiropractor, one optometrist, one dentist, one podiatrist and one physical therapist are included on the List, the employee *loses* freedom of choice to select *any provider*, and is unequivocally restricted to treat with one of the providers on the List for 90 days.

Based on the foregoing, nothing in the statutory language and three limited exceptions under § 531(1)(i) of the Act, legislative history, legislative intent or Supreme Court case law justifies the point of contact prohibition in subsection (b) and the list reduction clause under subsection (e).

From public policy and injured worker protection perspectives, the single point of contact management function is entirely appropriate. The single point of contact actually *helps injured workers* through ease of appointment scheduling. In fact, using a single point of contact to coordinate care allows the injured workers to choose with whom and when to receive care more effectively. Each injured worker is allowed to absolutely retain freedom of choice to select the particular physician or provider within the list. The freedom of choice element remains viable, intact and completely unrestricted when the single point of contact is applied. The single point of contact on the List does absolutely no harm to the insured worker. As noted above, there has never been a single complaint or concern raised by any injured worker or any union with respect to WorkWell's quality, utilization and management functions provided to employers.

The WorkWell model benefits injured workers throughout the treatment process. For example, assume an employee is injured. The injured employee chooses a medical care

[1] I argued the case in Commonwealth Court leading to the decision in Martin v. WCAB (Emmaus Bakery), 161 Pa. Cmwlth. 637, 638 A.2d 294 (1994), developed the *allocatur* petition to the Supreme Court, and drafted the Supreme Court brief.

provider from the List and simply calls the toll free WorkWell intake line to schedule an appointment with the chosen provider. Clearly, the employee has exercised his or her right to choose a medical care provider. The scheduling has simply been facilitated by WorkWell. After the employee is evaluated by the medical provider, a course of treatment may be prescribed, *e.g.* an MRI and a series of physical therapy treatments. Rather than forcing the injured employee to research and determine where a convenient MRI center is and what physical therapy center can perform the prescribed treatments, the injured employee simply calls WorkWell which is already familiar with the case and can suggest appropriate providers and schedule timely appointments with the injured employee's chosen providers.

In addition, WorkWell's relationship with over 5,200 medical care providers specializing in occupational injuries within the Commonwealth can make care available to an injured worker more readily than if the worker attempted to schedule this care without WorkWell's assistance. This accelerated scheduling on behalf of the injured worker is accomplished using WorkWell relationships to schedule priority appointments. A worker could then begin treatment within a matter of hours or days rather than weeks.

Further, injured workers may be unaware of their ability to obtain immediate care in an emergency. Injured workers may think that they must seek treatment *only* with a panel provider even in an emergency. Even though this information is written on the panel, an injured employee may be confused as to what is or is not an emergency. By calling WorkWell an injured employee is informed of their rights in an emergency. This process often prevents an injured employee seeking treatment with a panel provider who is unqualified to treat their severe injury and re-directs the injured employee to the emergency room.

In summary, the WorkWell single point of contact is an efficient and effective process that facilitates patient access to care. According to one employer, injured worker convenience is accomplished through the program. *See* enclosed letter from TRACO company.

From a public policy perspective, the List reduction clauses in subsections (b) and (e) undermine critical cost containment mechanisms developed by WorkWell and implemented by thousands of businesses throughout the Commonwealth of Pennsylvania. The Proposed Rulemaking advances nothing other than an effort to undermine WorkWell's successful, albeit difficult to replicate, business model. These proposed amendments are particularly troubling as no rationale or reasoning has been provided for their suggestion. It is unclear who -- the insured, the injured employee or the insurer -- these proposed regulations are meant to benefit. The proposed regulations will complicate the treatment of injured Pennsylvania workers and detrimentally affect thousands of Pennsylvania businesses if they are adopted into final

regulation. The proposed provisions in subsections (b) and (e) are unlawful and must be removed in their entirety from the final rulemaking.

SELF-REFERRAL STANDARDS: REMOVAL OF THE 30-DAY TIME LIMITATION IS INCONSISTENT WITH THE ACT

The Department proposes to modify 34 Pa. Code § 127.302, in part, as follows:

> **[Within 30 days of receipt of the provider's bill and medical report, the] An** insurer shall supply a written **[explanation of benefits] EOR** under § 127.209 (relating to explanation of reimbursement paid), stating the basis for believing that the **[self-referral provision has] referral standards have been violated.**

34 Pa. Code § 127.302(a); 36 *Pa. Bulletin* 2934 (6/10/06).

Current law requires the insurer to identify and deny a claim within 30 days of receipt of the provider's bill if the insurer has evidence to suspect non-compliance with the self-referral standards. The Proposed Rulemaking would appear to remove the 30-day time limitation, without any basis in law or in fact.

The Act unequivocally requires insurers to pay provider's bills within 30 days of receipt. *See*, *e.g.* 77 P.S. § 531(5) (all claims must be paid within 30 days unless medical necessity of treatment challenged to utilization review organization). Removal of the 30-day time frame in § 127.302(a) would allow insurers an unlimited amount of time to pay claims. The self-referral prohibition in the Act, 77 P.S. § 531(3)(iii) is loosely patterned after the federal Stark II Act and regulations. 42 U.S.C. § 1395nn(a)-(h). I personally recommended and drafted the exception clause under 34 Pa. Code § 127.301(c) that adopts and incorporates by reference all future exceptions to the Stark amendments and regulations and the anti-kickback exceptions and regulations as exceptions to the self-referral prohibition contained in the Act. I spent numerous hours in 1993 and 1994 with Department and Bureau personnel explaining the impact and implications of the self-referral prohibition on the federal level, as well as the comprehensive exceptions that were adopted to that point, and continue to be adopted by the federal government.

Providers routinely comply with federal Stark guidelines. Once they are in compliance with federal guidelines, they remain automatically in compliance with the self-referral standards under the Act. There is no evidence or information to suspect problems relating to self-referral non-compliance. In the only case litigated to date on the subject, the Pennsylvania Supreme Court found the structure to be appropriate under the federal Stark II amendments and regulatory exceptions, and found that the physical therapy arrangement in the physician's office satisfied those guidelines. 84 Mining Co.

v. Three Rivers Rehabilitation, Inc., 554 Pa. 443, 721 A.2d 1061 (1998). The Court held "it strains this Court's imagination to understand why the 'in-office ancillary services' exception, which the Department expressly incorporated by reference in its 1993 notice, and later adopted in its 1995 regulations, would not apply to the facts here." *Id.* at 1066. The Supreme Court reversed Commonwealth Court and required that all physical therapy prescribed by a physician and furnished by in-office physical therapists be paid by the carrier.

The 84 Mining case demonstrates carriers' chronic failure to understand or comprehend the complex federal Stark II guidelines and exceptions. As a matter of public policy, and in order to be consistent with the 30-day payment restrictions under the Act, carriers cannot be given unlimited amounts of time to deny, delay or pend bills based upon erroneous ideas or misapprehension of federal law. Removal of the 30-day time limitation clearly violates the Act. Therefore, in the final rulemaking, the 30-day payment clause contained within the brackets in the proposed rulemaking must be reinserted in its entirety. If an insurer fails to make a challenge within 30 days from the receipt of the bill based on an alleged violation of the self-referral standards, the insurer must pay the bill in full.

If any change is warranted at all to § 127.301, new language should be added to ensure the ***insurer has affirmative evidence of non-compliance in order to deny reimbursement based upon an alleged violation of the self-referral standards.***

DOWNCODING: THE PROPOSED DEFINITION IS TOO BROAD

Under current law, insurers may not "downcode" providers' charges or codes without complying with the four standards set forth in the Act and regulations. *See,* 77 P.S. § 531(3)(vii)-(viii); and 34 Pa. Code § 127.207(a)(1)-(4). WorkWell does not object to the modifications in § 127.207, and supports the clarification/change in the language in § 127.207(a)(4) from "Medicare guidelines" to "Correct Coding Initiative."

WorkWell does, however, object to the definition of "downcode" which would be defined under new § 127.2 as follows:

> **Downcode – altering or amending the HCPCS, CPT, DRG, ICD or other code that a provider utilized to seek payment for a particular treatment, service or accommodation.**

23 *Pa. Bulletin* 2921 (6/10/06).

The Office of Inspector General, the agency charged with enforcement and development of civil False Claims Act, administrative violations and sanctions, and

facilitating Department of Justice fraud and abuse criminal investigations, defines "upcoding" as follows:

> Upcoding is billing for a more expensive service than the one actually performed. For example, Dr. X intentionally bills at a higher evaluation and management (E&M) code than what he actually renders to the patient.

65 *Federal Register* 59434, 59439 (October 5, 2000) (OIG model compliance guidelines for physician practices).

OIG also defines "unbundling" as follows:

> Unbundling (billing for each component of the service instead of billing or using an all-inclusive code). Unbundling is the practice of a physician billing for multiple components of a service that must be included in a single fee. For example, if dressings and instruments are included in a fee for a minor procedure, the provider may not also bill separately for the dressings and instruments.

Id.

OIG is the premier agency in the United States for fraud and false claims enforcement. The phrase "altering or amending" in the proposed definition of "downcode" is not correct and is far too broad. The concept of "downcoding" may occur only as result of a provider's "upcoding." Upcoding must be defined as OIG defines the term, which is an improper *billing of a level too high within a particular code set*. The definition of "downcode" in the regulations should be limited to "***reducing the level of the applicable code within a particular code set in which levels of codes are established***", such as the E&M codes.

The Department cannot allow insurers to "alter or amend" codes because insurers will and have changed one code to another. That does not constitute downcoding. Downcoding is simply not equivalent to an insurer's unilateral decision to apply a different code. Downcoding can only mean, based upon the legislative intent, that a provider billed a level of code that was too high within a particular code set containing inherent ranges within the code set that must be reduced. The concept of "altering" would broaden the insurer's ability to completely change a code from one item to another, which is unjustified and impermissible under the Act and prevailing definitions of the term.

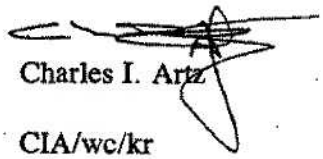
Moreover, including the concept of an "ICD" code is incomprehensible. The "ICD" codes involve the International Classification of Diseases. These are *diagnosis codes*. It is absurd to think that an insurer could change a physician's diagnosis. Because an insurer has no legal right, capability or authority to change a physician's diagnosis, it stands to reason the insurer cannot change a diagnosis code. Accordingly, the definition of "downcode" is inconsistent with the Act and should be revised pursuant to the suggested modifications outlined above.

Finally, the Department should include the definition of "unbundling" so that concept is not improperly interpreted as well.

* * *

WorkWell stands ready to assist the Department, Bureau of Workers' Compensation, the House and Senate Committees and the Independent Regulatory Review Commission in developing necessary modifications to the Proposed Rulemaking and to continue refining the Department's Medical Cost Containment Regulations to effectuate legislative intent. Thank you for your consideration. If you need additional information, please do not hesitate to contact me.

Sincerely,



Charles I. Artz

CIA/wc/kr
Enclosure
cc: WorkWell Physical Medicine, Inc.
Representative Michael Turzai