ORIGINAL: 2542

Gelnett, Wanda B.

From: LI, BWC-Administrative Division [RA-LI-BWC-Administra@state.pa.us]
Sent: Friday, July 07, 2006 3:20 PM
To: Wunsch, Eileen; Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: Comments on Regs. from Karla

-----Original Message-----
From: Tim Mosco [mailto:timmosco@sunstoneconsulting.com]
Sent: Friday, July 07, 2006 2:29 PM
To: ra-li-bwc-administra@state.pa.us
Subject: Comments for June 10th proposed rule

Attached please find our comments regarding the Department of Labor & Industry's June 10th proposed regulations. A formal copy has been mailed.

Thank you.

Tim Mosco
SunStone Consulting, LLC
Office: 717-489-1443
Fax: 717-489-1447
Mobile: 717-514-1848

SUNSTONE CONSULTING, LLC
HEALTHCARE REIMBURSEMENT & REGULATORY SOLUTIONS

July 7, 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

Dear Ms. Wunsch:

We appreciate this opportunity to submit comments related to the proposed rulemaking for the Department of Labor and Industry's June 10, 2006 publication related to changes to Chapter 127 (relating to workers' compensation medical cost containment). SunStone Consulting has extensive experience related to Pennsylvania Workers' Compensation billing and payment. We would appreciate consideration of our comments and recommendations.

Our comments follow:

Section 127.109

Relating to supplies and services not covered by fee schedule - to require that providers specifically identify supplies provided under this section.

Comments:

The change to this section specifically states "**The supplies shall be specifically identified on the HCFA 1500 or UB 92 form applicable to the treatment rendered.**" It is important to note that supplies used in a hospital outpatient setting will appear on both the UB92 and detailed billing forms. However, the UB92 billing form is not designed to provide a significant amount of detail. The detail is provided on the detailed bill.

This section appears to be directed to physicians and other free-standing facilities. However, it should be revised to specifically exclude hospitals and other cost-based providers that bill with both the UB92 and detailed billing forms. It is impractical, and in most cases impossible, for hospitals to provide any level of detail on the UB92 billing form.

Section 127.111a

(a) On and after January 1, 1995, inpatient acute care providers, whose payments under the act are based on DRGs plus add-ons under §§ 127.110--127.116 shall be paid using the DRG Grouper, relative weight, Geometric and Arithmetic Mean Lengths of Stay and Outlier thresholds in effect on the date of discharge.

Comments:

This modification violates the freeze on rates required by Act 44 of 1993 (the Act). Additionally, maintaining the unfrozen tables will be an additional administrative burden to the Bureau and payers instead of a relief.

Section 127.117 {also see 127.201(b)}

"...the Department proposes amending the means of identifying services in the charge master by reference to service descriptors instead of service codes."

Comments:

Using descriptions instead of service codes will provide no relief to the administrative burden currently being experienced. In practice, this method will cause significant confusion and an even heavier burden - mostly to the insurance industry. The payment process will remain essentially the same but the insurance companies will now have to input free-form text that could be as long as 40 characters ***per line item.*** Currently, most service code numbers are eight (8) to ten (10) characters.

Service descriptors are in no way fit to be used as a key to looking up payment rates. Clerical errors alone pose a significant risk to both hospitals and insurers. Furthermore, there is a significant risk of the same description occurring multiple times with varying payment rates. This is very common and occurs when the same service, supply or device is provided in multiple departments. The department-specific RCC drives the payment rate differences, which is appropriate based on the original intent of

Act 44. When an insurer must choose from a list of duplicate service descriptors with varying payment rates they are sure to choose the lowest rate listed ***without regard to whether it is the correct rate or not***. Note that the *correct* rate is currently *specifically* identified by the *service code* billed. The service code is the *only unique identifier* for a service or item and is the best way to identify an allowance under the current system. Any other option will foster confusion and discourage accurate payments.

This proposal essentially takes a very detailed and exact system with specific line-item pricing and moves to a highly speculative text-based system. By any data processing standards, free form text is inferior to a code-based system and should not be implemented. An extreme but relevant analogy would be searching for "John Doe"; would it be easier and more precise to search on the name "John Doe" or to use John Doe's Social Security Number? Clearly, a search on Social Security Number will provide only one result whereas a search on name may produce millions of results. There is no question that a specific unique code is superior.

We strongly object to this initiative and urge the Bureau to study this issue in more detail (e.g., an actual study by an independent firm with published results) and to delay the implementation of this language indefinitely. The effects of this proposal could be disastrous.

(c) To calculate rates frozen in subsection (b), the Bureau will multiply the provider's billed charges by the RCC associated with the appropriate Revenue Code. The appropriate Revenue Code is the Revenue Code that applies to the corresponding service descriptor in the charge master as of September 1, 1994, or the Revenue Code that applies to the corresponding service descriptor added to the charge master under subsection (f)(2).

Comments:

Many providers do not map RCCs based on revenue code only. The mapping of RCCs is often a function of the *grouping* or *mapping* schedule used in a hospitals reimbursement department. RCCs are created at a cost-center level and many of the specific services and items contained within an individual cost center have different revenue codes. For example, radiology departments often contain items with the following revenue codes: 32x, 27x, 62x, 94x, 25x and 63x. Mapping these items that reside in the radiology department to any other RCC (based only on revenue code) would simply be incorrect.

(g) Providers reimbursed under this section that, commencing _____ (*Editor's Note*: The blank refers to the effective date of adoption of this proposed rulemaking.), add new services for which the providers are reimbursed by Medicare on a fee-for-service basis, shall receive reimbursement according to the procedures established under this chapter for Medicare Part B services.

Comments:

Blending fee-based with RCC-based payments will create an even heavier administrative burden. Moving the traditionally RCC-based payment mechanisms to a fee-based process will force insurance companies to somehow delineate between the existing items that have frozen rates based on the Charge Description Master and RCCs, and the new items that are now fee-based for Medicare. This is simply not practical. Also, removing the frozen rates from the items that are now Medicare fee-for-service violates the freeze required by Act 44.

Section 127.201

(b) Cost-based providers shall submit a detailed bill including the service **[codes] descriptors** consistent with the service **[descriptors] codes** submitted to the Bureau in accordance with § **[127.155(b)] 127.117** (relating to **[medical fee updates on and after January 1, 1995 --]** outpatient acute care providers, specialty hospitals and other cost-reimbursed providers), or consistent with new service **[codes] descriptors** added under § **[127.155(d) and (e)] 127.117(d)--(i)**.

Comments: Please see our discussion under 127.117 above.

(c) Providers shall request payment for medical bills and provide all applicable reports required under § 127.203 (relating to medical bills--submission of medical documentation) within 90 days from the first date of treatment reflected on the bill.

Comments:

This language is far too restrictive and opens the door to many potential abuses. Medical providers often submit bills for payment to insurers and receive no payment or response. Upon follow-up, providers discover that office locations have changes, staff has been reassigned or there is simply no record of the bill. Often, this discovery is perilously close to, or beyond, the 90 days identified above. It would appear that the provider has no recourse when, through no fault of their own, a bill is mishandled or misplaced. Unfortunately, this occurs far too often, thereby making this time limit unreasonable. We feel that a minimum 1 year would be adequate, but suggest that this section be deleted completely.

Section 127.851

(c) The provider under review shall mail all requested medical records to the URO within 15 days of the postmark date of the URO's request.

Comments:

Considering the extreme workload of most providers' medical records staff, particularly in the hospital setting, it is unreasonable to require a turn-around of 15 days from the postmark date of the URO request. Adding to this problem is the fact that medical record information often is decentralized throughout the hospital and housed in the treating department(s). We recommend increasing this time to 30 days from the postmark date of the URO request.

****

We look forward to hearing your response to these comments and would appreciate the opportunity to discuss these issues with you in more detail.

Sincerely,

Timothy M. Mosco

Timothy M. Mosco
Senior Manager
SunStone Consulting, LLC
(717) 489-1443

ORIGINAL: 2542

Gelnett, Wanda B.

From: LI, BWC-Administrative Division [RA-LI-BWC-Administra@state.pa.us]
Sent: Friday, July 07, 2006 12:00 PM
To: Wunsch, Eileen; Kupchinsky, John; Kuzma, Thomas J. (GC-LI); Howell, Thomas P. (GC-LI)
Subject: Comments on Regs. from Karla

-----Original Message-----
From: Voelker, Frances [mailto:voelkerfa@upmc.edu]
Sent: Friday, July 07, 2006 10:25 AM
To: ra-li-bwc-administra@state.pa.us
Cc: tpeifer@haponline.org
Subject: FW: Workers' compensation proposed rule

Eileen,

I have entered comments throughout the document. My comments are noted as "RESPONSE" and are in bold.

I would like to add – it was very difficult to respond in this short of a time period, when most facilities were working on their Fiscal Year end.

-----Original Message-----
From: Tim Mosco [mailto:timmosco@sunstoneconsulting.com]
Sent: Thursday, July 06, 2006 3:38 PM
To: Voelker, Frances
Subject: Workers' compensation proposed rule

Francis,

Nice to talk to you today. Sorry for the late notice. Here is the proposed rule. Some of the language in here is almost too unbelievable to be true.

Tim Mosco
SunStone Consulting, LLC
Office: 717-489-1443
Fax: 717-489-1447
Mobile: 717-514-1848

attached Bulletin version of reg - not scanned